CLOSER TO HEART—A PROPOSAL TO REDUCE POLICE INVOLVEMENT IN INVOLUNTARY COMMITMENT IN NORTH CAROLINA*

DANIEL STAINKAMP**

Involuntary commitment ("IVC") is the civil legal process by which individuals are forced to receive treatment against their will, typically as a consequence of being perceived to pose a danger to themselves or others due to apparent mental illness or substance abuse. Though IVC can be beneficial, it can also be traumatic. Thus, it is appropriate only as a last resort. Nevertheless, IVC is on the rise, and people experiencing mental illness are increasingly justice-involved. This is troubling, since IVC disproportionately affects vulnerable and marginalized groups. Scholars have argued that IVC tends to deprive people of due process, advocating for procedural justice reforms. But despite six decades of advocacy in this realm, outcomes remain unacceptable.

This Article argues for the first time that, instead of being reformed, IVC law in North Carolina must be abolished and replaced by novel law and policy. This is the most practicable way to address the needs IVC law was designed to address, and the most comprehensive way to remedy the failures of the current legal regime. Abolition of IVC law as we know it will liberate people experiencing behavioral health crises by stemming needless application of force and reducing the risk of violence and death at the hands of law enforcement personnel. Far from abstract or idealistic, this proposal is grounded in two existing frameworks of law and policy. By implementing statewide the Holistic Empathetic Area Response Team ("HEART") model—which is already in use in the City of Durham—and the model Behavioral Health Response Team ("BHRT") Act drafted by Taleed El-Sabawi and Jennifer J. Carroll, our state

** J.D. Graduate, The University of North Carolina School of Law, Class of 2024. I go by "Nebraska," so you may know me by that name. I extend heartfelt thanks to Maxine Eichner, Eisha Jain, Brandon Garrett, Joe Kennedy, Joan Krause, Gene Nichol, Richard Saver, and Rick Su, who took my academic work seriously and encouraged me to do the same. Special thanks are due to Sofia Hernandez, who introduced me to HEART and its team of dedicated personnel. I thank E.J. Branson for their compassionate insights. I thank the staff and editorial board of the *North Carolina Law Review*, especially Taylor Coleman, Samuel Lahne, and Sam Scheipers, for their careful and considerate feedback, which elevated this piece to a level I could not have achieved alone. I thank my family of origin, my dear friends and kind mentors in the legal and scholastic communities, and my recovery community for their continued support. And most of all, I offer deepest gratitude to L.L.L., whose friendship amid psychic struggle and psychiatric detention I will always treasure, and whose untimely departure from this world inspired this piece. Miss you so much.

can more compassionately and effectively address the needs of people subjected to IVC, materially improving their health and preserving their dignity.

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INTRODUCTION

In North Carolina,[1] involuntary commitment ("IVC")[2] is a legal process that facilitates confinement of persons experiencing behavioral health crises perceived as evidence that they present a danger to themselves or others.[3] IVC involves

1. The scope of this Article is limited to North Carolina. Notably, "the U.S. Supreme Court has addressed a handful of cases regarding due process" in involuntary commitment ("IVC"), but "the Court has not specified the procedural protections to which [people subjected to IVC] are entitled[;]" accordingly, "states largely design their own [IVC] systems." *See* Margaret J. Lederer, Note, *Not So Civil Commitment: A Proposal for Statutory Reform Grounded in Procedural Justice*, 72 DUKE L.J. 903, 911 (2023).

2. A variety of terms for forced treatment abound. I use "involuntary commitment" because it accurately portrays the process. Other more anodyne terms exist, like "forensic mental health detention" and "civil commitment," but I disfavor these terms because they obscure the inherent coercion and carcerality of IVC. At least one scholar has alluded to the fact that this process is "not so civil." *See id. passim*.

