

**House Select Committee on Involuntary Commitment and Public Safety  
Thursday, November 13, 2025 at 9:30 AM  
Room 643 of the Legislative Office Building**

**MINUTES**

The House Select Committee on Involuntary Commitment and Public Safety meets at 9:30 AM on November 13, 2025 in Room 643 of the Legislative Office Building. Representatives Blackwell, T. Brown, Clark, Cunningham, Greene, Lambeth, Liu, Miller, Morey, Potts, Pyrtle, Reeder, Rhyne, Carson Smith, Charles Smith, Torbett, Wheatley, and Willingham are in attendance.

Representative Hugh Blackwell, Co-Chair, presiding.

Introduction of Sergeant-at-Arms and House Pages.

*Chairman Hugh Blackwell delivers opening remarks.*

*Chairman Hugh Blackwell recognizes Representative Timothy Reeder, MD, to deliver opening remarks.*

Representative Timothy Reeder, MD, delivers opening remarks.

Chairman Blackwell recognizes Ms. Jessica Boney, Legislative Analysis Division, to explain the charge of the committee.

Ms. Jessica Boney describes the charge of the House Select Committee on Involuntary Commitment and Public Safety.

*Chairman Blackwell introduces Mark F Botts, JD to present on involuntary commitment.*

**Mark Botts, JD, Associate Professor of Public Law and Government School of Government at UNC-Chapel Hill, presents on Involuntary Commitment (Attachment 1).**

Chairman Blackwell asks Mr. Botts to provide background information on the outpatient commitment process and research on the minimum recommended stays in hospitals to the Legislative Analysis Division, who can then share that information with the committee.

Chairman Blackwell asks Representative Timothy Reeder, MD, if he would like to ask questions. Rep. Reeder, MD, declines.

*Chairman Blackwell recognizes Representative John A. Torbett.*

Representative Torbett asks Mr. Botts about the space available in 24-hour facilities.

Mr. Botts answers that statutory law requires police officers to take individuals to a 24-hour facility. However, after an evaluation at a hospital emergency department, the emergency department may say they do not know of an available bed at a 24-hour facility. That could be due to a lack of beds, or to a lack of staffing.

Representative Torbett asks Mr. Botts if law enforcement officer's reports to a judge can include observations eyewitnesses told the officer, in addition to the officer's own observations.

Mr. Botts says the report may also include what witnesses have told the officer.

Representative Torbett asks Chairman Blackwell if he may ask one more question. Chairman Blackwell agrees.

Representative Torbett says he is concerned that 7-day custody orders may be issued repeatedly if there is no bed available. He asks Mr. Botts if commitment exams conclusions are a single opinion from one person or a three-judge panel, or if the criteria are so exact that the boxes could be checked off easily.

Mr. Botts says the commitment exam is performed by one person, but two commitment exams must be performed prior to a court hearing. Those exams are both performed by commitment examiners, just at different stages of the process.

Representative Torbett asks Mr. Botts if the exams are just boxes being checked and the outcome would be the same regardless of the individual performing the exam.

Mr. Botts says the second examiner could disagree with the first. There are forms provided to the examiners that have check boxes, but also a space to write down an explanation for why they are checking that box.

*Chairman Blackwell recognizes Representative A. Reece Pyrtle, Jr.*

Representative Pyrtle says he heard a similar presentation to Mr. Botts' twenty years ago when he was a police officer. Representative Pyrtle says in practice, the system is much more complex than it appears in the presentation. For example, when a law enforcement officer picks someone up and transports them to a crisis center for an evaluation and the individual is determined to need treatment, sometimes a bed is not found before the crisis center closes at 5:00PM. Then, the officer must transport the individual to a hospital, which triggers another evaluation. And even if a bed is found prior to 5:00PM, often the officer will have to take the individual to hospital to be medically cleared. Representative Pyrtle says that if that individual has pending charges, the only facility available to them will be a state facility. And that individual may have to wait in the emergency department for weeks or months before a bed becomes available.

Mr. Botts says he agrees with everything stated by Representative Pyrtle. Mr. Botts says that a new law which sends more people to a commitment examiner may also mean more people need to go to a 24-hour facility. But there is already a lack of capacity. There is a question of what will happen if you add more people to that process.

Representative Pyrtle thanks Mr. Botts for what he does and thanks Speaker Destin Hall for getting the committee together and says there is a lot of work to be done by the committee.

Mr. Botts says a possible answer may be to build more 24-hour capacity. Another answer may be to strengthen preventative community services, specifically Assertive Community Treatment Team Service (ACT Service). An ACT Services goes out to where an individual is to check on them, ensure they are taking their medication, and see what else may be done to assist them.

Representative Pyrtle says there are many consumers who are not getting the services they deserve and there is a lot of bureaucratic red tape they have to go through.

*Chairman Blackwell recognizes Representative Carson Smith.*

Representative Carson Smith thanks Mr. Botts for his presentation and shares his background. Rep. Carson Smith says he was a sheriff and ran a jail in the early 2000s when the state made the system worse by not keeping people in longer term commitment and instead releasing them to the community. The state said the money saved would follow the individuals who needed treatment, but Rep. Carson Smith does not think that worked.

Representative Carson Smith says he used to be able to quickly reach the various directors for his three counties, but by 2018 counties were grouped together in groups of thirty or more. And because of that, it took a lot longer to get answers. Counties also had to start hiring their own psychiatrists.

Representative Carson Smith says that if commitment examiners determine a patient is dangerous, they are referred to inpatient care. If they are determined to be safe, they are released, whereas Rep. Carson Smith is concerned they will not be sufficiently supervised. Rep. Carson Smith asks Mr. Botts if outpatient commitment is used much and whether it ought to be.

Mr. Botts says there is not a sufficient data collection system in North Carolina to track how often outpatient commitment is used. There are some states that require more supervision for outpatient commitment. Mr. Botts says that a patient could be determined to be nonviolent but still require care, there may be individuals in the community who could help provide treatment for the patient.

Mr. Botts says in North Carolina, the court's involvement ends once a patient is referred to outpatient commitment. But some other states require those patients to return to court for evaluation and monitoring to ensure the outpatient care is effective. Mr. Botts says more requirements of that kind could be added to the law in North Carolina.

Representative Carson Smith asks why North Carolina no longer has long term commitment. Rep. Carson Smith says it is not humane to keep someone with Alzheimer's disease locked up. Some individuals repeat a cycle where they are picked up, receive care and improve, but are then released and deteriorate again until they are picked up by police again. Rep. Carson Smith asks why those individuals cannot be held in long term commitment instead of living on the street.

Mr. Botts answers that the U.S. Supreme Court ruled in 1975 that mentally ill individuals cannot be held indefinitely unless they are dangerous to themselves or others. However, states write their own definitions of dangerous and that can vary between states. The question is whether the definitions of dangerous are being properly applied and if there is room to implement longer commitment that is still not indefinite. But the U.S. Supreme Court decision is the main reason why long-term commitment is no longer utilized in North Carolina.

*Chairman Blackwell recognizes Representative Terry M. Brown, Jr.*

Representative Terry M. Brown, Jr thanks Mr. Botts for his presentation. Rep. Brown asks if telehealth could be utilized for the first examination of a patient if an in-person provider is not available.

Mr. Botts says that current law allows for the first examination to be done through telehealth.

Rep. Brown asks how often that is done, considering that many counties are struggling to find enough providers.

Mr. Botts says he does not know how much telehealth is used compared to in-person exams. He says that the Department of Health and Human Services may have that information.

*Chairman Blackwell recognizes Representative Marcia Morey.*

Representative Marcia Morey thanks Chairman Blackwell and Mr. Botts. She states that she is concerned there is a never-ending loop of 7-day commitments. She asks if there is a limit on how many of those petitions may be granted or if the process continues until a bed becomes available.

Mr. Botts says there is not a statutory limit on the number of 7-day commitments. He says it does not happen often, but he has heard of cases that go on for weeks or months.

Rep. Morey says those individuals do not have a right to an attorney during that time.

Mr. Botts says that is correct. He says an individual may be held at an Emergency Department for days or weeks with no hearing and no attorney. They may be held longer than if they had gone to a hearing and received a court-ordered commitment.

Rep. Morey asks if any data is kept on how long patients have to wait.

Mr. Botts says that information ought to be available, but that there is not a lot of it out there. He says the Department of Health and Human Services may have some information and that question would be best directed to them. Mr. Botts says there will not be quality data collected without a legislative requirement.

Chairman Blackwell comments that if North Carolina had a decent Longitudinal Data System, that sort of data would be available.

*Chairman Blackwell recognizes Representative Donny Lambeth.*

Representative Donny Lambeth says he is interested in learning about magistrates, specifically who can be appointed, what is the training, who they work for, who evaluates them, what is the workload, what the vacancy rates are, and how difficult it is to fill that position. Rep. Lambeth says the General Assembly staff may be best able to put that information together.

Representative Lambeth says DHHS has a very comprehensive mental health reform plan. The General Assembly approved \$835 million in funding for a variety of purposes, including to open more beds and train more staff. Rep. Lambeth says he assumes at some point DHHS will present on the current status and plans for that rollout.

*Chairman Blackwell recognizes Representative Charles Smith.*

Representative Charles Smith says that during court proceedings, the clinician can testify if the content of a witness petition was used in their determination. Rep. Charles Smith asks if that has ever been challenged by a respondent on due process grounds since they are not able to question or cross-examine the individual who first started the petition, which the clinician could then use to make their determination.

Mr. Botts says he would have to look into things to get an answer on that.

Representative Charles Smith asks if there is an issue with clinicians stating legal conclusions in their affidavits and if the state provides any training to clinicians to only state facts and not conclusions.

Mr. Botts says that is an ongoing issue in the training he provides to magistrates and clinicians. The law requires the examiner to state whether they think the individual meets the requirements of being a danger to themselves or others. The law also requires the examiner to provide the factual basis for their conclusion in the examination form and on the petition affidavit. The magistrate should only issue an order after reading that reasoning and coming to the same conclusion. The magistrate should not just accept the conclusion of the examiner.

However, Mr. Botts says magistrates often defer to the examiner out of respect to their medical credentials.

*Chairman Blackwell recognizes Representative Carla Cunningham.*

Representative Carla Cunningham says Mecklenburg County is the least likely county in North Carolina to get a state facility bed for both juveniles and adults. Rep. Cunningham says the U.S. Supreme Court in 1975 required patients to be reintegrated into their communities, but the resources didn't follow. She would like more information on partial hospitalization programs. Rep. Cunningham says there is a level of accountability that needs to be placed with individuals in the community. If the guardianship process was easier, that would allow relatives of patients to get custody faster and have more authority over the individual with the psychological illness or substance use issue.

Rep. Cunningham would like the committee to hone in on that issue because the guardianship process currently takes four or five steps and requires the person requesting guardianship to keep track of a number of records. She says that would empower family members to help patients stay on their medications, stay in the community, and relieve the burden on emergency rooms.

Mr. Botts says there is also the healthcare power of attorney, which allows a patient to grant decision-making authority to a family member or another person.

*Chairman Blackwell recognizes Representative Timothy Reeder, MD.*

Rep. Timothy Reeder, MD, asks if magistrates have access to the medical records of patients in any meaningful way.

Mr. Botts says they do not.

Rep. Reeder, MD, asks if the district court has access to the medical records of patients.

Mr. Botts says they do.

*Chairman Blackwell recognizes Representative Charles W. Miller for a question.*

Representative Charles W. Miller thanks Mr. Botts for his presentation. Rep. Miller asks if someone's record of involuntary commitment stays on their record if they are released prior to the court hearing.

Mr. Botts says the involuntary commitment does not stay on the individuals record. It only becomes attached to their record if the judge orders a commitment. It would not impact an individual's ability to purchase a firearm in the future.

Representative Charles Miller asks if there is a rule that the commitment examination needs to be done prior to an individual being committed to jail.

Mr. Botts says there is not a rule like that. A person being detained in jail could potentially meet the commitment criteria, but there is not a law that specifically addresses that and that scenario often causes confusion.

Representative Charles Miller says he understands that situation, but he is asking about prior to a person is committed to jail. Rep. Miller says the magistrate should tell the officer to take that individual for a commitment examination before committing them to jail.

Mr. Botts says that Iryna's Law requires that an individual be taken for an exam before being taken to jail.

*Chairman Blackwell recommends that if committee members have further questions, they should provide them to the committee staff and Mr. Botts' answers will be shared with the committee. Chairman Blackwell thanks Mr. Botts for his presence at the committee.*

*Chairman Blackwell introduces Dr. Jeni Corn and recognizes Dr. Corn to speak about a research plan being developed by the North Carolina Collaboratory as an outgrowth of a directive in Iryna's Law.*

**Jeni Corn, PhD, presents on HB 307: Research Update (Attachment 2).**

*Chairman Blackwell recognizes Representative John A. Torbett.*

Representative John A. Torbett says it is always wonderful to see Dr. Corn.

There are no other questions from members of the committee.

*Chairman Blackwell thanks Dr. Corn for presenting and says the committee is looking forward to hearing more about the North Carolina Collaboratory's work.*

*Chairman Blackwell says the next presentations deal with the Impact of IVC on the Healthcare System and Emergency Providers*

*Chairman Blackwell introduces Nicholle Karim, the Vice President of Policy at the North Carolina Healthcare Association, and Johana Troccoli, the System Vice President of Behavioral Health at the Duke University Health System.*

**Nicholle Karim presents slides 1-2 on Hospitals and Involuntary Commitment (Attachment 3).**

**Johana Troccoli presents slide 3 on Hospitals and Involuntary Commitment (Attachment 3).**

*Chairman Blackwell welcomes Congressman Tim Moore, who is observing the committee meeting.*

*Chairman Blackwell recognizes Representative Carson Smith.*

Representative Carson Smith addresses his question to Ms. Troccoli. Rep. Carson Smith says he completely agrees Emergency Departments are not where the mentally ill should be housed for weeks or months. In his experience, it was much easier to get patients into a facility run by the North Carolina Department of Health and Human Services if that patient had insurance. Rep. Carson Smith asks if that is the case.

Ms. Troccoli says she would have to follow up with data on specifically what that would look like. She says from the Emergency Department perspective, it is payer-agnostic when referring patients. It may depend on the facility, but the payer should not be a factor.

Representative Carson Smith says he is asking if the facilities that Emergency Departments refer patients to are taking insurance into consideration. He thinks that needs to be looked into.

*Chairman Blackwell recognizes Representative Timothy Reeder, MD.*

Representative Timothy Reeder, MD, asks if Ms. Karim or Ms. Troccoli have any data from their members on how many of the Emergency Departments are using telehealth for the first commitment examination.

Ms. Karim says they could get that data to Rep. Reeder, MD, but they do not have that data with them.

Rep. Reeder, MD, asks for a ballpark number.

Ms. Karim says telehealth is used more often by rural hospitals, but she is uncertain how many evaluations are happening virtually. She would have to dig into the issue further to see if they have that data available.

*Chairman Blackwell recognizes Representative Donny Lambeth.*

Representative Donny Lambeth reiterates Ms. Troccoli's comments about insurance. Rep. Lambeth says when he ran a large hospital's emergency room, they did not know about the insurance for specific individuals. However, they aggregated in the total and knew they would not be able to find a bed without sufficient resources to cover the expenses. His hospital had to close units because they did not have enough patients with insurance coverage to justify the costs, in addition to concerns about safety and care for patients. Rep. Lambeth says it is now a crisis in North Carolina and despite the General Assembly's previous efforts, there is still a lot of work to be done to address the issue.

*Chairman Blackwell recognizes Representative Diane Wheatley.*

Representative Diane Wheatley asks if there are police officers or other personnel assigned to individuals while they are waiting for evaluation.

Ms. Karim says some hospitals have arrangements with local law enforcement agencies around the custody of the individual. It varies by locality, but generally there is an arrangement made so there is a law enforcement officer available.