3. "Whether someone requires hospitalization is a complex question of psychology, medicine, and substantive law." *Id.* at 903. For the particulars of N.C. IVC law, see *infra* Part II. There are two main legal principles said to undergird a state's IVC authority. The first is the *parens patriae* doctrine, which holds the government responsible for intervening on behalf of citizens who are deemed unable to act in their own best interest. Megan Testa & Sara G. West, *Civil Commitment in the United States*,

temporarily incarcerating a person in a health facility against their will, without their (or their guardian's) permission.[4] IVC results in the temporary loss of an individual's right to make their own decisions and forces them to receive treatment.[5] Unlike criminal incarceration, psychiatric detention pursuant to IVC may continue indefinitely.[6]

The usual legal process of an IVC in North Carolina involves a layperson or medical professional petitioning a local magistrate to order mental-health or substance-use treatment for an individual against their will.[7] A person subjected to IVC[8] may be admitted to a state hospital if they are deemed "so extremely dangerous that they pose a serious threat to the community and/or to patients committed to nonstate hospital psychiatric units," or if they are "so gravely disabled by both multiple disorders and medical fragility . . . that alternative care is inappropriate."[9]

Initiating the IVC process triggers the transmission of a custody order to local police, who then take custody of the person subjected to IVC and transport them

7 PSYCHIATRY 30, 31 (2010). The second is the "police power," which is "the fundamental ability of a government to enact laws to coerce its citizenry for the public good," usually understood to require a state to protect the interests of its citizens. *Id.*; *Police Powers*, CORNELL L. SCH. LEGAL INFO. INST., https://www.law.cornell.edu/wex/police_powers [https://perma.cc/7UBR-VKCE] (last updated Dec. 2020).

4. *Involuntary Commitment*, DISABILITY RTS. N.C. (May 3, 2022), https://disabilityrightsnc.org/resources/involuntary-commitment/ [https://perma.cc/6WQS-6J3K].

5. *Id.* This can include being forced to take medication. N.C. GEN. STAT. § 122C-273 (2024). Patients may also feel pressured into receiving electroconvulsive therapy. *See* Sinead Maguire, Shelagh-Mary Rea & Paul Bernard Convery, *Electroconvulsive Therapy—What Do Patients Think of Their Treatment?*, 85 ULSTER MED. J. 182, 183–84 (2016).

6. Cynthia A. King, *Fighting the Devil We Don't Know:* Kansas v. Hendricks*, A Case Study Exploring the Civilization of Criminal Punishment and Its Ineffectiveness in Preventing Child Sexual Abuse*, 40 WM. & MARY L. REV. 1427, 1431 (1999) (citing State v. Turner, 556 S.W.2d 563, 566 (Tex. 1977)); *see also* Brian T. Lawler, *Out of Sight, Out of Mind: Indefinite Confinement and the Unconstitutional Treatment of North Carolinians with Mental Retardation*, 35 CAMPBELL L. REV. 257, 263–65 (2013) (discussing how sections 15A and 122C of the General Statues of North Carolina create the legal conditions in North Carolina to permit long-term and even indefinite detention for arrested persons deemed "mentally retarded" and "dangerous").

7. Taylor Knopf, *More NC Psych Patients Are Ending Up Handcuffed in a Police Car. Why?*, NC HEALTH NEWS (Dec. 14, 2020), https://www.northcarolinahealthnews.org/2020/12/14/more-nc-psych-patients-are-ending-up-handcuffed-in-a-police-car-why/ [https://perma.cc/M3MS-WPSZ] [hereinafter Knopf, *More NC Psych Patients*].

8. Note that people subjected to IVC are sometimes referred to as "patients" or "respondents." Though technically accurate, I disfavor those terms because they downplay the experience of being coerced into psychiatric incarceration. I also disfavor the agentic quality they imply; I feel that the term "persons *subjected to* IVC" better matches their lack of agency.

9. In North Carolina, this determination is made by the director of the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or the director's designee. N.C. GEN. STAT. § 122C-262 (2024).

to the hospital.[10] Though IVC is technically a civil legal process, its carceral aspects can make people feel criminalized.[11] And regardless of how people may feel, the material reality is that people with mental illness are increasingly "judiciarized."[12] "This judiciarization may have detrimental effects . . . including interruptions in services, social isolation, economic [precarity], stigmatization, and difficulties reintegrating [into] society after hospitalization or incarceration."[13]

These problems "disproportionally affect vulnerable and marginalized groups, especially [poor], Indigenous, and racialized individuals."[14] In other words, our neighbors and loved ones are having their mental illness treated like a crime,[15] which subjects them to needless deprivation and degradation. This state of affairs is discriminatory, unethical, and inhumane. It affects many of us.