Representative Diane Wheatley asks if mental healthcare units are in most communities.

Ms. Karim says she does not have data with her today, but mental healthcare units are all across North Carolina. However, they are not as prevalent as local emergency departments. Mental healthcare units look and feel differently from emergency departments because they are designed specifically for people who are in a behavioral health crisis. She offers to follow up with Rep. Wheatley about the locations of those units.

*Chairman Blackwell recognizes Representative A. Reece Pyrtle, Jr.*

Representative A. Reece Pyrtle, Jr. asks Ms. Karim if the North Carolina Healthcare Association calculates the number of Emergency Department beds that are occupied in North Carolina. Is there any real-time tracking system to show the number of beds occupied by involuntary commitment patients awaiting placement.

Ms. Karim says there is some daily data about available in-patient psychiatric beds that hospitals submit to the NCDHHS through BHSCAN. NCDHHS might be able to respond to referral requests with information on how many beds are available. But for Emergency Departments, there is no good data on how many beds are being occupied.

Representative Pyrtle says that data collection needs to be looked into because without it, the General Assembly cannot determine the scope of the problem.

*Chairman Blackwell recognizes Representative John A. Torbett.*

Representative John A. Torbett comments that the Behavioral Health Assessment Teams in schools throughout North Carolina are helping to address mental health issues for students.

*Chairman Blackwell recognizes Representative Marcia Morey.*

Representative Marcia Morey gives background on her former experience as a District Court Judge. Rep. Morey asks if hospitals are starting to do the district court hearings remotely.

Ms. Troccoli says they are. She says the reforms implemented in SB 630 allow the court hearing to be done virtually.

Rep. Morey asks if that has helped considerably or if a lot of people are still going through the old process.

Ms. Troccoli says the Duke University Health System still goes to the courthouse, but it varies by region.

Rep. Morey says that for the district where she served as a judge, no one represents the doctors or hospitals at involuntary commitment hearings. She asks Ms. Troccoli if she has heard of that issue and has any concerns regarding it.

Ms. Troccoli says Duke University Health Systems physicians do go to the courthouse. She would have to follow up with their legal team to get a specific answer.

*Chairman Blackwell asks a question to Ms. Troccoli.*

Chairman Hugh Blackwell says his observation so far is that the lack of beds is due more to staffing limitations than a lack of physical beds. Chairman Blackwell asks Ms. Troccoli if Duke is having the same issues staffing behavior health beds as Chairman Blackwell has observed at Broughton Hospital. Or are some places doing a better job finding the necessary staff.

Ms. Troccoli says it depends on what workforce there is in that community. It is very specialized care, so having a skilled workforce is critical. As a whole, there are staffing shortages.

Chairman Blackwell says he believes there are two focal points of the committee. The first is to identify the problems the General Assembly needs to address. The second is determining what to do about the problems. Chairman Blackwell asks that Ms. Karim and Ms. Troccoli provide the committee a list of regulatory and legislative recommendations for the General Assembly.

Ms. Karim says their final slide has recommendations and they would also be happy to provide a comprehensive list of recommendations to the committee.

**Nicholle Karim presents slide 4 on Hospitals and Involuntary Commitment (Attachment 3).**

*Chairman Blackwell recognizes Representative Donny Lambeth.*

Representative Donny Lambeth says transporting patients is a major issue. He says in his county, patients could only be picked up once a day. And an available bed could be filled while that patient is waiting for transportation. Rep. Lambeth recommends that the committee hear from someone regarding transportation in the future.

*Chairman Blackwell recognizes Representative Charles Smith.*

Representative Charles Smith states that from 2020-2022, his firm represented hospitals at court hearings like the ones discussed in the presentation. He says the most challenging part of that process was discharging and sometimes the patient would not be picked up. Sometimes there were children in DSS custody and the parents would not come and pick them up. And DSS does not have a way to place that child in a treatment facility. Rep. Charles Smith says it is a difficult problem, and he recognizes the need for it to be addressed.

There are no other questions from members of the committee.

*Chairman Blackwell thanks Nicholle Karim and Johana Troccoli for their presentation.*

*Chairman Blackwell introduces Jeremiah D. Gaddy, MD.*

**Jeremiah D. Gaddy, MD, Fellow of the American College of Emergency Physicians (FACEP) presents on North Carolina College of Emergency Physicians Testimony. (Attachment 4).**

*Chairman Blackwell recognizes Representative John A. Torbett.*

Representative John A. Torbett thanks Dr. Gaddy for his service in the U.S. military.

There are no other questions from members of the committee.

*Chairman Blackwell introduces Christopher Graves, the Wake County Chief Magistrate.*

**Christopher Graves, the Wake County Chief Magistrate under the North Carolina Administrative Office of the Courts, presents on Magistrate Perspective on IVC.**

*(Attachment 5).*

*Chairman Blackwell recognizes Representative Diane Wheatley.*

Representative Diane Wheatley presents a case where someone comes before a magistrate, is not charged or evaluated, goes back onto the street, and comes before the magistrate again. Rep. Wheatley asks if there is a mandatory threshold where magistrates have to then ask for an evaluation.

Mr. Graves says the evaluation has to be ordered in conjunction with the initial appearance before the magistrate. So once someone is released, they could not be ordered to undergo an evaluation until they had been arrested again.

Rep. Wheatley asks how long the process could continue with the law enforcement officer sending an individual to a magistrate and the magistrate releasing them. At some point, is the magistrate required to order the person to be evaluated.

Mr. Graves says he does not think there is anything proscribed in statute that requires an evaluation after a certain time period.

*Chairman Blackwell recognizes Representative Marcia Morey.*

Representative Marcia Morey gives an example where an officer brings an individual into court who is required to undergo an evaluation because they have committed a violent crime and have a prior involuntary commitment, or because of another discretionary reason. Furthermore, the magistrate has reasonable grounds to believe the person is a danger to themselves or others. Rep. Morey asks if the magistrate lay eyes on that individual.

Mr. Graves says yes, they do.

Rep. Morey asks about a scenario where the magistrate who has seen the person's criminal record issues a secure bond that will likely keep them in jail. She asks if that reduces the probability of that individual causing harm to themselves or others or abusing a substance because they are incarcerated.

Mr. Graves says magistrates would issue a secure bond because they have found that the person would be a danger to themselves or others. That person would also be evaluated. Mr. Graves says a magistrate should look at the person's prior record and demeanor when answering questions and hearing the officer's testimony.

Rep. Morey asks if, in Mr. Graves' opinion, the possibility of being held in custody does not reduce the chances an individual harms themselves or others or abuses a substance. And therefore, does not need to undergo evaluation.

Mr. Graves says a person is probably less likely to be a danger to themselves or others if they are in custody, but he cautions that magistrates should not assume a person will not make their bond because they do not know the outcome of that during the initial appearance in court.

*Chairman Blackwell recognizes Representative Donny Lambeth.*

Representative Donny Lambeth asks of the people who come before Mr. Graves as a magistrate, how many go to the emergency room, jail, or back home.

Mr. Graves says he does not have any data on that. For public initiated involuntary commitments where someone is asking for an exam to be ordered, the magistrate does not receive a report on where the person ends up. Anecdotally, Mr. Graves would guess that it is about a 50/50 split.

*Chairman Blackwell recognizes Representative A. Reece Pyrtle, Jr.*

Representative A. Reece Pyrtle, Jr. says when he was a police administrator, they tracked where patients ended up. He said that about 50% of people brought in for involuntary commitment were found to meet the standards for treatment. They also tracked the amount of hours spent at Emergency Departments by those individuals. He noticed resources being used more and would see the same respondents a number of times. Because there was no "soft handoff," when the patient would be released from treatment back to their home, they would not continue outpatient treatment. Rep. Pyrtle asked why the mobile crisis unit could not help with the soft handoff and was told it did not meet the service definition. So, the issue of the revolving door never got resolved. Rep. Pyrtle says that at the end of the day, it is law enforcement and hospitals who cannot say no. And the patient who needs the services, does not end up getting them and instead is stuck in Emergency Departments for extended periods of time.

*Chairman Hugh Blackwell asks a question.*

Chairman Blackwell says there is a new Iryna's Law provision which requires law enforcement officers who bring an individual before the magistrate are required to share observations they made which a reasonable person might conclude is evidence of potential danger to self or others. Chairman Blackwell asks if there is training that magistrates go through already or in the future on recognizing the relevant characteristics of people who may be a danger to themselves or others. Alternatively, are the magistrates supposed to, as reasonable people, apply their own individual standards. Chairman Blackwell thinks it would be a more effective exchange if the magistrate did not wait for the officer to volunteer information. He asks Mr. Graves how that process works to ensure the information the officer has will be brought to the attention of the magistrate and what training might be appropriate.

Mr. Graves says more training is always good when it comes to mental health issues and the law. The initial training starts at basic magistrate school, which spends a whole section on involuntary commitment law. It is also part of the required yearly education for magistrates. So, magistrates are trained on the matter already, but would probably still benefit from increased training. In Wake County, magistrates go and talk to officers to talk to them about the involuntary commitment process and what they can expect at the magistrate's office. Wake County has found that is an effective tool for getting the right information to magistrates at the right time. Mr. Graves says there are plans to incorporate questions to the officer about their observations into the standard things magistrates ask about at an initial court appearance.

There are no other questions from members of the committee.

*Chairman Blackwell gives closing remarks about the future dates the committee may meet and potential future presenters.*

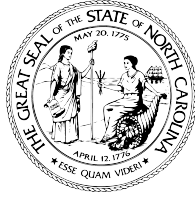
The meeting stands adjourned at 12:32 PM.

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Representative Hugh Blackwell, Co-Chair  
Presiding

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Isaiah Garner, Committee Clerk



**House Select Committee on Involuntary Commitment and Public Safety  
Wednesday, December 17, 2025 at 9:30 AM  
Room 544 of the Legislative Office Building**

**MINUTES**

The House Select Committee on Involuntary Commitment and Public Safety meets at 9:30 AM on December 17, 2025 in Room 544 of the Legislative Office Building. Representatives Blackwell, Campbell, Clark, Cunningham, Greene, Miller, Morey, Potts, Pyrtle, Reeder, Carson Smith, Torbett, Wheatley, White, and Willingham are in attendance.

Representative Timothy Reeder, MD, Co-Chair, presiding.

Introduction of Sergeant-at-Arms.

Chairman Timothy Reeder, MD, presents opening remarks at 9:32.

**Leslie Cooley Dismukes, Secretary, NC Department of Adult Corrections and Arthur L Campbell, III, MD, Chief Medical Officer and Chief of Health Services, present on the Safekeeper's Program (Attachment 1).**

*Question from Chairman Timothy Reeder, MD, to Arthur L Campbell, III, MD*

Chairman Reeder, MD: "Do you have physical beds that could be opened up if you had additional staffing? Is that a limitation?"

Campbell, III, MD: "Yes sir. Absolutely-- Do you mean medical beds or just custody beds?"

Chairman Reeder, MD: "Medical."

Campbell, III, MD: "We do-- for instance there is a unit over at the Central Prison Healthcare complex that doesn't have any patients. Within-- a 45 bed unit that we had officers we could staff that unit fully and provide more patient care within that facility."

Chairman Reeder, MD: "Is it both officers and nurse medical staff?"

Campbell, III, MD: "Oh, yes sir."

*Leslie Cooley Dismukes joins Arthur L Campbell, III, MD, to help answer Chairman Timothy Reeder, MD, questions.*

Dismukes: "We have a critical need to open in many of our facilities because there are also other facilities where we can do some of our folks who are serving sentences with us, their medical care but we do not have either the security staff or the medical staff to run those beds."

*Question from Representative Torbett to Leslie Cooley Dismukes*

Rep. Torbett: "You said it was 8.2 million dollars additional funds. You said if we have more beds, what would that 8.2 million dollars covert into departmental funds if you didn't have to put it over to where you are putting it?"

Dismukes: "So, right now we have a contract with a community care facility long term care. The General Assembly funded a long term care unit at Central Prison several years ago and we do have that up and running but it is full. And so, anytime we have someone that comes into our custody to serve a sentence who has long term care needs and those beds are full we send that [individual] to our contracted facility which is in the private community-- that's the 8 million last year and 6 million this year that we are paying to that facility. So it's basically us not having this capacity and space inside so that we are paying outside. If we had more space and could open up our beds inside or could expand our long term care facility on the inside of Central Prison then we would not have to send those individuals to the external contractor for the long term care beds that's costing us 6 million dollars this year."

Rep. Torbett: "So you're saying no additional costs?"

Dismukes: "No sir. There would definitely be additional costs to open up that entire wing. We can't just open a couple beds in a wing, if we open an entire wing we have to security staff the whole wing and medical staff the whole wing and so we would have to run those numbers for you but are happy to get you the numbers of what it would cost to open up those additional beds."

Rep. Torbett: "That would cost 8.2 million dollars?"

Dismukes: "Yes sir, absolutely it would."

*Question from Representative White to Leslie Cooley Dismukes*

Rep. White: "Could you tell us if this increase happened very rapidly or has this been over a period of time. And if it's been over a period of time can you tell us if it's been 5 years, 10 years, or 3 years that you are seeing this increase in these fragile Safekeeper's?"

Dismukes: "If I could just clarify the increase in the Safekeeper's or the long term care beds needed?"

White: "Both."

Dismukes: "I will defer this to our security staff.. I believe that we stay close to 200 at all times with the Safekeeper's. I believe that and probably the sheriffs could tell you there is a need for those 200 and probably more but we don't have the capacity for more than that."

Rep. White: "Could you tell us just the kind of diagnosis that you see most in the Safekeeper's?"

*Question from Representative White to Leslie Cooley Dismukes is deferred to Arthur L Campbell, III, MD.*

Campbell, III, MD: "Yes ma'am. That is largely what we would see in the community for medical conditions it's often going to be cardiovascular disease that we see, diabetes, some complications of kidney disease, mental health is kind of a mixed bag. There are folks that have psychotic disorders, depressive disorders we have a very significant population of individuals who repeatedly self injure themselves so it's a little bit of a mix when it comes to the mental health population."

*Question from Representative Miller to Leslie Cooley Dismukes*

Rep. Miller: "... How much do you charge back to the county per day? And also, if you take them out to a medical facility you're charging the county back for that service that you are providing, right?"

Dismukes: "Yes sir, so it's 40 dollars a day for each Safekeeper. And then when we take them to outside medical those charges are billed directly to the sheriffs most times through a program set up through the Sheriffs Association and so there are other medical bills that we incur in house if it exceeds a certain amount. We have our inpatient care that we do in house and then some other care but most of the outside medical is billed back to the sheriffs directly through the Sheriff Association program."

Rep. Miller: "What kind of revenue is that generating?"

Dismukes: "I do not know off the top of my head but we can run that for you."

*Question from Representative Morey to Leslie Cooley Dismukes*

Rep. Morey: "...So if a jail is requesting because of mental illness that they have the need, if you have the staffing, you can take on more Safekeeper's?"

Dismukes: "We could."

Rep. Morey: "You said, the statue has set the 200 limit Safekeeper. Do you know when that passed? Was that years ago?"

Dismukes: "I don't off the top of my head. It was definitely years ago. We've been operating in a 200 cap for quite a while but I don't know when the statue was passed."

Rep. Morey: "So, that's something that we could look to in our statues that we could raise that but you'd also have to have the staffing to accommodate?"

Dismukes: "We would-- there are roughly 700 people in county jails that are ready to serve a sentence in the Department of Adult Corrections but we do not have the staffing to admit them into our facilities. Those are non Safekeepers, those are people ready to serve sentences so we have to take those people in but that is a similar problem. We have to have the money to hire the staff to staff the prisons."

*Question from Representative Pyrtle to Leslie Cooley Dismukes*

Rep. Pyrtle: "Community long term care facility, could you give me an example of what that would be? That's somebody you contract with-- like a skilled nursing facility?"

Dismukes: "The facility that we contract with is Kindred and it's in Greensboro."

*Question from Representative Pyrtle to Leslie Cooley Dismukes is deferred to Arthur L Campbell, III, MD.*

Campbell, III, MD: "Yes sir. We've secured basically an entire floor of that facility so our officers have to staff that floor. It's a secure floor and that's where we place these patients. I will say that when the legislature passed the Our Long Term Care facility, it was tremendously impactful to us. We went from spending 22 million dollars a year at that same facility to this 8 million dollars a year so it has been tremendous having to have that facility within our footprint but it's still over capacity. It was full essentially when we opened it and it's remained that way."

Rep. Pyrtle: "Well, you must have a great contract price because most skilled nursing facilities even the medicaid reimbursement rate is..."

Campbell, III, MD: "... That's running an average about 5 patients so that's about 150,000 dollars per patient per month, is what that comes out to."

*Question from Representative Blackwell to Leslie Cooley Dismukes*

Rep. Blackwell: "I've developed the distinct impression that there is space in our prisons and in our hospitals for the people that need to be there but that we don't have beds open because we don't have staff, so I want to focus my question on that. You mentioned that the entry level pay for prison guards is 37,000 and a lot of local sheriff offices pay more. To what extent is the problem of staffing a matter of outbidding others for the same people and to what extent is it a matter that we don't have enough people qualified or willing to actually go into the jobs and so when we compete by raising the pay we don't solve the problems so much as we simply shift more cost to our competitors who then raise their rates? One way we need to find a way to fill the pipeline if there are enough people out there that we just need to try to find the money so we can attract them to work so could you maybe comment, or Dr. Campbell's comment on that, both as it may relate to nurses and as it relates to the correctional officers or other staffing needs."

Dismukes: "Yes sir, -- I say it is that the rising tide lifts all ships and the entry level pay at 37,000 probably would not make as big a difference in our recruiting as the other two steps. That then come above that if we were to raise the pay which would allow us to retain those 21,000 people who left our department this year. The increase in salary is what our folks... because it's a good job to have. We have a good community, good people, good comradery, but they don't get paid enough for what they have to go through so if we were bale to raise those steps for our other two I think that could really aide in our retention. We have done a good job recruiting this year but it's getting people to stay. Part of that though is the culture at our facilities which we are working on. Part of the culture is if you work in a facility that is broken down and in need of repair that effects moral of staff so we are critically working on that to try to increase moral. We are trying to increase access for our people to be able to have communication to their family that will work on retention but also the increase in staff that we would be able to get on by increasing the steps would allow us to not work so much mandatory overtime. The mandatory overtime last month, the bill for that was 6 million dollars in our agency. Having to work the mandatory overtime is what burns people out of our agency and makes them want to leave. The money would help us ease that so that then the good people would in fact stay. With nurses it's a little bit different because we're having to pay contract nurses because we can not recruit competitively in the nursing market right now. The contract nurses, we're paying roughly 30 percent overhead on those nurses which increases the cost for those nurses to our facility but we are still down even with contract nurses."

Rep. Blackwell: "How much money has the department asked for to fund the increases in those two steps that you made references to?"

Dismukes: "... In order to be competitive on the local and national market I think that any starting salary has to start with a 4. We've got to bring our base level up to 40,000 dollars in order to be competitive with the sheriffs offices with the other types of jobs in public safety that exist in North Carolina. We are right now second lowest in the nation, lowest in the South East and so our competing states we could recruit from them on our borders if we were able to bring that up to 4. The steps would come up 42 and then 44 perhaps, but I would have to run down the exact steps on that."

**Eddie Caldwell, Jr., Executive Vice President and General Counsel of the North Carolina Sheriff's Association, present on Law Enforcement's Perspective on Involuntary Commitment and Medical Care in Jails. (Attachment)**

*Question from Chairman Reeder MD, to Eddie Caldwell, Jr.*

Chairman Reeder, MD: "Jails are required to have that medical plan that we talked about. Do you have any information on how many jails directly employ those medical professionals and how many of them contract out to some other company?"

Caldwell: "I don't have any data on that. The majority of the jails contract with a third party provider that provides the medical care in their jail. There are some jails, very few, that employ the medical staff directly by the county by the sheriffs office... In the past, I don't know if there still is or not, some that use the county health department to provide their services."

Chairman Reeder, MD: "Do you know if most of those contracts are both for medical and mental health or is it two separate contracts?"

Caldwell: "I don't know."

*Question from Representative Carson Smith to Eddie Caldwell, Jr.*

Rep. Carson Smith: "... Is a jail or DAC where we put these folks now, is it the appropriate place? You know obviously my background in law enforcement years ago we had a state mental hospitals. I guess we still do, I know one of them's apart now and some of them still are there. I'm not sure what to do and I'm sure DHHS will be before us at some point. These folks that are either on IVC or they may be charged criminally wouldn't they be better in a Cherry Hospital or what was a Dorothea Dix Hospital in a secure lock down area where they can get mental care treatment? ... You want to do what you can for these folks but you don't have the availability to do what a state mental hospital could do. Don't you think that would maybe be a better model?"

Caldwell: "Absolutely. Without question and we don't have the numbers but anticipate that it would actually be cheaper because it's just about impossible. Many of our jails may have 40 or 50 inmates so to have adequate medical care for these specialty of psychiatry even if you are doing telemedicine and all that, telepsychiatry can not be done efficiently in the jail."

Rep. Carson Smith: "Would you say it's possible that if these robust state mental hospitals were open and were able to be used that potentially these folks who are out of the streets committing crimes might be in a hospital. These folks that have been arrested 10, 15, 20 times for mental health issues that go in and out of these revolving doors, if we put them where they need to be, if

they are not out on the street committing crimes, that's also going to help the problems we have on the jail and the prison system too. Don't you think?"

Caldwell: "It is and it's also going to help with the number of victims that we have-- the crimes won't be committed and we shouldn't lose sight of the fact that there won't be victims of those crimes. The other part of that is the individual is not getting the care they need to restore their mental faculties in the jail and they were in a state hospital where they could get the professional mental health treatment they need then they would be better and perhaps never need to be involved with the criminal justice system once they got treated now they are not getting the treatment they need and so then they're just revolving through and back out on the streets."

*Question from Representative Miller to Eddie Caldwell, Jr.*

Rep. Miller: "...I've changed shifts in ER's before waiting on beds and then I have also passed deputies-- coming from the East passing deputies coming from the West doing the same thing I'm doing, transporting IVC patients. So, I would absolutely support the 1-800 holiday number. Is that something the Sheriffs Association could try to put together and is that something y'all could manage?"

Caldwell: "We have advocated for that for over 10 years and it would need to be a partnership between the Association, the sheriffs, and DHHS because they have all the data on who has the beds, which beds are approved and that kind of thing. Definitely it should be very doable and we would be very interested being apart of that."

Rep. Miller: "I think it would work very well if we could pull that together. I'm sure Rep. Smith and others would support that so if you could follow up with us on that I'd appreciate it."

*Question from Representative Pyrtle to Eddie Caldwell, Jr.*

Rep. Pyrtle: "... When you have a consumer that meets the criteria for inpatient treatment and you're looking for placement the first thing you have to do is call to see if there's any private opportunities, if they have any insurance before you go to a state facility. If they try to do a placement in somewhere besides a private facility before they do a state facility but in reality that is never going to happen with this set of consumers that you're talking about who have outstanding criminal charges. Is that a fairly accurate statement?"

Caldwell: "Only rarely do criminal defendants have insurance, like most everybody in this room has."

Rep. Pyrtle: "... When we are talking about the reduction in the state beds with the mental health reform act that is where it really has impacted law enforcement, is that we've had this group of individuals and hospitals that placement is really not an option or is really difficult for this section of consumers who has been in crisis, committed some type of criminal act that they can be held accountable for."

*Question from Representative Morey to Eddie Caldwell, Jr.*

Rep. Morey: "Are you familiar with like in Durham, the HEART program, if there's a mental health crisis. Instead of calling 911, you're calling the county mental health rapid response or you're calling 988 for the suicide crisis line. For someone that's not committed a violent crime against the victim but it's a minor crime, maybe a property, but you see there's a huge mental

health issue coming up, is the Sheriffs Association supportive of counties implementing that? Like Durham has, I think Mecklenburg has, [and] a few others."

Caldwell: "The Association hasn't really taken a position on that. I'm aware of programs like that. Mostly just from reading about different activities through the news media. I don't have any first hand information and we haven't looked at it. I have heard anecdotally that sometimes when a victim calls because they're encountering someone, if a counselor or whatever the proper terms is for one of these folks that's coming, they also want a law enforcement officer because often they feel fear for their safety and so I think that some folks call that a co-responder model. How effective those are and how they're working, I haven't seen an data ... Most law enforcement agencies do have their personnel go through specialized crisis intervention training to address some of the issues that you were addressing about everything doesn't need to result in a arrest and a lot of folks situations can be diffused and everybody taken care of without an arrest and law enforcement is very committed to that.

*Question from Representative Torbett to Eddie Caldwell, Jr.*

Rep. Torbett: "... What's the calculation for inmate or incarceration per sheriff deputy in the jail facility? How do you calculate whether you're short or not short?"

Caldwell: We don't have any data on a statewide basis and there's no formula for that each jail in most cases. Certainly when jails are built the planning process includes how many detention officers it will take to staff that jail but it's not necessarily tied to head count it's also the physical construction of the facility. Depending on how it's constructed you may need more or less detention officers so there should be a number for each jail or a number that could be calculated but there's no statewide database on that.

*Comment from Representative Blackwell based on what Rep. Carson Smith said.*

Rep. Blackwell: "Regarding the existence of our state hospitals and the people that you keep rearresting, I think the two aspects that we've got hundreds of beds in our hospitals that are not open because they're not staffed so that's one problem. The other problem which I hope this committee is going to deal with is we release people back out into the community from the state hospitals before they are able to stay off of whatever the problems were that caused them to get there to begin with. That's what creates the revolving door as soon as we find that they're not a danger to themselves or others because they've been medicated while they're in the hospital then they get out, they stop taking the medicines for example and we need to deal with that piece about not releasing them fully, so quickly in my judgment."

*Question from Representative Blackwell to Eddie Caldwell, Jr.*

Rep. Blackwell: "... On this issue that I think was on slide 35 about if there's no Safekeeping bed the defendant stays at the jail and whatever the available resources are is what they deal with, there in the jail. Has there been litigation at this point over the failure of the local jails to provide adequate treatment or care to these folks? Is that an issue also that's out there?... I don't know if the staff knows anything or if you are aware of people being sued over that?"

Caldwell: "I know that sheriffs in jails get sued periodically related to care of inmates but I don't have any data on your specific question."

*Comment from Representative Miller in response to Rep. Blackwell.*

Rep. Miller: "... In our jail when someone needed services and there was not safekeeping available we would have them admitted to a hospital, which drove the cost through the roof for the county. They may be there a week, they may be there two or three weeks."

Rep. Blackwell: "Not a state hospital but a regular hospital?"

Rep. Miller: "Yeah a regular hospital, our local."

*Question from Representative Green to Eddie Caldwell, Jr.*

Rep. Green: "... About the rise program that you were talking about, I know that was something that we were dealing with often getting somebody back and forth as their competency was a moving target seemingly through the trial process. Do you know if there's other jails that have capacity for that or is there any interest in any other jails doing that program?"

Caldwell: "I don't know that. I know that the folks at DHHS have worked to implement the three programs that we have and if anyone has any data about others sheriffs have expressed an interest, they may have that information but I have not been contacted by any."

Rep. Green: "...You said that often times or not often there's an involuntary commitment situation that has criminal charges. I suspect we're probably gonna see more of those in the event you've got someone in custody and you're waiting for a bed to clear up for whatever reason, is there any mechanism for the county to get reimbursed for the time that they're waiting on a bed to clear up such as there is if we have a DOC backlog...?"

Caldwell: "I'm not aware of any provision for that in the current law. There could be one in the law someday."

**Sy Atezaz Saeed, MD, MS, FACPsych, Founder and Executive Director of Ecu Center of Telepsychiatry and Professor and Chair Emeritus of the Department of Psychiatry and Behavioral Medicine at the Brody School of Medicine at East Carolina University presents on the North Carolina Statewide Telepsychiatry Program (NC-Step) (Attachment 3).**

*Question from Representative Pyrtle to Sy Atezaz Saeed, MD, MS, FACPsych.*

Rep. Pyrtle: "...Will you just give me your statistics when you talked about overturn or override? Is that when the consumer was evaluated and found not to meet the criteria for inpatient treatment?"

Saeed, MD, MS, FACPsych: "Yes sir."

Rep. Pyrtle: "But it still meets outpatient treatment?"

Saeed, MD, MS, FACPsych: "Yes, they have a diagnosis. They still need treatment. They will be discharged from the ED but is still linked for care."

Rep. Pyrtle: "And I shared with this committee at our last meeting, the agency that I oversaw at the police department about a 50 man department. I was there back in 2002 with the Mental Health Reform Act and we actually started tracking the same data that you're tracking now and we continue to track that data today... Are you seeing that as your program continues to improve and you've outreached, are you reaching having less consumers come back? Or dealing with the same consumers over and over?... With your telepsych, are you seeing a reduction in that?"

Saeed, MD, MS, FACPsych: "One of the things that we study is reduction and recidivism on that which is a little more difficult to track but the fact that we are in so many different hospitals, we can track that. So, for example, a patient may have been-- in Beaufort County for one visit, they didn't come back to Beaufort County but they showed up in Pitt County. So, tracking that is a little bit challenging. We have a HRSA funded grant with the federal dollars that we completed two years ago, where what we were doing was that somebody actually would reach out to that patient at home say well you are linked for an outpatient care, did you go there, what are the results and basically track. So, the point was that once you linked that did they follow through with that care and if they did were there some positive results with that. Which showed actually reduction and recidivism and improvement in results but that was a much smaller study. For the larger scale program we don't have the resources to do that for all the 28 hospitals."

*Question from Representative Carson Smith to Sy Atezaz Saeed, MD, MS, FACPsych.*

Rep. Carson Smith: "There's a bunch of ED's in the state. I saw your dots on the map that don't use it. Does there have to be an agreement in place with ECU or why don't you think maybe more ED's are coming online?"

Saeed, MD, MS, FACPsych: "So, initially we did have 76 and our model is basically literally to put ourselves out of business. We try to educate the psychs, provide training, and once they develop they're own capacity. So, while they continue the program they will not show up on our map as a red dot. So, if you would've seen our map about 6 years ago you would've seen literally all of this state showing up in purple colors but we graduated those programs. The programs are still running there but they are running on their own... Yes, there may still be some of the hospitals, our approach is pretty straight forward that we will welcome anyone who wants to join the program. We have never turned anyone down so if there are any hospitals that want to join the door is open and we certainly welcome them."

Rep. Carson Smith: "... I understand that but folks were pushed out into the community the money will flow behind them. I don't think the money flowed, I don't know what they have in the community, it was certainly much easier back then to deal with acute situations. You've got on here community sites, y'all run community sites, what is that?"

Saeed, MD, MS, FACPsych: "These are primary care clinics. A lot of those are health department run clinics but there may be other, for example, private practice as long as they accept all patients. So, rule is that if they would have to accept all comers: medicare, medicaid, no insurance. So, we would welcome this. And what we do is in-bed a license clinical mental health worker in the clinical and then we would bring the psychiatrist using telepsychiatry for a consultation and we enhance the capacity at that clinic. So, the goal is not to turn those clinics into mental health centers but the goal is to enhance the scope of their work so they are more and more comfortable treating these psychiatric..."

*Question from Representative Blackwell to Sy Atezaz Saeed, MD, MS, FACPsych.*

Rep. Blackwell: "...What do we know about the --accuracy of the assessment by the telepsychiatrist who releases back into the community folks that they have assessed? Do we have any data telling us do those people end up back with a mental health thing that was missed or that escalated or do they basically a large percentage behave in such a way that confirms the assessment?"