In 2021, one in five U.S. adults—57.8 million people—experienced mental illness, and one in twenty—14.1 million people—experienced serious mental

10. Knopf, *More NC Psych Patients*, *supra* note 7. This procedure can involve being restrained via handcuffs and ankle shackles, and the transportation usually takes place in a law-enforcement vehicle. *Id.* (quoting Mark Botts, Professor at the University of North Carolina Chapel Hill School of Government: "Under the IVC process, law enforcement is obligated to provide the transport . . . ."; and quoting Carrie Brown, Chief Medical Officer of Behavioral Health at the North Carolina Department of Health and Human Services: "The entire country has reverted to law enforcement for transportation of IVC, which on principle doesn't make a lot of sense because there's no crime being committed . . . .").

11. *Id.* (quoting Sonia Padial, Parent of a Young Man Subjected to IVC: "Though [a young man subjected to IVC] did nothing wrong, he felt criminalized and humiliated for having a mental illness . . . .").

12. Judiciarization is a growing phenomenon defined as "[t]he involvement of people living with mental illness in the judicial process, whether in [the] civil or criminal justice system. . . . Such over-representation of people with mental illness in the justice system is related to several issues, including stigma, experienced coercion, loss of autonomy and social isolation." Etienne Paradis-Gagné, Dave Holmes, Emmanuelle Bernheim & Myriam Cader, *The Judiciarization of People Living with Mental Illness: A Grounded Theory on the Perceptions of Persons Involuntary Admitted in Psychiatric Institution*, 44 ISSUES IN MENTAL HEALTH NURSING 1200, 1200 (2023). Note that the title is listed correctly here, though it might be more grammatically correct to say "Persons Involuntar*ily* Admitted in Psychiatric Institution*s*." *Id.* Another author put it this way: "[T]he prison system is the largest mental health facility that exists nationally, and the overlap between health care and justice undermines the effectiveness of each system while harming human lives in the process." Emily Bachar, The Criminalization of Mental Illness: An Ethical Analysis of the Need for Disentanglement of Mental Illness and Criminal Justice 3 (2022) (Markkula Center for Applied Ethics, Santa Clara University), https://www.scu.edu/media/ethics-center/hackworth-fellows/The-Criminalization-of-Mental-Illness.pdf [https://perma.cc/8WYV-9HY6]. In an effort to humanize and to destigmatize people who are exposed to the legal system, this Article uses the terms "justice-involved" and "judiciarized" instead of terms like "criminal" or "offender." *See, e.g.*, Sunny Khan Frothingham, Note, *Unfair, Deceptive, and Abusive: Prison Release Cards and the Protection of Captive Consumers*, 28 N.C. BANKING INST. 227 *passim* (2024).

13. Paradis-Gagné et al., *supra* note 12, at 1200.

14. *Id.* at 1201.

15. Arguably, we treat mentally ill people *worse* than we treat alleged criminals. Crucially, even when behavior is dangerous to others, in most cases criminal law permits confinement of healthy people only *after* they have done something that is considered legally harmful to public welfare; with people subjected to IVC, our civil law system allows us to confine them *beforehand*.

illness.[16] In North Carolina, "1,469,000 adults . . . have a mental health condition" and "356,000 adults have a serious mental illness."[17] Among this population, many experience behavioral health crises of such a perceived severity that IVC is deployed as an intervention to attempt to resolve the crisis and either restore their behavioral stability or incapacitate them so that they no longer pose a threat to society at large.

The number of people subjected to IVC is growing rapidly, yet it is unclear why this is so.[18] Although IVC is practiced nationwide, basic statistics about

16. *Mental Health by the Numbers*, NAT'L ALL. ON MENTAL HEALTH, https://www.nami.org/mhstats [https://perma.cc/V5FS-BARM] (last updated Apr. 2023); *see also infra* note 17.