Saeed, MD, MS, FACPsych: "... Telepsychiatry that we provide is not provided in isolation as a stand alone service. Our model is a team based approach so telepsychiatry is basically one part

of the whole team. That team includes a staff in the ED or at the clinic. The physician at the clinic or at the ED and then the psychiatrist coming in so the overall assessment is based on not just what happened on the camera but what also happened in the clinic or in ED all those observations, collateral information and everything is part of that. So, that's why we rely on clinical records and that's why we build that web portal that we would get all this information so just like any good diagnosis and care. I've been a psychiatric educator for 4 decades and I know the value of care, that you need all of those sources. If it is done correctly, the reliability and validity of psychiatric diagnosis as proven by research for the last almost 3 decades, the reliability of the diagnosis in psychiatry is 80 percent and the validity of that diagnosis is in the same range. When we compare that with for example, if I have heart disease and somebody actually took a picture of my heart, look at those arteries whether they are blocked. That's diagnosis reliability, and when you do a psychiatric diagnosis they have and compare in many cases the diagnosis reliability for psych diagnosis is as good as any of those other diagnosis. What we do is and take good pride in being an academic program, we bring all of this information. Are we always right? Of course not. We make mistakes like anybody else but to date-- we have not been litigated against. Nobody has questions about this thing and we feel really good about that. "

Rep. Blackwell: "But the answer is that you don't have any data about your particular program in terms of the sequels if you will for the patients released back in the community using telepsychiatry as a part of the analysis?"

Saeed, MD, MS, FACPsych: "... Aside from the HRSA study that I mentioned..."

Rep. Blackwell: "Which was not based on your program step only."

Saeed, MD, MS, FACPsych: "No, that was a HRSA grant that was for [a] North Carolina statewide telepsychiatry program expansion and we did that for 3 years. So, that was just our program."

Rep. Blackwell: "... I notice in your data that's in the report, you've got in 2013, 12 years ago how many hospitals had behavioral health ED visits and then you've got some data for 2008-2010, that sounds rather dated to me. Can we get some updated, more current data on that?"

Saeed, MD, MS, FACPsych: "Absolutely, yeah. The reason I have those numbers is to basically show you when the program was starting or being conceptualized what was going on..."

Rep. Blackwell: "But where we started compared to where we are though is instructive perhaps. So just showing it was bad back then but not knowing exactly what those numbers are now leaves the record incomplete in my view."

Saeed, MD, MS, FACPsych: "I'm happy to provide that."

*Question from Representative Torbett to Sy Atezaz Saeed, MD, MS, FACPsych.*

Rep. Torbett: "... If you're consulting a patient and you derive at an outcome and you talk to that patient about how to positively impact that patient and next week that patient speaks with another psychiatrist, are there standards, are there rails in place to the point that that psychiatrist is going to have the same findings the previous psychiatrist had? Therefore keeping the patient on a aggressive path forward."

Saeed, MD, MS, FACPsych: "Yes, I think you mean like in the same program. So, if they saw somebody today and if they are still in the ED next time. So far our community based program there's the same psychiatrist so there's no variation there so each clinic has a designated individual. For the ED, yes it's possible that if they saw someone on Friday and then they saw someone on Saturday, these are different people and the person who is starting, they would always start where the other psychiatrist left off. So, they would start with that review of the literature and if there's a question about disagreements with the diagnosis that would be actually in the diagnostic, found relation and that would be matching. Doesn't happen very often... when the new data comes like the previous psychiatrist has not collected collateral information... the next psychiatrist did and they would mention that and then would discuss why the diagnosis is being changed."

**Carrie Brown, MD, MPH, DFAPA, Chief Psychiatrist of the NC Department of Health and Human Services and Chief Medical Officer of the Division of State Operated Healthcare Facilities presents on the role of telehealth in the IVC process (attachment 4).**

*Question from Chairman Reeder, MD to Carrie Brown, MD, MPH, DFAPA.*

Chairman Reeder, MD: "...Of the 400 that are licensed or certified, do we have any idea how many of them are actually doing that work on a routine basis?"

Brown, MD, MPH, DFAPA: "... I believe all of them are but I don't know that we have an easy way to tell that because what we do is we certify them and then we provide a list that is available to every magistrate in the state so that they know when they receive an evaluation signed by a provider that's not a physician that they are permitted to do that evaluation. I do think we survey them so we'll see if we can get you some better data on that.

*Question from Representative Blackwell to Carrie Brown, MD, MPH, DFAPA.*

Rep. Blackwell: "Same question with respect to the psychiatrist. Do we know of that 3,211, do they all do this or do some of them say I don't do that?"

Brown, MD, MPH, DFAPA: "... Every board certified psychiatrist is more than competent to complete such an evaluation and technically everyone has to at least consider that possibility because even if you're in your own private practice you're going to have individuals that are actively suicidal and you're going to have to consider whether it is your responsibility to involuntarily commit them or they are willing to voluntarily engage in treatment. That being said that that would be available to the patients that you serve not necessarily the broader public."

Rep. Blackwell: "I believe I'm correct that we've got thousands of physicians across the state who technically are qualified to take medicaid but thousands who do not. Is there a similar issue here with psychiatrist that because of the pay they don't take it, or you don't know?"

Brown, MD, MPH, DFAPA: "I don't have exact numbers... Your point is valid in that we really need to make sure psychiatrists are working in the public space. I do not have an exact number for you but we can look into that and see if we can get it."

Rep. Blackwell: "When we say we don't have an exact number, that gets us over into the data side of things that I feel like we don't do a very good job of in North Carolina, certainly not on a longitudinal basis but maybe that you would want to refer this to your follow up but the sheriffs association says that for 10 years they've been trying to get the department to come up with a data system so that they didn't have to make multiple calls from a hundred different sheriffs

offices trying to find a bed. Can you offer any explanation as to why the department has not been willing to do that, or can't do it, or disagrees with doing it.?"

Brown, MD, MPH, DFAPA: "I'd be happy to do that, sir. In fact, I think we do actually have a solution for them. So, over the last several years we've put a tremendous amount of energy and with some generous funding from the General Assembly into developing a statewide bed board. So, we actually have a product called BH Scan (Behavioral Health Scan), that has almost all of our inpatient psychiatrist beds across the state enrolled. There are a few free standing facilities that have chosen not to participate but everyone is able to participate at no cost. That allows us to see not only how many licensed beds we have but more importantly how many of those licensed beds are being operated. We have not only just the inpatient beds. We also have our facility based crisis beds, we have our behavioral health urgent care beds, and we have our psychiatric residential treatment facility beds, all being on-boarded. I think we would welcome a conversation with the sheriff's association about creative ways to get you all access to behavioral health scan. We would welcome that conversation because we certainly appreciate that it is a needed resource for you all that are on the front lines."

Rep. Blackwell: "I noticed in responding that you made reference to how many beds that were active, is that the same thing as open and to what extent is this system going to be or is real time. The sheriff's department was describing the problem that a bed that is open or closed at 5 pm on one day may be open or closed at 8 am the next morning. It seems to me that in this day of AI and technology and computers, people ought to be able to input this information and it ought to give you a real time answer and maybe there ought to be a way of somebody putting a hold or reserve on a bed so that you don't arrive from Western North Carolina to Eastern North Carolina and say well yeah you checked that 3 hours ago and left Marion, the bed was opened but now it's filled."

Brown, MD, MPH, DFAPA: "Yes sir, so right now it is updated daily. However and importantly, we have piloted an automated process so that it would be essentially instantaneous. That we're working with the technology, we've been piloting that with UNC and it seems to be working. The plan is to roll that out to all hospitals that have electronic medical record systems where they have their own internal Bedboards so that is an automatic update. So, we aren't quite where we would need to be sir but we are forging our way towards there quickly."

*Question from Representative Pyrtle to Carrie Brown, MD, MPH, DFAPA.*

Rep. Pyrtle: "... Fully staffed, how many state psychiatric beds are available right now? Total number of beds, whether they are occupied or unoccupied, how many state beds do we have?"

*Question from Representative Pyrtle to Carrie Brown, MD, MPH, DFAPA held by Chairman Reeder, MD, until later in the committee.*

*Question from Representative Greene to Carrie Brown, MD, MPH, DFAPA.*

Rep. Greene: "... You talked about various exams that were happening and some of them were required a second exam by a different person and so forth. Is that, number one, a statutory requirement that's out there? And the second part about that, it seems like there's some redundancy built in there. Do you feel like that's beneficial or cumbersome to you?"

Brown, MD, MPH, DFAPA: "So, you're correct. There's a first exam and a second exam and they do need to be by statute different people. It is true that the second exam must be done by a physician. Personally, in my opinion, at least as a practicing psychiatrist, I actually think that's a

very good system. It's really important that you have some sort of crosscheck. It's a way to make sure that your reliability is very high and I think also the other thing is that individuals change. These are very dynamic presentations for individuals that are in acute mental health crises. How an individual looks at the beginning of the process may not actually be where they are 24, 48, 72, and unfortunately now we know the way our system works, weeks later. It's currently built in as a protection. It does not appear to slow anything down, because it could be done as quickly as a first exam and then 24 hours later as a second exam. That is the standard across the country to have that sort of double check system.

**Kelly Crosbie, Director of the Division of Mental Health, Developmental Disabilities, and Substance Use Services at the NC Department of Health and Human Services; Carrie Brown, MD, MPH, DFAPA, Chief Psychiatrist and Chief Medical Officer of the Division of State Operated Healthcare Facilities; and Karen Burkes, Deputy Secretary for Facilities and Licensure present on a overview of Behavioral Investments, the role of IVC in the crisis system, the IVC facility designation process and state operated healthcare facilities (attachment 5).**

*Question from Representative Pyrtle to Karen Burkes*

Rep. Pyrtle: "... Between Broughton and Central Regional and Cherry, you're fully staffed, how many beds do you have available between those three hospitals and how many beds did you have available 25 years ago between those three hospitals? Where's the reduction?

Burkes: I'll have to follow up on where we were 25 years ago. Partly because as I mentioned Central Regional was a merger between Dorothea Dix. Also all three of our hospitals are in new buildings so I'll have to follow up on that. Ultimately, we would be in the 800's but we need to take into account acuity of our patients."

*Question from Representative Green responded to by Carrie Brown, MD, MPH, DFAPA.*

Rep. Pyrtle: "I'm talking about acute care, long term placement. That being said the concerning that I have I guess is in your description of how Iryna's Law's gonna impact used optimized discharges. Obviously if there's not a soft handout, whether it's coming from the private sector or state sector or I'll even say from DAC back into the community. I know one time I proposed mobile crisis be that soft hand off to make sure that consumer signed up for their next appointment to make sure they had meds to continue on so that we wouldn't have a consumer repeat those actions and go back into crisis. My question is, is it anything this body can do or that you need to look at from a service definition standpoint to ensure that, that soft hand off happens so that the success rate of that consumer transitioning from inpatient care to outpatient care is a smooth transition and a successful transition?"

Brown, MD, MPH, DFAPA: "Obviously that transition is crucial. We do actually prioritize doing a relatively warm hand off. In fact, in many of our cases particular individuals with psychotic disorders that will be followed by an assertive community treatment team that's the community team that goes and see's the individual at their home or place of residents. That team often comes and visits with the patient and establishes that relationship and that is allowed by current service definitions. They can bill for that. In order to establish that relationship, prior to discharge, also all of our 3 state psychiatric hospitals provide 7 days of medicines in hand. When we're talking about optimizing discharges we're talking about the individuals that really are ready for discharge and they may be completely psychiatrically stable but say for example they have a history of arson you could imagine it is incredibly difficult to find housing for that individual. So, it's problem solving those specific cases but it's not discharging people before they're ready.

In fact, we pride ourselves on actually not discharging individuals until they are ready. Our average length of stay is well over 100 days, which is incredibly thorough compared to the average private psychiatric hospital that sits around 5 days. We actually don't see the recidivism that we used to see years ago when there was much more of a quick cycle through. Yes, warm hand offs are super important. We will not take those away."

Rep. Green: "... Do you have any recommendations-- for additional measures out there that we could initiate?"

Brown, MD, MPH, DFAPA: "So, we work very closely with our health plans. Specifically, LME/MCO'S because all the individuals that are served in our facilities that have medicaid are served by tailored plans. Those tailored plans do, do things like assertive engagement. They do have evidence based treatments for this patient based population. I think one of the things that was a recommendation in the white paper that the Governor put out that we referenced earlier-- March of 2024, one item that did not get funded was a specific fun that was much more flexible than the normal medicaid service definitions where you have to meet all kinds of things in order to bill but a much more flexible pot of funding that would must be used specifically for getting individuals that are in our state psychiatric hospitals into the community. It would allow for things like enhanced rates-- enhanced staffing, so if the individual did in fact have a history of arson they would have dedicated staffing in their home which would allow them one to be served in the least restricted environment and safely. That is one possible suggestion..."

*Question from Representative Green to Karen Burkes.*

Rep. Miller: "Out of the 3 state hospitals that we have, how many vacant beds do we have at each one and how many of those vacancies are a result of wings being closed? And if the wings are closed, why?"

Burkes: "So, at all 3, and I can get you the specific numbers but at all 3 of our hospitals total, it's a little over 300 beds that we currently are not operating. Those units that we currently have closed, they're closed because we don't have enough staff. I mentioned, we needed those 42 healthcare techs and 17 nurses, I mentioned how many nurses and healthcare techs and psychiatrist that we need. If we start to staff up then we can start to open up a handful of beds within a particular unit. We want to make sure we have that right ratio available but it comes down to staffing."

Rep. Miller: "How many FTE's are you vacant right now?"

Burkes: "... On average it costs our hospitals that are about 25 percent vacant and when you combine our healthcare tax and our nurses, it takes you about 700."

Rep. Miller: "What are you doing with the lap salary?"

Burkes: "So, our lap salary, we use it for a number of things. One of them is for our overtime. We also include workers comp. In order to keep our beds open we do use some for our contract nurses. So, those are our three buckets of money that we use our lap salary for."

*Question from Representative Carson Smith to Carrie Brown, MD, MPH, DFAPA.*

Rep. Carson Smith: "... I do agree... not only for the patient but it does free up resources and two examinations I think is a wonderful checking balance... for those with serious and persistent

mental illness... What triggers a person that's in and out and in and out when they're out, what triggers them going back in?"

Brown, MD, MPH, DFAPA: "Certainly from a clinical standpoint the number one factor is probably non adherence with medication. We know that for certain illnesses such as schizophrenia there's actually a term-- it's a core part of the illness that the individual does not have insight into the illness. So, does not have the insight that they have the illness that requires medication. So, one of the things that's most effective is when that individuals followed by something I mentioned previously which is assertive community treatment team. That is a community team that actually stays in the community and literally goes and sees the person wherever they are staying... Those programs are particular effective at catching individuals earlier in the process and getting them to willingly voluntarily seek treatment or doing an involuntary commitment if they have to but earlier in the process before there's actually a crisis that involves harm to themselves or others. So, those treatments exist. We probably need more of them. I think the other thing you're alluding to is called outpatient commitment and that is the process by which the individual is ordered into treatment while they're in the community... The department is working very closely with the collaboratory... on recommendations on how we might want to change outpatient commitment law in North Carolina to be more effective."

*Original Question from Representative Carson Smith responded to also by Kelly Crosbie.*

Crosbie: "...Most people don't want to be on medicine. When you feel better we all like to go off our medicine. People with serious mental illness are no different, so it happens. I would also say that medicine is only part of it as is court ordered and directed treatment. We have to get the treatment models of care correct. Today is not the moment, but we've been working very hard on not just clinical models of care like ACT teams... people with SMI need safe and stable places to live which we do not have enough but they also need communities. They need things like clubhouses and peer support specialties so they actually have buddies that go and love them and aren't just trying to hospitalize them all the time. So, we're actually trying to build a community infrastructure that actually supports these individuals because medication enough is not going to help the fact that they don't have houses or they don't have stable communities that understand their illness and actually help them maintain their recovery. There are plenty of people that despite the fact that they have schizophrenia do not get hospitalized every 3 months. They may start that way but if we get everything right, it is a rare thing that they become hospitalized ever again. So, it can happen."

Rep. Carson Smith: "Yeah, I'm not talking about the folks that get it right. We have to worry about the public safety of the folks to be protected against the ones that don't want to take their medications. I don't have a problem with the community based model, I think there's some folks that its not meant for ... it's a revolving door and you say build clubhouses or whatever, the government can't do that but you know we can build hospitals, we can build places where they can stay up and be safe... I don't remember Cherry taking IVC's, so you say they still take IVC's and I assume that would tie up beds for more longer term folks also?"

*Question from Representative Carson Smith responded to by Karen Burkes.*

Burkes: "Yes, that is correct. they still take IVC but we have to prioritize ITP patients so that's why the ITP takes up a larger percentage of our population."

*Question from Representative Torbett to Chairman Reeder, MD.*

Rep. Torbett: "Could you ask someone on staff to provide us if the state still owns any property at Dix Park? How much property the state actually is in ownership of?"

Chairman Reeder, MD: "We'll do that."

*Question from Representative Morey to Karen Burkes.*

Rep. Morey: "We need money. What would you say would be the optimum amount in a budget to fully staff the facilities we have and open up these beds? Roth a year."

Burkes: "... We will have to circle back... Part of the challenge is we've increased our salaries for our nurses and our healthcare techs and it's helped a lot but what happens every time we've made an increase so does everyone else. So, that's part of the reason why we wanted to do a larger study-- to understand how do we need to structure our salaries and also what other benefits can we offer. And some of that may not be tied to money for example. One of the benefits or flexibilities that staff have asked for and we've piloted on a limited scale are flexible schedules. So, working 12 hours verses 8 hours. There's things like that, that don't cost anything but we do need better insight into where we can really move the mark when it comes to money."

*Question from Representative Blackwell to Carrie Brown, MD, MPH, DFAPA, Karen Burkes, and Kelly Crosbie.*

Rep. Blackwell: "... Idea of if a patient is in a psychiatric state hospital because of an IVC they've been determined that they are danger to themselves or others. I think that's the standard. If they seem to be a danger to themselves and others do we have to discharge them?..."

Brown, MD, MPH, DFAPA: "Technically we do, so there's a judicial review... In some cases the doctor actually believes that they no longer meet IVC criteria and arranges for the discharge. Another thing that happens is the individual believes they no longer meet criteria, the physician disagrees and then it goes before at a regular interval as required by statute it goes before a judge who then makes a determination as to whether the individual should be released. We are seeing more and more that they'll be times where their judicial releases. That has to do with the rights of an individual to be in a restricted environment. There is one other pathway that perhaps you're references which is that an individual can be signed in voluntarily by their guardian and that is a slightly different standard to remain in the hospital. that standard is about benefiting from continued hospitalization as opposed to the standard of acute dangerousness to self or others based on relevant past."

Rep. Blackwell: "Would the department be open to taking a look at the standard for discharge? To go away from whether they are at that point still a danger to themselves or others and to go more of a standard that you mentioned maybe in a more limited area of whether they would benefit from further hospitalization or-- a order for community care that would not release them but would maybe put them in a situation which they in a sense were involuntarily required to cooperate with these teams or with wrap around services..."

Brown, MD, MPH, DFAPA: "So, with outpatient commitment it does vary from state to state but the individual is released from the hospital because the idea is to return them to the community but the treatment within the community is required by that order and then of course there's judicial review of that to make sure that the individuals rights are not being violated. I think the challenge with looking at any of those standards is we know that we have people waiting to get in the front door. So, the longer the individuals stay in the facility the harder it is to bring in new individuals... Right now, we have on the order of 150 individuals in our jails across the state that

are incapable to proceed, waiting for a bed in a state hospital... Similar to DAC, those individuals need to be accepted first and then we can move on to patients in in emergency departments."

Rep. Blackwell: "I have to say it troubles me some what that we're saying we need to let them out so we can bring more people in, even if they're going to revolve back in later... On page 26-- Previously one of you were talking about... opening up 112 new beds for children... I'm wondering how you manage to staff 112 beds but we can't staff the beds that we already had?... When new Broughton Hospital was completed-- isn't there a forensics unit that was supposed to be there that has never opened? Isn't there another unit-- of 80 beds or 120 beds that has never opened and has never been staffed since that new hospital opened?"

Burkes: "So, yes, Broughton has beds and units-- that they have never been able to open because they don't have the staffing. It's not just for Broughout, it's not just healthcare techs and it's not just nurses. It's also psychiatrists and they work really-- hard to recruit psychiatrists to come work at Broughton. We've tried different things and we're not quite where we need to be. We're still coming up with creative solutions but yes, there are units that we are not currently operating at Broughton Hospital.

Cosbie: "On the 112 new beds in communities it's slightly different from the facilities for a couple of reasons. One, these are typically 8 beds at a time in community. It takes a long time to create them and hire the staff. The staffing models, these are really small facilities they have different staffing models than is required for our state facilities. It is a community based setting so the staffing standards are not necessarily as intense so it's also like you're in one county looking for maybe 8 staff rather than hundreds and hundreds of nurses at one facility like Broughten or Cherry. It's just kind of different scale but also different staffing patterns. It's not easy-- but it can be why it takes so very long to open them all up.

Rep. Blackwell: "I notice on this page 26, -- When did we establish the staff committee that you mentioned at the top of that slide? When did we hire the nurse recruiters? When did we implement this competitive salary scales? And, who besides UNC School of Medicine is one of your partners on the expanded work force training?-- When did you all start working on all of the stuff that you've got on page 26?"

Burkes: "The nurse recruiter, I think Cherry Hospital was the first one to hire a nurse recruiter. It's definitely been a couple years, I would say at least 2 to 3 years. Broughton hired and then Central Regional is the newest. They probably had a nurse recruiter for about a year. it took them some time to figure out how best to work-- Cherry is really starting to see, all of them really but Cherry, because they've had a nurse recruiter the longest to see a change there. In terms of our staff, work groups, we have formed work groups in the past but we have not had a consistent one. So, earlier this year is when we really formed the one together. Some additional feedback on the recruiter and retention, looking at what policies we can put in place. Especially those things that we can control. In particular for our staff who are exempt from the state HR Act. The walk in hire events, we actually had walk in hiring events a couple years ago. What we did not have was that same day contingency offer and so what we did was revived those walk in hiring events and set up that structure to offer those contingent offers, that was in June."

Rep. Blackwell: "Based on just the reference to Broughton Hospital and the length of time that the new hospital has been open-- It doesn't seem to me to be a sense of urgency at the department nor much consistency in having pursued this... We need to have a program for staffing that focuses on changing what you're doing when it doesn't work. We've got to do something differently. I think you said just paying more doesn't get it done. Working conditions, we take

surveys of state employees all the time about working conditions. This is all stuff that we need to get handled."

Burkes: "We agree. We want to operate as many beds as we can. We are trying to do that as fast as we can. We are trying new things out... It's going to take us some time. It's part of the reason we also want to bring in that third party to help us to take a look to see what else we can be doing and move faster."

Crosbie: "About the hundred new beds in the community, this is kind of important. Those are not run by us... Providers can hire the staff. They can hire way quicker than we do. They hire very different pay scales. I need to credit our LME/MCO's as well because they really help with the cost of those facilities. They are able to recruit and maintain staff in different ways than we can... We don't own those, we don't run those, we don't staff those at the state."

*Comment from Representative White responded to by Karen Burkes.*

Rep. White: "... I would just suggest that for years North Carolina was known as one of the nation to provide mental health care to folks that needed it. This is because Dorothea Dix came from the North and came down here and decided to serve folks with mental health issues. It was a plan that was done at Cherry, at John Umstead, at Dorothea Dix, and obviously at Broughton. I think we need to go back to the history books and look at the plan that was implemented there for staff, for admissions... I would just recommend as this committee thinks, that we think about looking back at what was working really well and what is not working now because it seems like we're just trying to open up more things and more entities that just cost a lot more money but we're not seeing any results. We need to just take a look back at history and see what we can do to fix some of this."

Burkes: "We'll take a look, thank you."

The meeting stands adjourned at 12:27 PM.

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Representative Timothy Reeder, MD, Co-Chair  
Presiding

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Allison Gilbert, Committee Clerk

**ATTACHMENTS:**

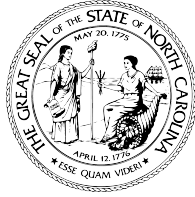
**Attachment 1:** *Safekeeper Program: NC DAC*, PowerPoint Presentation

**Attachment 2:** *House Select Committee on Involuntary Commitment and Public Safety, NC Sheriff Association*, PowerPoint Presentation

**Attachment 3:** *The North Carolina Statewide Telepsychiatry Program (NC-STeP): Enhancing Access to Mental Health Care in North Carolina, ECU Brody School of Medicine*, PowerPoint Presentation

**Attachment 4:** *DHHS Overview on House Select Committee on Involuntary Commitment and Public Safety, DHHS*, PowerPoint Presentation

**Attachment 5:** *Annual Report to Legislative Oversight Committee, NCGA Fiscal Research Division and DHHS*, Report PDF



**House Select Committee on Involuntary Commitment and Public Safety  
Wednesday, January 14, 2026 at 9:30 AM  
Room 544 of the Legislative Office Building**

**MINUTES**

The House Select Committee on Involuntary Commitment and Public Safety meets at 9:30 AM on January 14, 2026 in Room 544 of the Legislative Office Building. Representatives Blackwell, Campbell, Clark, Cunningham, Greene, Lambeth, Liu, Miller, Morey, Potts, Reeder, Rhyne, Carson Smith, Charles Smith, Torbett, Wheatley, White, and Willingham are in attendance.

Representative Hugh Blackwell, Co-Chair, presiding.

On behalf of Representative Timothy Reeder, MD, and himself, Chairman Blackwell acknowledges receipt of a letter from Representatives Erin Paré and Mike Schietzelt asking that the committee look into the murder of Zoe Welsh. Chairman Blackwell says it is the chairs' intention to look into the circumstances surrounding the murder to inform the committee on its recommendations.

*Chairman Blackwell introduces Dr. Marvin Swartz.*

**Dr. Marvin Swartz, a Professor at Duke University School of Medicine in the Department of Psychiatry & Behavioral Sciences, the Director of the Duke AHEC Program, and Faculty Member for the Wilson Center for Science and Justice under the Duke University School of Law, presents slides 1-9 on Involuntary Outpatient Commitment (aka Assisted Outpatient Treatment) What is it? Can it reduce adverse outcomes? (Attachment 1).**

Introduction of Sergeant-at-Arms and House Pages.

*Chairman Blackwell recognizes Representative Carla D. Cunningham.*

Representative Carla D. Cunningham says the program described by Dr. Swartz is similar to partial hospitalization in Mecklenburg County. Patients transition to partial hospitalization after six months of treatment. She asks if Dr. Swartz has looked into that, especially because it takes Medicaid.

Dr. Swartz says he has not studied partial hospitalization. He says state hospitals used to allow trial visits back home where patients would be discharged officially if they did well. However, the program he was talking about is under court order.

*Chairman Blackwell recognizes Representative Timothy Reeder, MD.*

Representative Timothy Reeder, MD, asks if there is any data on the amount of outpatient commitments over time in North Carolina.

Dr. Swartz said he believes counties report data to the Administrative Office of the Courts, but he would have to see if he is able to obtain that data.

Rep. Reeder, MD, said Dr. Swartz mentioned people who failed outpatient treatment and got back in for reevaluation. He asks how many of those people would then be involuntarily committed and how many would go back to outpatient commitment.

Dr. Swartz says he does not have good data on that. Some are hospitalized and others are released if providers think it is a futile attempt. The program is best for people who still believe in the authority of the court and can be nudged by the court.

*Chairman Blackwell recognizes Representative Donny Lambeth.*

Representative Donny Lambeth asks how many facilities are in North Carolina that provide intensive outpatient treatment.

Dr. Swartz says he does not know.

Rep. Lambeth says he does not know either, and that is a symptom of the problem that even he does not know.

Chairman Blackwell says staff is on it.

Dr. Swartz said they would like to know. There are a fair number of outpatient treatments that are ordered at discharge as a risk management technique by clinicians to cover themselves. Whether that treatment is actually followed through with is unknown. In New York, the court proceeding includes a treatment plan.

*Chairman Blackwell recognizes Representative Carson Smith.*

Representative Carson Smith says his understanding is that involuntary outpatient commitment is law in North Carolina.

Dr. Swartz says that is correct.

Rep. Carson Smith asks who monitors the person who is ordered to undergo outpatient treatment.

Dr. Swartz says there is a lack of accountability in the new system because the LME/MCOs are supposed to delegate care to an outside provider. He does not know if there is any record keeping on that. It is also easy to release people from outpatient commitment.

Rep. Carson Smith asks if the court would have to be notified.

Dr. Swartz says the court is supposed to be notified. But he is not sure how often that actually happens since that is not monitored.

Rep. Carson Smith ask if someone is in inpatient commitment and released, is there any follow up with them. Additionally, if the clinician recommends outpatient treatment, who monitors that situation.

Dr. Swartz says, in theory, the LME/MCOs should monitor that, but he is not sure if they do.

Rep. Carson says that sounds like a huge gap in the floorboards.

*Chairman Blackwell recognizes Representative John A. Torbett.*

Representative John A. Torbett asks if Dr. Swartz calculated recidivism. He also asks if the 90-day and 180-day examples given by Dr. Swartz just align with billing cycles or if that is the time frame actually needed for patients to get better.

Dr. Swartz says the court order is for 90 days and you can go back to court and request another 90 days. Those periods are dictated by the court order. Dr. Swartz asks Rep. Torbett if he is asking about criminal or civil recidivism.

Rep. Torbett says he is asking about everyone who went through the program. He wants to know how many people repeatedly went through the program.

Dr. Swartz says he does not have the numbers on him. He says some patients are kept under outpatient commitment for long periods of time. He thinks the third time you go to court, you can request a 365-day extension. Some people benefit from continually being in the program. Longer commitments in general seem to work better. But there is not much data on what happens when people are released from prison into an outpatient treatment program.

*Chairman Blackwell recognizes Representative Donna McDowell White.*

Representative Donna McDowell White asks if Dr. Swartz ever met with the LME/MCOs to discuss the study.

Dr. Swartz says he never met with them. He believes the LME/MCOs were aware of it, but there was not a formal meeting. He notes there is significant opposition to outpatient commitment in North Carolina. Previously, he had proposed focusing outpatient commitment orders on just the patients most likely to benefit. But he was accused of trying to increase the rates of outpatient commitment.

Rep. White says she was raised when the model of extended stays was common. Now, her community has one local hospital. The Department of Social Services picks someone up, brings them to the hospitals, the LME/MCOs are contacted, and there is no response. Once, a patient stayed in the hospital for six months. Rep. White says she applauds Dr. Swartz's work and thinks the General Assembly should support his work.

*Chairman Blackwell recognizes Representative Ya Liu.*

Representative Ya Liu thanks Dr. Swartz for his presentation and study. She asks how has North Carolina has done with outpatient commitment, particularly compared to New York. She also asks if there any barriers from doctors, judges, insurance companies, or clinicians.

Dr. Swartz says it is not about the statute per se, but the implementation of the statute. He believes the mental health reforms and lack of backs has made it difficult for outpatient

commitment to operate in North Carolina. He believes New York has the most effective system. New York has oversight teams to ensure patients are being looked after. He believes the North Carolina system has fallen into neglect and it would take a state-wide effort to make it work again. It will require a substantial amount of funding.