17. NAT'L ALL. ON MENTAL HEALTH, MENTAL HEALTH IN NORTH CAROLINA 1 (2021), https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/NorthCarolinaStateFactSheet.pdf [https://perma.cc/S7QY-K4VV] [hereinafter MENTAL HEALTH IN NORTH CAROLINA]. The statistics presented here reflect the terminology used by National Alliance on Mental Health ("NAMI"). *Id.* The NAMI used the term "experienced" when reporting U.S. mental health statistics, *Mental Health by the Numbers*, *supra* note 16, but used the term "have" when reporting North Carolina mental health statistics, MENTAL HEALTH IN NORTH CAROLINA, *supra*, at 1. I prefer the term "experienced" with regards to mental illness over the term "have," because it connotes a variability and fluidity that accords with the transdiagnostic dimensional understanding of how neurodiversity occurs. "The National Survey on Drug Use and Health (NSDUH), conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA), provides nationally representative data on," among other things, "mental health issues and use of mental health services among the civilian, noninstitutionalized population aged 12 or older in the United States." SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2021 NATIONAL SURVEY ON DRUG USE AND HEALTH 5 (2022), https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf [https://perma.cc/P4YC-WY33].

> The 2021 NSDUH provided estimates of any mental illness (AMI) and serious mental illness (SMI) for adults aged 18 or older. Adults aged 18 or older were classified as having AMI if they had any mental, behavioral, or emotional disorder in the past year of sufficient duration to meet criteria from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), excluding developmental disorders and [substance use disorders]. Adults aged 18 or older who were classified as having AMI were classified as having SMI if they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities.

Id. at 39.

18. One possible reason for this increase is that healthcare providers are concerned about liability and may believe (mistakenly) that IVC is a prerequisite for admission to psychiatric facilities. There has been a growth in the assumption that loss of rights is a necessary condition for adequate medical care. This is a misconception not just among the public, but among hospital workers, lawyers, and even psychiatrists. *See* Knopf, *More NC Psych Patients*, *supra* note 7. Other possible reasons are population growth, funding cuts, lack of community mental health services, long wait times for therapists, and longer wait times experienced by patients "in emergency departments with referrals to one of the three state-run psychiatric hospitals." *See* Taylor Knopf, *New Mental Health Data Show 'Unsustainable' Burden on NC Hospitals*, WRAL NEWS, https://www.wral.com/story/new-mental-health-data-show-unsustainable-burden-on-nc-hospitals/20424644/ [https://perma.cc/S4G9-TQNA] (last updated Aug. 21, 2022, 5:30 AM) [hereinafter Knopf, *'Unsustainable' Burden on NC Hospitals*]. Also, the high costs of mental health services and inadequate insurance coverage can lead people who need help to forgo it, which in turn can result in more crisis encounters and higher rates of IVC. *Id.*

IVC remain largely unknown or inaccessible.[19] Tracking IVC is "complicated by numerous factors, including patient privacy concerns, decentralized systems of mental health care, and variable commitment criteria across jurisdictions."[20] Accordingly, there is a dearth of clear data about IVC. The most robust study to date estimates that approximately 1.4 million people are subjected to IVC each year.[21] That study concluded that "involuntary psychiatric detentions between 2011 and 2018 varied 33-fold across 25 states, and the mean state rate increased by three times the mean state population increase."[22] In other words, "involuntary psychiatric detentions outpaced population growth by a rate [of] 3 to 1."[23]

One factor that may be contributing to the increase in psychiatric incarceration is the rollout of 988, the suicide and mental health crisis hotline.[24] Since 2022, nearly 100,000 people have been subjected to IVC as a consequence of reaching out to 988.[25] Across the country, states have passed new legislation

19. For example, the numbers of involuntary psychiatric hospitalizations each year is unclear. *See* Nathaniel P. Morris, *Detention Without Data: Public Tracking of Civil Commitment*, 71 PSYCHIATRIC SERVS. 741, 741 (2020). *See also infra* notes 22, 27, and 31 and accompanying text (discussing incomplete and murky IVC data).

20. *See* Morris, *supra* note 19, at 741.

21. Gi Lee & David Cohen, *How Many People Are Subjected to Involuntary Psychiatric Detention in the U.S.? First Verifiable Population Estimates of Civil Commitment*, SOC'Y FOR SOC. WORK & RSCH. (Jan. 18, 2019), https://sswr.confex.com/sswr/2019/webprogram/Paper34840.html [https://perma.cc/QJQ5-7MGY] ("Across the eight states, 477,419, 496,752, and 442,107 people in 2013-2015, respectively, were detained on emergency, extrapolating to the country as 1.39, 1.44, and 1.27 million, with longer civil commitments (extrapolated from five states reporting) for 381,950, 381,400, and 174,500 people, respectively. The rate of emergency detentions for all ages varied between 2013-2015: 439, 450, and 396 per 100,000 individuals.").