*Chairman Blackwell recognizes Representative Charles Smith.*

Representative Charles Smith asks about forced medication in the involuntary outpatient commitment setting. He says in his legal experience, patients often deteriorated because they would not continue to take their medication. He asks if it could be useful to force it for a short period of time or if refusal to take medication could lead to that patient being involuntarily committed to inpatient care because they are now a danger to themselves or others.

Dr. Swartz says the answer is more political than clinical. It is a red line in most states to ever force medication on someone. In North Carolina, there is an emergency exception. The judge orders the patient to take medication, which leads to patients thinking they must take the medication. That is most effective when the patient is taking long-term, injectable medication.

*Chairman Blackwell informs the committee that they only have a few minutes left to ask questions if they want to stay on schedule.*

*Chairman Blackwell recognizes Representative Dudley Green.*

Representative Dudley Green asks if he understands correctly from the presentation that in the early 2000s the law changed that shifted LMEs from provided to LMEs managing the care.

Dr. Swartz says that is correct. He says the transition to privatizing the mental health system was problematic. The workforce that was established before sent them to work for various employers, which was very disruptive. They also received less funding than was initially planned.

*Chairman Blackwell recognizes Representative Marcia Morey.*

Representative Marcia Morey says when she was a judge, there would often be many IVC hearings lined up which then were canceled as patients decided to commit themselves voluntarily. The IVC process pitted families against each other and escalated some of the issues. She asks if it is best to get a voluntary commitment.

Dr. Swartz agrees. He says the process he has discussed is for when people cannot be persuaded to undergo voluntary treatment. If you want to transfer someone via a police transport, you have to put someone under involuntary commitment. That leads to involuntary commitments that could have been voluntary if there was better transportation.

*Chairman Blackwell asks a series of questions.*

Chairman Blackwell asks how much New York is currently spending on the assisted outpatient treatment program.

Dr. Swartz says he does not. In New York and California, they also include homelessness onto the assisted outpatient treatment program.

Chairman Blackwell says it would be very helpful to the committee to find out what the cost was. He asks if Dr. Swartz is aware of any efforts by any efforts by the NC DHHS to monitor outpatients treatment patients better.

Dr. Swartz says he is not aware of any efforts. The main recommendations in a 2018 Senate bill did incorporate suggestions from NC DHHS.

Chairman Blackwell asks what the programming for assisted outpatient treatment is like. To what extent are people living on their own versus in a specialization community.

Dr. Swartz says it varies widely. In New York, people under AOT go to the front of the line for housing assistance and first priority for other assistance. In New York, if you change the treatment for a patient, you have to go back to the judge. In North Carolina, it depends greatly on the patient.

*Chairman Blackwell asks committee members to submit further questions to the committee staff.*

*Chairman Blackwell introduces Dr. Carrie Brown.*

**Carrie Brown, MD, the Chief Psychiatrist of NC DHHS, the Chief Medical Officer of the Division of State Operated Healthcare Facilities at NC DHHS, presents NCDHHS Presentation on Outpatient Commitment. (Attachment 2).**

*Chairman Blackwell recognizes Representative Timothy Reeder, MD.*

Representative Timothy Reeder, MD asks if all of Dr. Brown's recommendations would require statutory changes.

Dr. Brown says yes, they would.

Rep. Reeder, MD, asks if there is a central monitoring system in place.

Dr. Brown says monitoring should be at state level. Theoretically, DHHS staff could be dedicated to that project.

Rep. Reeder, MD, asks why Dr. Brown's recommendation was for it to only apply to violent patients. He asks if it could be beneficial even to nonviolent patients

Dr. Brown says she spoke about violent patients because it's a small population. She says there are some patients who repeatedly go through the system who are not violent.

*Chairman Blackwell recognizes Representative Carson Smith.*

Representative Carson Smith asks how outpatient commitment would help for patients who decline treatment or who demonstrate violence. Rep. Carson Smith says he would think it would be for patients who just needed some extra support.

Dr. Brown says the idea is you offer a choice, but the choice is limited to doing your treatment plan or being hospitalized. The NC DHHS change is to make the choice more clear.

Rep. Carson Smith says he believes that not being able to force medication needs to be looked into.

*Chairman Blackwell recognizes Representative Charles Smith.*

Representative Charles Smith asks about the specificity of court orders as it relates to treatment. Rep. Charles Smith is worried that too much specificity might slow down treatment if they have to go to court every time the treatment plan changes.

Dr. Brown says she thinks clinicians would need to be trained in how to develop a treatment plan. She thinks the statute could require naming the specific provider and what medication and frequency of medication is necessary. There is a balance to be made, but more specificity is needed.

Rep. Charles Smith asks if refusal to comply with outpatient treatment could be a reason for someone to be involuntarily committed or would there be a separate ground for that.

Dr. Brown says it could potentially set up that way. She says right now, you have to wait for someone to deteriorate before you could involuntarily commit them.

*Chairman Blackwell recognizes Representative Heather H. Rhyne.*

Representative Heather Rhyne asks how long NC DHHS has recognized the gaps in treatment.

Dr. Brown says NC DHHS is always aware the system is imperfect and they are always working to fix those gaps. Since 2018, there have been active discussions on how to approach outpatient commitment.

*Chairman Blackwell asks a question.*

Chairman Blackwell asks who has been involved in those discussions and how long they have been going on.

Dr. Brown says the main thing is that NC DHHS always recognized there was more work to be done in the IVC system. They really want to focus on the voluntary system first because the vast majority of individuals voluntarily engage with treatment. They are working to improve their crisis system to immediately get people care. There is constant discussion on how they can get better.

*Chairman Blackwell recognizes Representative Donna McDowell White.*

Representative Donna McDowell White asks what NC DHHS has specifically done since being granted more funding the previous year.

Dr. Brown says DHHS has added a significant number of beds throughout the state, which are an alternative to hospital beds. They are also developing alternative locations for capacity restoration to help overloaded state psychiatric hospitals. She says DHHS would be happy to provide the committee with a comprehensive list.

*Chairman Blackwell introduces Senitria Goodman.*

**Senitria Goodman, the General Counsel and Chief Compliance Officer for Trillium Health Resources, presents on The Role of LME/MCOs in Crisis Response for North Carolina.**  
*(Attachment 3).*

Ms. Goodman answers questions from Representative Timothy Reeder, MD, Torbett, Miller, Blackwell, Rhyne, and Greene.

**Stephen Eide, Senior Fellow, Manhattan Institute. The Discharge Process from Hospital-Based Psychiatric Care to Community-Based Psychiatric Care.**

Mr. Eide answers questions on bed shortages, staffing shortages, incomes and signing bonuses, from Representative Miller, Wheatley, Blackwell, and Torbett.

*Chairman Blackwell makes closing remarks about the future meetings times and locations of the committee.*

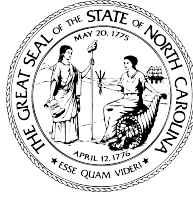
The meeting stands adjourned at 12:03PM.

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Representative Hugh Blackwell, Co-Chair  
Presiding

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Isaiah Garner, Committee Clerk



**House Select Committee on Involuntary Commitment and Public Safety  
Tuesday, February 10, 2026 at 1:00 PM  
Room 643 of the Legislative Office Building**

**MINUTES**

The House Select Committee on Involuntary Commitment and Public Safety meets at 1:00 PM on February 10, 2026 in Room 643 of the Legislative Office Building. Representatives Blackwell, T. Brown, Budd, Campbell, Clark, Greene, Lambeth, Liu, Miller, Morey, Potts, Reeder, Rhyne, Carson Smith, Charles Smith, Torbett, Wheatley, White, and Willingham are in attendance.

Representative Timothy Reeder, MD, Co-Chair, presiding.

Introduction of Sergeant-at-Arms and House Pages.

**Charles Spahos, General Counsel and Legislative Liaison for the Conference of District Attorneys, opens the meeting with a brief explanation as an introduction for Lisa Coltraine and the Judges brought along to help with feedback from Members of the committee.**

**Lisa Coltraine of the NC Conference of District Attorneys (NC AOC) is recognized to give a presentation titled: In Court and Incapable to Proceed (*Attachment 1*).**

Lisa Coltraine explains the entirety of the presentation.

Chairman Reeder, MD, opens the floor for questions and comments from committee members regarding the presentation.

Rep. Campbell, MD, questions the rate that individuals are released for non violent crimes and questions if the reason for the quick release is due to capacity or that they are not capable to proceed in that 48 hour time span. Rep. Campbell, MD, requests the checklist that needs to be followed in order to release these individuals.

Lisa Coltraine responds, stating that she cannot give an actual checklist because she is not physician. Coltraine states that the medical professionals, once an inmate is in IVC, job is to just be looking; not understand court. They are supposed to determine if the individual is a danger to self or others after being involuntarily committed. It is a civil process, therefore, prosecutors are not involved. She continues on to reply that a doctor would be better fit to answer Rep. Campbell's, MD, question.

Rep. Blackwell is recognized to ask a series of questions. Rep. Blackwell begins by asking a question regarding AOC and if there is data on when a judge does not do what the statute requires.

Lisa Coltrain responds stating she is unsure and that this presentation is from when she was a prosecutor out in the field and from hearing prosecutors throughout the state. She continues to state that this [IVC] is a very difficult process and the statues inter reference each other and sometimes this step is missed when in court. She states that she does not have a number but she knows it had occurred several times when she was a prosecutor.

Rep. Blackwell asks a follow up question asking to know who is responsible for transporting individuals who need an evaluation and who is responsible for covering the cost. Rep. Blackwell questions if there has been discussion of creating sites that are conveniently available so these individuals do not have to be transported all over the state.

Lisa Coltrain responds by explaining that evaluations can only be done at Central Regional Hospital, however, evaluations are done in the field in every county. Most of these evaluations are done virtually, which is more time efficient and aids in keeping from having to have individuals transported across the state.

Rep. Blackwell questions why evaluations can only be done in person at Central Regional Hospital, making it less available to those in need.

Lisa Coltrain responds that she is unsure and shares that is has nothing to do with a bed shortage, but rather a doctor and nurse shortage.

Rep. Blackwell follows up once more to ask Coltrain about the three recommendations given at the end of the presentation and her feedback on what the committee should do to address the concerns presented.

Lisa Coltrain responds stating that she is unsure and that this is a very complicated process.

Rep. Morey requests information regarding recommendations for the committee statutorily and what about the numbers and shortages based on evaluations. Rep. Morey questions if the number 2000 within the presentation represents the amount of defendants needing an local or state forensic evaluation each year.

Lisa Coltrain responds stating that the number is roughly over 2000 defendants that are getting evaluation each year. Additionally, that some of those individuals are getting multiple evaluations within the year.

Rep. Morey asks a follow up question. Rep. Morey questions if we have too few evaluators and qualified and if that's the reason this process is slowed down.

Lisa Coltrain responds stating that the numbers is not the problem but rather the evaluations are not to the standard that they would like to see them.

Rep. Morey then questions if Coltrain believes that the training hour requirements need to be higher for evaluators.

Lisa Coltrain responds in her personal opinion and says yes.

Rep. Carson Smith is recognized for a question to ask about the gas station example given in the presentation and for a suggestion on how to come up for an answer to this example. Rep. Carson Smith then questions that if these individuals do not understand what happens in a court room

and are not capable to proceed in a court of law then how are they supposed to take care of themselves on the street.

Lisa Coltrain responds by pointing out capacity to proceed and competency and explains the difference between the two and how they differentiate.

Rep. Carson Smith makes a comment and states that if one knows how to find food and pay your bills, then there is confusion for how an individual does not understand how one cannot understand what is going on in court of law.

Chairman Reeder, MD, recognizes Rep. Charles Smith for a question about one of the flow charts shown in the presentation. Rep. Charles Smith wants to know if a judge can make a determination on capacity of an individual or if they have to have an evaluation.

Lisa Coltrain states that a judge can make the determination with or without an evaluation. The evaluation is not necessary, no matter the crime.

Chairman Reeder, MD, questions Coltrain as to if local evaluators are paid by LME's.

Lisa Coltrain responds stating that as far as she is aware, yes.

Chairman Reeder, MD, makes a comment and questions if the quality of care and payment structure of the evaluations reflects the quality.

Rep. Morey is recognized for a question. Rep. Morey states that the session is interesting from a District Attorney perspective, but she states that the answer is not always a criminal answer and hopes that people will keep in mind that jail is not always the answer.

Rep. Greene asks about if there is data or numbers on the amount of people who walked out of jail who would benefit from capacity restoration. As Rep. Greene states that there are a lot of individuals who could have benefited from it.

Lisa Coltrain states that she is unsure, but she reiterates that capacity restoration is for violent crimes and a danger to self or others.

Chairman Reeder, MD, recognizes Rep. Blackwell for a follow up question on Rep. Charles Smith's question. Rep. Blackwell asks if the determinations made by the judge are able to be appealed.

Lisa Coltrain responds stating not that she is not aware.

District Court Judges Rashad Hauter and Brain Ratledge are brought forth before the committee. Judge Hauter gives an introduction on his line of work and adds comments on Coltrains presentation. Judge Hauter states that Wake County does not have a mental health court, but is dealt with it comes through any court room. Judge Ratledge then gives an introduction and thanks Coltrain for her presentation and it's accuracy.

Chairman Reeder, MD, then requests that both Judges talk about their experiences and challenges with mental health cases within the court room.

Judges Hauter and Ratledge both respond to the question and talk about how they deal with mental health in their courtroom. Both judges both state that it is important for the committee to listen to everyone about involuntary commitment in order to make informed decisions.

Chairman Reeder, MD, then asks the Judges to talk about quality of experience with evaluators.

Both Judges speak about times they have worked with evaluators and said that the reports are found to be mostly helpful when they are making decisions about people.

Chairman Reeder, MD, steps down momentarily and Chairman Blackwell takes over as briefly. Chairman Blackwell questions the Judges the judges on the involuntary outpatient commitment process that is within statue book.

Both Judges mention the rarity of the situation but that the court system could benefit from having a Judge that is an expert in the mental health area.

Additionally, Chairman Blackwell asks for the Judges thoughts on how make the standards better in order to close the inconsistency and gaps that occur in many of these cases.

Judge Ratledge responds that the standards seem to work and that they often work with the information that they are presented with within the court session.

Chairman Blackwell follows up with a comment about the approach taken in these situations and questions that the repeated situations need to be dealt with.

Judge Ratledge does not disagree with Chairman Blackwell, however, he shares that the biggest question is how as the determination is based upon the medical evaluation due to limited time in the courtroom.

Chairman Reeder, MD, steps back up to chair the committee. Rep. Torbett is recognized to speak and questions if there is a habitual finding or any sort of rule of elimination for repeat offenders.

Judge Hauter responds that there is for general crimes but nothing to address the individuals with mental health issues as the cause of problem. Judge Hauter shares that addressing the underlying issue and making sure the defendant is on their medications and received the needed treatment.

Rep. Torbett questions if that would be a helpful tool.

Judge Hauter mentions that the District Attorneys office in Wake County has began doing mental health deferrals, similar to mental health court. The goal being treatment as it is typically a low level, non violent offense.

Rep. Charles Smith shares his belief that it would be difficult to enforce the order as there is not a large understanding from the respondent.

Rep. Clark applauds Chairman Reeder, MD, for the conversations pertaining to the committee. Rep. Clark asks the Judges if there are any effects on their role as Judges due to Iryna's Law.

Judge Ratledge thanks Rep. Clark for her question and shares that there is nothing specific that comes to mind based on her question.

Rep. Potts questions who absorbs the cost of an individual sent out for evaluations repeatedly.

Judge Ratledge shares that he has no idea pertaining to that specific area of the money. Chairman Reeder, MD, mentions that the staff will look into that aspect.

Rep. Morey questions who presents the petitions to the court for IVCs.

Judge Hauter explains that they receive roughly 300 IVC's a week. The cases are dealt with typically on Thursday mornings, virtually.

Rep. Morey shares how IVC cases were handled when she was a District Attorney.

Judge Hauter continues to share how the IVC's are handled now but specifically in Wake County.

Rep. Morey questions if a county does not have a state hospital where an attorney is presented as they are treated as a witness, if the cases are handled in civil court or criminal court.

Charles Spahos responds to Rep. Moreys question. That there is no statutory standard for District Attorneys to have a role in Rep. Moreys situation as there is no authority.

**Robert Ryan, Staff Attorney Legislative Analysis Division (NCGA) is recognized to present on Assisted Outpatient Commitment in New York (*Attachment 2*).**

Rep. Carson thanks Robert Ryan for his presentation and states that he is in favor of the information shared as it is an effective tool.

Rep. White questions who funds the program in New York.

Robert Ryan responds that the program is funded and mandated by the state.

Chairman Reeder, MD, requests to know the cost of the program.

Robert Ryan provides that the cost is roughly 30 million dollars a year for state of New York to do this program.

Rep. Campbell, MD, asks for clarification that the presented process can be used outside of criminal cases but also by families and friends.

Robert Ryan clarifies that it is a civil process and that in the case of it being a criminal matter this process would likely not be an option.

Rep. Campbell, MD, questions an individual being found eligible after a non violence crime, however, they are non compliance and do not meet the criteria for outpatient commitment, and if there is any pathway within program within the state or if the situation is back at the beginning.

Robert Ryan explains that non compliance is very common and is one of the main criteria. He goes on to share that New York and North Carolina have the same issue with individuals falling within the gap due to some aspects of the processes set up in federal constitutional law. Ultimately, if the individual falls between the gaps there are limited things can be done legally.

Rep. Blackwell questions slide page 3 on AOT eligibility, if an 'and' and 'or' for further clarification as well as the provision that discusses being a danger to ones self.

Robert Ryan responds that the New York law from his belief has not received scrutiny.

Rep. Blackwell follows up to gain clarification on the qualifications or credentials necessary for a care management provider, who is to be hired.

Robert Ryan responds that he was not able to see any criteria mentioned within statues around hiring, however, every county is mandated to fund and employ their own employees.

Rep. Blackwell requests any data surrounding how frequently order are extended, renewed, or released.

Robert Ryan responds that can gather the exact data. Additionally, he recalls that roughly 50% are renewed and shares the criteria around extending an order or if the individual desires to stay on voluntarily.

Rep. Blackwell is recognized for a final follow up question to ask about the use of this order and requests information on data of the frequency of this used in North Carolina, as well as the renewal of services.

Robert Ryan responds that he does not obtain that data and that staff will look into getting the information requested. Ryan shares that New York does have a essential repository report to share the data publicly, but that it has been seen for North Carolina.

The meeting stands adjourned at 2:47 PM.

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Representative Timothy Reeder, MD, Co-  
Chair  
Presiding

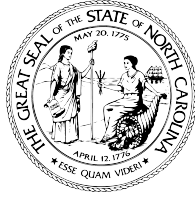
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Allison Gilbert, Committee Clerk

**ATTACHMENTS:**

**Attachment 1:** *In Court and Incapable to Proceed, NC Conference of District Attorneys,*  
PowerPoint Presentation

**Attachment 2:** *Assisted Outpatient Commitment in New York, Legislative Analysis Division,*  
PowerPoint Presentation



**House Select Committee on Involuntary Commitment and Public Safety  
Wednesday, March 18, 2026 at 9:30 AM  
Room 544 of the Legislative Office Building**

**MINUTES**

The House Select Committee on Involuntary Commitment and Public Safety meets at 9:30 AM on March 18, 2026 in Room 544 of the Legislative Office Building. Representatives Blackwell, Campbell, Cunningham, Greene, Liu, Miller, Morey, Potts, Pyrtle, Reeder, Rhyne, Carson Smith, Torbett, Wheatley, and White are in attendance.

Representative Hugh Blackwell, Co-Chair, presiding.

Introduction of Sergeant-at-Arms and House Pages.

*Chairman Blackwell introduces Sam Thompson.*

**Sam Thompson, the Executive Director of the Health Information Exchange Authority, presents Data Support at the NCDIT Enterprise Data Office. (Attachment 1).**

**Trip Stallings the Executive Director of the NC Longitudinal Data System, says he is also available to answer questions via WebEx.**

*Chairman Blackwell asks members of the committee to give their reimbursement forms to the Sergeant-at-Arms.*

*Chairman Blackwell recognizes Representative John A. Torbett.*

Representative John A. Torbett asks Mr. Thomson to define "near real-time."

Mr. Thompson says for the Health Information Exchange, it means as soon as a clinical node is completed. Other organizations, such as pharmacies, only update two or three times a day.

Rep. Torbett asks if it's not a big time lapse.

Mr. Thompson says it is not. But claims from Medicaid are only daily.

*Chairman Blackwell recognizes Representative A. Reece Pyrtle, Jr.*

Representative A. Reece Pyrtle, Jr. thanks Mr. Thompson for his presentation and says data collection is very important. He says from a law enforcement perspective, they started collecting data in 2002 and 2003. He believes that data is particularly important for law enforcement and

physicians to have the context of all the past contacts an individual has had with law enforcement or the IVC. Not everyone will need the same data.

Mr. Thompson says he 100% agrees. He thinks that privacy and security are the first concerns. People will only see how much that they need to see. Their understanding from Iryna's Law is that both sets of data need to be strongly considered before making a decision.

Mr. Stallings says any solutions put together by their teams will use role-based data. They need to know what the questions are and who needs to see what. That will allow them to make sure people see the specific data they ought to and not every piece of data in the basket.

*Chairman Blackwell recognizes Representative Timothy Reeder, MD.*

Representative Timothy Reeder, MD asks if all mental health treatment facilities and individuals included in the clinical encounter data, including for state facilities.

Mr. Thompson says state facilities are included in the dataset and that has gone live so data can be submitted in real-time. However, that does not include individuals with substance abuse disorders. There is a higher level of security for that data. Patients are also able to opt out so that their data is not collected. Mr. Thompson says they wish to change that to an opt-in model to ensure proper consent and sharing of data.

Rep. Reeder, MD, asks if a private psychiatry facility like Holly Hill would not be contributing to Health Information Exchange Authority for mental health data.

Mr. Thompson says they are contributing. The line is just drawn at the substance abuse data if that individual is in a facility that receives SAMSA funding. They do not receive specific data on what services were provided.

Rep. Reeder, MD, asks if e-courts are part of the dataset.

Mr. Thompson says e-courts are a data source, but he would defer to CJ Leads for further details.

A representative from CJ Leads says they integrate data from many sources, and they have integrated data from all e-courts in all 100 counties of North Carolina.

*Chairman Blackwell recognizes Representative Dudley Greene.*

Representative Dudley Greene asks if data from other states can be tracked by the Health Information Exchange Authority if they have had incidents in other states.

Mr. Thompson says yes, they can. They participate in a national e-health exchange where they can receive queries from other states and also query other states.

*Chairman Blackwell asks questions of the presenters.*

Chairman Blackwell asks if the Health Information Exchange Authority is the same system that relies on electronic medical records and is in place at all state psychiatric hospitals and mental facilities.

Mr. Thompson says yes, that is his understanding. He is not sure how recently that was implemented.

Chairman Blackwell asks if the information is coming in from all state facilities in addition to private providers.

Mr. Thompson says information is coming in from both. But not everyone has gotten connected yet. And if a facility takes Medicaid or State Health Plan money, they are required to connect, but it can take some time to connect.

Chairman Blackwell asks about the higher level of security that is required for substance abuse cases. He asks how much of that extra security is due to federal regulations and how much of it is due to state level regulations.

Mr. Thompson says the law that regulates that exchange of data is a federal law. It requires consent from the individual and separate storage of the data. In addition, North Carolina passed an act that bars that data from being submitted to the Health Information Exchange Authority. That has a cooling effect on all health data submitted because some health providers will not submit out of fear of accidentally violating a regulation. HIE does have a plan in place for how to obtain consent and store the data separately.

Chairman Blackwell says it sounds like a big gap in the system if they cannot view substance abuse data.

Mr. Thompson says he agrees completely. He says patients are very complex and receive care for both their physical and mental health. And if there are gaps in that information regarding substances, they cannot do as effective of a job.

Chairman Blackwell asks if legislators or the legislature can submit requests to HIE asking them to analyze a particular aspect of the data.

Mr. Thompson says yes, but typically they receive requests from state agencies, the private sector, or local governments. He asks Mr. Stallings to comment on how the Longitudinal Data System functions.

Mr. Stallings says there is a general portal for receiving requests to sort the question. If it is a question best addressed by the Longitudinal Data System, they will work on that request. There are a number of different ways for the legislature to reach out and ask about a specific need.

Chairman Blackwell asks about data owners and if the system's intake of information is limited by the refusal of some data owners to participate.

Mr. Thompson says yes, it is. The HIE owns the data in their system, but they are beholden to their partners such as universities. If they disapprove of how the HIE is handling data, they can stop submitting it and HIE is not able to make them send their data. Some entities are also moving slowly to connect despite being required to. And others only submit the bare minimum of data which is required to be submitted.

Chairman Blackwell says it sounds like the substance abuse data is not being collected, private data owners are dragging their feet, and state agencies who are also delaying which leads to a lot of gaps. Although HIE could theoretically be getting data from everyone, in practice they are not able to.

Mr. Thompson says that is true, but he would reiterate that the vast majority of North Carolinians are in the system. But there could be stronger enforcement mechanisms to make data owners connect to the system. There were financial penalties at one point, but that has been rolled back due to urging from the North Carolina Department of Health and Human Services.

Mr. Stallings says in the non-health data space, state agencies have to navigate challenging federal policies. That can feel like a lack of cooperation, but it can just take a long time to figure out how to operate within those rules

Chairman Blackwell says once data has been collected, the presentation says it can only be accessed by covered entities and their business associates. Chairman Blackwell asks for clarification on what those are.

Mr. Thompson says covered entities are entities that are helping with healthcare treatment or payment operations. That covered entity can enter into an agreement with a business to analyze their data on their behalf.

Chairman Blackwell asks if state statutory action could expand the definition of covered entities or business associates.

Mr. Thompson says he is not an attorney so he is reluctant to speak to that. However, HIPAA law is flexible and seeks to implement safe practices, not ban any sharing of data.

Chairman Blackwell asks about Mr. Thompson's comment that CJ Leads can only be accessed by law enforcement or covered entities. Chairman Blackwell asks if that is a state or federal statute.

A representative from CJ Leads says that it is a state statute.

Chairman Blackwell asks if the General Assembly could theoretically modify that.

The representative from CJ Leads says yes.

Chairman Blackwell asks about the Longitudinal Data System, which says it currently can only access educational and workforce data. Chairman Blackwell asks if that is a state statutory limitation that could be expanded by the North Carolina General Assembly.

Mr. Stallings says yes.

*Chairman Blackwell recognizes Representative Carson Smith.*

Representative Carson Smith asks if an entity does not provide the data they are required to provide, could they be prohibited from accessing the data exchange itself.

Mr. Thompson says that is how it currently works, by and large. If HIE has a participation agreement with a practice, on the first day the practice can utilize the clinical portal. If that practice does not uphold their end of the participation agreement, they are locked out of the system. There is also a submit-only agreement, which are LMEs who say they will follow the letter of the law on what they are required to submit, but they do not want to access the system at all

*Chairman Blackwell recognizes Representative A. Reece Pyrtle, Jr.*

Representative A. Reece Pyrtle, Jr says that at the end of the day, the data collection is to allow law enforcement to have safe contact with individuals and for those people to receive the best care possible from their clinician. Rep. Pyrtle says hospitals and law enforcement already collect data, even if it does not go into CJ Lead's system. It is just a matter of getting that data together. CJ Leads is on the criminal justice side of things, but IVC patients are involved in a civil matter and need assistance.

There are no further questions from the committee.

*Chairman Blackwell thanks Mr. Thompson and Mr. Stallings for their presentation*

*Chairman Blackwell introduces Sean Schreiber and Allison Gosda.*

Due to technical difficulties, Chairman Blackwell puts the committee on break for 5 minutes.

**Sean Schreiber, the Executive Vice President and Chief Innovation and Strategy Officer at Alliance Health, presents slides 1-4 of LME/MCO's Perspective on Mobile Crisis Teams (Attachment 2).**

**Allison Gosda, the Chief of Clinical Services at Partners Health Management, presents slides 5-8 of LME/MCO's Perspective on Mobile Crisis Teams (Attachment 2).**

*Chairman Blackwell recognizes Representative John A. Torbett.*

Representative John A. Torbett says the committee is to help with outpatient committee services and there are many improvements that need to be made. Rep. Torbett asks for the presenter's assistance in addressing this issue and thanks them for the work they do.

*Chairman Blackwell recognizes Representative Marcia Morey.*

Representative Marcia Morey asks how many mobile crisis teams there are

Ms. Gosda says there are some teams that cover multiple counties.

Rep. Morey asks if there were more licensed evaluators, do they think that would help serve more people in need.

Ms. Gosda says those licensed evaluators would not necessarily be in the mobile crisis and they may be more effective working independently.

*Chairman Blackwell recognizes Representative A. Reece Pyrtle, Jr.*

Representative A. Reece Pyrtle, Jr. asks if mobile crisis teams can assist with soft handoffs to ensure continuation of care.

Mr. Schreiber says in his areas, they partner with bridging teams which do the soft handoffs. It is better for the patient and also saves money. The urgent care teams also help patients who miss their initial appointment.

*Chairman Blackwell recognizes Representative Donna White.*

Representative Donna White asks for the committee to be sent the results of the SAMSA model and which counties were involved.

Ms. Gosda says she would be happy to send the results, and it was piloted in Burke, Catawba, Cleveland, Gaston, Iredell, and Lincoln counties.

*Chairman Blackwell recognizes Representative Timothy Reeder, MD.*

Representative Timothy Reeder, MD, asks if there is a billing code when a crisis team deals with a patient.

Mr. Schreiber says there is a time-based code for billing.

Rep. Reeder, MD, asks if it is the same billing code if the person who shows up to help is not licensed.

Mr. Schreiber says yes, it is.

Rep. Reeder, MD, asks about implementing an enhanced rate for first responders.

Ms. Gosda says she cannot speak on commercial insurance, but they already tier rates and that plan is very feasible.

Mr. Schreiber says the broader funding challenge is that there always need to be teams on the clock, which incurs costs even when there are not mental health emergencies

*Chairman Blackwell asks questions of the presenters.*

Chairman Blackwell asks if mobile crisis units put the data they collection from non-IVC interactions into a system that a clinician can access later if that person ends up being admitted into the IVC process.

Mr. Schreiber says they are required to report their data into the HIE system, which clinicians can then check.

Chairman Blackwell asks if that data is just about the claim filed to collect payment, not relevant details about the condition of that person when they first interacted with the mobile crisis unit.

Mr. Schreiber says he would have to follow up with the committee about what specifically the clinician can see.

Ms. Gosda says when clinicians go into the data portal, they can see the clinical assessment that gets filed along with the claim.

Chairman Blackwell asks if that clinical assessment is to justify the claim.

Ms. Gosda says yes.

Chairman Blackwell asks about the supports Ms. Gosda said were needed after Iryna's Law was passed. Chairman Blackwell asks what is preventing LME/MCOs from acquiring those supports right now and if lack of funding is the issue.

Ms. Gosda says paying for more licensed physicians would increase costs. Additionally, first examinations in jails are not covered by Medicaid, which means state funding would have to be used to cover those costs. That removes money from the one big pot available and therefore reduces the amount of funding available to use on other priorities.

Chairman Blackwell asks about whether the coordinated crisis system workflows issue mentioned in the presentation requires more funding from the General Assembly or more time for LME/MCOs to work out.