22. Gi Lee & David Cohen, *Incidences of Involuntary Psychiatric Detentions in 25 U.S. States*, 72 PSYCHIATRIC SERVS. 61, 61 (2021) [hereinafter Lee & Cohen, *Incidences of Involuntary Psychiatric Detentions*] ("Between 2011 and 2018 across 25 U.S. states, all-ages emergency detentions per 100,000 persons ranged from a low of 29 in Connecticut to a high of 966 in Florida. In 22 states with continuous data, the average yearly detention rate increased by 13%, while the average state population grew by only 4%. In 2014, 24 states—accounting for 51.9% of the U.S. population—recorded 591,402 emergency involuntary detentions, a crude rate of 357 per 100,000 persons. Most states released incomplete counts, impeding efforts to chart the incidence and duration of inpatient civil commitments.").

23. Les Dunseith, *Study Finds Involuntary Psychiatric Detentions on the Rise*, UCLA NEWSROOM (Nov. 3, 2020), https://newsroom.ucla.edu/releases/involuntary-psychiatric-detentions-on-the-rise [https://perma.cc/QL5D-MEXY].

24. *988 Suicide & Crisis Lifeline*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/find-help/988 [https://perma.cc/2VUN-28US] (last updated Apr. 24, 2023).

25. *See* Rob Wipond, *Psychiatric Detentions Rise 120% in First Year of 988*, MAD AM. (May 20, 2023), https://www.madinamerica.com/2023/05/psychiatric-detentions-rise-988/ [https://perma.cc/BC3M-GL3S]. A related problem is that there has been a "dramatic rise" in police interventions on 988 callers; nearly four times as many callers to 988 as previously publicly claimed are getting visited by police or emergency medical services. Rob Wipond, *Dramatic Rise in Police Interventions on 988 Callers*, MAD AM. (June 1, 2024), https://www.madinamerica.com/2024/06/dramatic-rise-in-police-

making involuntary treatment easier to initiate, exposing thousands of people to coerced psychiatric care in inpatient and outpatient settings.[26] In North Carolina, about 100,000 IVC petitions were filed statewide in 2018—a ninety-one percent increase in IVC petitions from 2009.[27] This rate is three times faster than the population growth in the other twenty-five states where IVC data is available.[28] Another study found that from 2011 to 2021, IVC petitions in North Carolina nearly doubled, increasing by at least ninety-seven percent.[29] Moreover, UNC Medical Center's main psychiatric clinic saw a 150 percent increase in patients per month from spring 2020 to spring 2022.[30] Even though

interventions-on-988-callers/ [https://perma.cc/B4TN-9CDT]. Developments in suicide response efforts are not

> stemming the stream of 988 callers who receive unasked for, unwanted, or unexpected visits from police and emergency medical services (EMS)—and then get taken, with or without consent, to hospitals or crisis centers for mental health evaluations. Some report having been further subjected to forced stripping, solitary confinement, prolonged detentions, and even involuntary treatments. Callers to 988 targeted by these practices describe feeling misled, betrayed, and ultimately battered by their experiences.

Id.

26. Daniel Morehead, *Involuntary Treatment of Mental Illness: Here We Go Again*, PSYCHIATRIC TIMES (Feb. 13, 2023), https://www.psychiatrictimes.com/view/involuntary-treatment-of-mental-illness-here-we-go-again [https://perma.cc/U75G-8NS5]; Leah Harris, *And Now They Are Coming for the Unhoused: The Long Push to Expand Involuntary Treatment in America*, MAD AM. (Dec. 10, 2022), https://www.madinamerica.com/2022/12/unhoused-expand-involuntary-treatment/ [https://perma.cc/3AAH-GAVF].