Mr. Schreiber says Iryna's Law creates new questions on timeframes, location of examinations, and other matters that need to be figured out. For example, jails would have to figure out a protocol.

Chairman Blackwell asks if that is something LME/MCOs can do without action by the General Assembly.

Mr. Schreiber answers yes.

Chairman Blackwell asks about workforce and funding for first level evaluation examinations. He says his understanding is that there is a shortage of staff, not physical beds. He asks if they have any recommendations on how to fix the staffing issue, especially through increased salaries.

Mr. Schreiber says they have worked with an organization which works with various states to provide supplemental staffing and he can send the report on that to the committee.

Chairman Blackwell references a slide in the presentation which says the current outpatient commitment process presents operational challenges and would likely require structural changes to the system to function effectively. He asks what the structural changes are that would be required.

Ms. Gosda says she would like to return with a more thorough proposal. She says unlike assisted outpatient treatment, outpatient commitment does not have care management, intense tracking, follow ups, and similar supports.

*Chairman Blackwell recognizes Representative John A. Torbett.*

Representative John A. Torbett asks if suddenly the presenters needed 100 new staff, what would they do to attract them.

Mr. Schreiber said they would utilize virtual models of care so they could leverage those providers from satellite locations. They also recruit providers to partner with and help shoulder some of the costs. They would also leverage the peer support workforce to handle some tasks so clinicians can focus on what only doctors can do.

*Chairman Blackwell thanks Sean Schreiber and Allison Gosda.*

*Chairman Blackwell introduces Meredith Smith, Mark Botts, and Shea Denning.*

**Meredith Smith, JD, an Associate Professor at the UNC School of Government, presents slides 1-18 of The Intersection of Guardianship, Involuntary Commitment, and Capacity to Proceed presentation. (Attachment 3).**

**Mark Botts, JD, an Associate Professor at the UNC School of Government, presents slides 19-26 of The Intersection of Guardianship, Involuntary Commitment, and Capacity to Proceed presentation. (Attachment 3).**

**Shea Denning, JD, a James E. Holshouser Distinguished Professor and Director of the North Carolina Judicial College at the UNC School of Government, presents slides 27-32 of The Intersection of Guardianship, Involuntary Commitment, and Capacity to Proceed presentation. (Attachment 3).**

*Chairman Blackwell recognizes Representative Donna White.*

Representative Donna White asks if the hypothetical Paula talked about in the presentation is still on the street.

Ms. Denning says there are not good answers for Paula.

Ms. Smith says a critical question for the court is if the guardian is doing what they need to do, has Paula been connected to a mental health provider, and has Paula adhered to the treatment plan.

Mr. Botts says the guardian has access to all of Paula's treatment information, so they can call the LME or MCO to ask if there is a provider and if she has been getting treatment. The guardian is a facilitator and plays a very important role in arranging things for the patient. The guardian might be doing everything they can do, but they still need Paula's cooperation.

Rep. White says she thinks these issues in the system are why the General Assembly passed Iryna's Law. As a public health nurse, she dealt with a lot of folks who were not doing their job in different departments where guardians are appointed from. And based off of the presentation, she thinks those problems still persist.

*Chairman Blackwell recognizes Representative Marcia Morey.*

Representative Marcia Morey thanks the presenters. She gives background prior to the passage of Iryna's Law. She says misdemeanor cases never even get to the involuntary commitment process. Until Iryna's Law was passed, the classification of the case was the main driver of where that patient ended up. She asks if the presenters agree with that assessment.

Ms. Denning says the felony cases proceed through a track where if the person is committed, they will go to a state hospital. That is also the case if crimes are designated as violent. For the other types of crimes, those people are unlikely to ever be sent to the state hospital for treatment. That means they are more likely to be involuntarily committed.

Mr. Botts says the incapacity to proceed uses the criminal process to find someone who may fit the involuntary commitment criteria. If so, the judge issues an order for that patient to be taken to a state hospital if it is a violent offense. But that patient may never get there due to a lack of staffing.

Mr. Botts says Iryna's Law does a similar thing. It uses the criminal process to identify when the person being considered for release may be mentally ill and a danger to themselves or others. If so, the magistrate issues an order which starts the IVC process. That person goes into the process, but it does not mean they get to the end of the process and get treatment. At some point, that patient will be discharged. But the way Iryna's Law is written right now does not cover all patients.

Rep. Morey says a district court judge from Orange County wrote her that when the charge is a "non-violent misdemeanor," the law only allows the judge to order a local evaluation. However, local hospitals can and do refuse to hold the individual for the evaluation without an allegation of harm to self or others. Those individuals either have to be released until their trial or held in jail. Rep. Morey says that is one of the main frustrations from judges because they are not able to act as they see fit to ensure someone receives care.

*Chairman Blackwell asks a series of questions.*

Chairman Blackwell gives an example for a case like the "Paula" from the presentation where the guardian argues in court that Paula should be in a mental health facility and the judge agrees with her. In that case, are there no enforcement mechanisms to make Paula actually get treatment?

Mr. Botts says the guardian has to show up at a given facility with Paula. The difficulty is to get Paula to initially go the facility when the guardian fills out an application. That process triggers the scheduling of a meeting before the court.

Chairman Blackwell proposes an example where Paula goes and is admitted. Can Paula decided to leave?

Mr. Botts says no, she cannot.

Chairman Blackwell asks how Paula would get out.

Mr. Botts says there are three ways. First, the guardian can apply to the court to have her discharged on the grounds that Paula no longer has a mental illness or does not benefit from treatment at that facility. The other two ways are if the court or facility decide to discharge her.

Chairman Blackwell asks that from Paula's perspective, if she makes the mistake of showing up the first time, she will be stuck in treatment.

Mr. Botts says that is correct.

Chairman Blackwell asks that the only way out is if Paula's guardian, the court, or the facility change their mind about Paula needing treatment.

Mr. Botts says that is correct.

Chairman Blackwell asks if dangerousness does not enter into consideration.

Mr. Botts says that is correct.

Chairman Blackwell asks if the standard for release is lower if a patient goes to treatment voluntarily.

Mr. Botts says that is correct.

Chairman Blackwell asks if the dangerousness standard is required by federal courts or constitutional law. Or could that standard be changed to have someone involuntarily committed if someone has a mental illness and is in need of treatment.

Mr. Botts says federal law and Supreme Court precedent requires that the individual be a danger to themselves or others to be confined in this way.

Chairman Blackwell asks if that is the specific standard because that is not his understanding.

Mr. Botts says the caveat to the dangerousness is that states can define for themselves what dangerousness means in order to have more people qualify as dangerous. The danger does not need to be imminent.

Chairman Blackwell asks if someone could be defined as dangerous if they are mentally ill and in need of treatment to some degree.

Mr. Botts says he does not think federal law would allow that. In North Carolina, there are six ways someone can be considered dangerous. One is through lack of care of themselves, which is a fairly expansive definition. Mr. Botts says if he was Chairman Blackwell's lawyer, he would recommend changing the definition of dangerousness if the aim was to have more people qualify as dangerous.

Chairman Blackwell mentions legal decisions from other states that were mentioned in the presentation. He asks if those decisions apply to North Carolina.

Ms. Denning says those decision absolutely do not apply to North Carolina. Those cases were used as examples, although the principles applied by those courts would likely be applied in North Carolina courts too.

Chairman Blackwell asks if in North Carolina, the General Assembly could pass a law that lets a guardian enter in a guilty plea on behalf of a mentally ill individual.

Ms. Denning says she thinks there would be a constitutional bar to that. The Oregon case said it was not permissible for a lawyer to make the decision to waive some rights on behalf of their client.

Mr. Botts clarifies that an individual can be committed in North Carolina without being dangerous, but they have to be committed to outpatient treatment.

*Chairman Blackwell recognizes Representative Dudley Greene.*

Representative Dudley Greene asks who has the right or standing to make a motion to get an individual a guardian. For example, could a treatment provider make that recommendation?

Ms. Smith says North Carolina law says any person can file a petition for incompetency to get someone a guardian.

*Chairman Blackwell thanks Meredith Smith, Mark Botts, and Shea Denning.*

*Chairman Blackwell introduces Dr. Christopher Sharp.*

**Dr. Christopher Sharp, a Senior Fellow at the Cicero Institute, presents on Involuntary Commitment In North Carolina.**

*Chairman Blackwell recognizes Representative Marcia Morey.*

Representative Marcia Morey asks Dr. Sharp if he lives in North Carolina.

Dr. Sharp says he does not.

Rep. Morey says she has concerns about his comments about specialty courts and does not think they should be combined together. She also believes Disability Rights have fulfilled their purpose.

Dr. Sharp says he is not referring to juvenile or domestic violence courts when he refers to specialty courts. He believes those serve an important purpose. But juvenile courts do not usually deal with mental health issues.

*Chairman Blackwell recognizes Representative Carson Smith.*

Carson Smith says he thinks Disability Rights of North Carolina has set North Carolinians back.

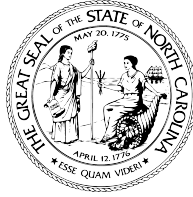
The meeting stands adjourned at 12:39PM.

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Representative Hugh Blackwell, Co-Chair  
Presiding

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Isaiah Garner, Committee Clerk



**House Select Committee on Involuntary Commitment and Public Safety  
Tuesday, April 14, 2026 at 10:00 AM  
Room 544**

**MINUTES**

The House Select Committee on Involuntary Commitment and Public Safety meets at 10:00 AM on April 14, 2026 in Room 544 LOB. Representatives Blackwell, T. Brown, Budd, Campbell, Cunningham, Greene, Lambeth, Liu, Miller, Morey, Potts, Pyrtle, Reeder, Rhyne, Torbett, Wheatley, and White are in attendance.

Representative Timothy Reeder, MD, Co-Chair, presiding.

Introduction of Sergeant-at-Arms and House Pages.

Rep. Reeder, MD, provides opening remarks and thanks the committee Members, Staff, and advocates for their work within the committee. Rep. Reeder, MD, shares that this committee is an ongoing process.

**Approval of Committee Minutes**

Rep. Reeder accepts a motion from Rep. Miller to approve the Committee minutes, with authority for staff to make technical changes and to compile today's minutes.

Rep. Pyrtle seconds the motion.

With no opposition the Committee minutes are approved by a voice vote.

**Overview of Committee Report, presented by Jessica Boney, Staff Attorney for the Legislative Analysis Division (Attachment 1).**

Jessica Boney provides a brief overview of the Committee Draft Report. Boney highlights the various findings and recommendations made from the Committee regarding involuntary commitment. Additionally, Boney shares the recommendation of authorizing House Select Committee on Involuntary Commitment and Public Safety to continue its work and the committees re-establishment to continue to work through the 2027-2028 biennium.

Chairman Reeder, MD, opens the floor to questions from the committee.

Rep. Torbett questions if committee language offers the Department of Health and Human Services the ability to make corrections or aid in fixing the problem immediately or if it is legislative change.

Chairman Reeder, MD, responds that the committee has been in communication with the Department of Health and Human Services throughout the committees process. Chairman Reeder, MD, encourages the department to implement changes that can be made without the legislative process and if legislative action, it can be worked on.

Rep. Torbett is recognized for a follow up question to ask if there is a way of being notified that actions are being taken by the department if they chose to implement changes to improve the involuntary commitment process.

Chairman Reeder, MD, responds that the House Select Committee on Involuntary Commitment and Public Safety and Oversight meet with the Department of Health and Human Services regularly. Additionally, Chairman Reeder, MD, shares he is committed to making sure the committee is notified as changes are made by the Department of Health and Human Services.

Rep. Lambeth thanks everyone involved in the committees process and emphasizes that the committee and process is ongoing. Rep. Lambeth questions if the draft can be changes slightly to encourage private providers to expand as well as evolve into a grants program to help the private providers that need assistance at the beginning. Additionally, Rep. Lambeth encourages the committee to look into metrics that can be monitored on a regular basis.

Rep. Blackwell responds to Rep. Lambeth, to clarify that language was added to the draft report to address the issue of non-state providers and beds. Rep. Blackwell notes that Rep. Lambeth's point is well taken. Rep. Blackwell addresses that the longitudinal date in the data collection will tie into the metrics that Rep. Lambeth encourages, in order to have an indication of improvement and data refer to.

Rep. Liu shares her appreciation for the comprehensive draft report, displaying the work done by the committee and staff members. Rep. Liu shares a comment to suggest making the data available to state agencies and researches so that additional data and insights can be shared to the committee in return.

Chairman Reeder, MD, responds that the committee will carry that suggestion forward.

Rep. Morey is recognized to follow up with Rep. Torbetts questions regarding some specifics in which she wishes to be addressed as the General Assembly deals with budgeting and funding for issues found by the committee.

Chairman Reeder, MD, follows up to note "I think that's well said." to Rep. Moreys comment. Chairman Reeder, MD, continues to discuss the need to have state operated facilities operating at a higher capacity, as the state operated facilities have funding.

Rep. Pyrtle comments that due to the limited funding, if prioritizing some of the recommendations as some issues need quicker attention than others.

Rep. Wheatley comments to suggest partnering with community colleges to provide some of the staff training that is necessary.

Rep. White comments addressing aspects of funding left over that was allocated for employees of state hospitals. Rep. White shares that within a facility, such as the hospitals discussed within the committee that house mental health patients, the need to people with determination, education and training to be safe, however, they may not always have the highest level of expertise in terms of medical training, outside of the nursing component.

Rep. Cunningham address invest \$835 million dollar investment that the Department of Health and Human services has been giving out when Medicaid dollars were drawn down and went over for mental health, intellectual and developmental disabilities, and substance use services. Rep. Cunningham highlights that as of now there are no social norms within society and that the mental health crisis has always been present but is now exacerbated and requiring a larger amount of attention. She notes that we are living in past times and the need to look into those individuals who are not going to self medicate and are aware of how to manipulate the system as they are in and out of it. Rep. Cunningham mentions that this issue will take a long time.

Rep. Potts follows up regarding Rep. Morey and Rep. Pyrtles comments, to question if there is a plan to take various priorities to the Senate.

Rep. Reeder, MD, shares in response that conversations have already began with the Senate, some draft language has already been started, and there will be meetings with Senate Counterparts in attempts to figure out what will happen next regarding legislation.

Rep. Blackwell adds that the committee does not need to be waiting on things because of the thought that they are not as high of a priority but rather plan to move several things, whether it be in an omnibus bill or separately. Rep. Blackwell agrees with Rep. Reeder, MD, previous comment regarding the opportunities for the future of the committee.

Rep. Torbett questions if Chairman Reeder, MD, sees the committee meeting again after 2026 short session, before 2027 long session.

Chairman Reeder, MD, shares that he is unsure and that the committee has not planned that far ahead. Chairman Reeder, MD, notes that one of the recommendations in the draft report is to continue the committee through the calendar year, implying time with the committee together.

Rep. Blackwell adds to Chairman Reeder, MD, comment that the committee meeting may be depended on the availability of members.

Rep. Campbell, MD, motions for approval of the draft report.

Chairman Reeder, MD, states that Rep. Campbell moves to approve the Committee report, with authority for staff to incorporate the summary of the final committee proceeding and make any other technical issues.

Rep. Potts, seconds the motion. The motion carries by a voice vote.

Chairman Reeder, MD, closes the committee meeting by thanking staff, members of the committee, recognizing those who have submitted public comments as they were helpful, feedback from the Department of Health and Human Services, Administrative Office of the Courts, and the Sheriffs Association.

The meeting stands adjourned at 10:29 PM.

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Representative Timothy Reeder, MD, Co-  
Chair  
Presiding

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Allison Gilbert, Committee Clerk

**Attachments:**

**Attachment 1:** *The House Select Committee on Involuntary Commitment and Public Safety Report to the 2026 Session of the 2025 General Assembly of North Carolina, Report PDF.*