27. Yanqi Xu, *NC Court of Appeals Issues Controversial Rulings on Involuntary Commitment Process*, NC NEWSLINE (July 23, 2021, 6:07 AM), https://ncpolicywatch.com/2021/07/23/nc-court-of-appeals-issues-controversial-rulings-on-involuntary-commitment-process/ [https://perma.cc/K4SV-S6U3]; Taylor Knopf, *NC Didn't Track the Data on Mental Health Commitments, So Some Advocates Did It Instead*, NC HEALTH NEWS (Dec. 21, 2020), https://www.northcarolinahealthnews.org/2020/12/21/nc-didnt-track-the-data-on-mental-health-commitments-so-some-advocates-did-it-instead/ [https://perma.cc/W4XR-4E9D] [hereinafter Knopf, *NC Didn't Track the Data*].

28. Knopf, *NC Didn't Track the Data*, *supra* note 27.

29. Knopf, *'Unsustainable' Burden on NC Hospitals*, *supra* note 18.

30. *Id.*

the data is somewhat murky,[31] it is clear that coerced psychiatric treatment—including IVC—is on the rise.[32]

Given the increased deployment of IVC—and the inhumane criminalization and judiciarization to which neurodiverse people are subjected via IVC—it is critically necessary for legal and medical practitioners to scrutinize the laws and processes that govern treatment of people experiencing acute behavioral health crises. While the current legal regime of IVC attempts to provide care, it often falls short.[33] People subjected to IVC are routinely subjected to force, punishment, humiliation, and other carceral apparatuses—none of which are effective or therapeutic. IVC can even compound the harms that led to forced treatment in the first place, leaving people subjected to IVC traumatized and worse off than when they started.[34]

Scholars have critiqued our failure to afford meaningful procedural protections to people subjected to IVC—six decades of legal scholarship has

31. *See* Knopf, *NC Didn't Track the Data*, *supra* note 27. This article details the painstaking efforts of Robert Ward, a public defender, to track down and collect IVC data when he learned that North Carolina did not do so. *Id.* Ward partnered with "Promise Resource Network, a mental health services agency in Charlotte run entirely by people who've had their own encounters with the mental health treatment system." *Id.* Together they discovered the ninety-one percent increase in forced psychiatric treatment under IVC discussed above, despite the many bureaucratic roadblocks and issues with state agency data collection methods that cause the larger problem of IVC to be obscured. *Id.* The article describes the available data on IVC variously as limited, "complicated," and "very siloed," and it states that "[t]he data doesn't tell us what ultimately happened to [IVC] patient[s]." *Id.* Furthermore, an early draft of a recently passed piece of legislation, Senate Bill 630, contained language that would have provided for more robust collection of IVC data, but that language was left out of the bill due to opposition by some hospitals. *Id.* Mark Botts has said that collection of IVC data to answer several key questions regarding the nature of patient experiences "would be helpful for making informed policy decisions moving forward[.]" *Id.* With that said, IVC is certainly on the rise, both in North Carolina and nationwide. *See, e.g.*, Lee & Cohen, *Incidences of Involuntary Psychiatric Detentions*, *supra* note 22; Knopf, *'Unsustainable' Burden on NC Hospitals*, *supra* note 18 (noting that "the entire [IVC] process is convoluted and the data limited," but reporting that county-level data showed that the number of IVC petitions continued to increase year-over-year in roughly half of North Carolina's counties throughout the pandemic and that the other half reported numbers that reflect pre-pandemic levels, which were already rising). For more on the Holistic Empathetic Area Response Team's ("HEART") data-driven methodology, see *infra* Section IV.A.

32. *See, e.g.*, Nev Jones, Jessica Rice & Emily Cutler, Univ. S. Fla., The Impact of the Involuntary Psychiatric Hospitalization of Youth & Young Adults: Unpacking Mechanisms & Moderators (Mar. 2019), https://www.northcarolinahealthnews.org/wp-content/uploads/2020/12/Tampa-Childrens-Conference-2019-Baker-Act.pdf [https://perma.cc/6PBH-76VA] (finding that in Florida, from 2000 to 2017, involuntary examinations for children increased 86%, involuntary examinations for adults increased 111%, and that in Florida in 2016–17 alone, approximately 237,000 children and adults were involuntarily hospitalized).

33. *See* Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CALIF. L. REV. 54, 105 (1982).

34. *See, e.g.*, Daniel Morehead, *The Traumas of Involuntary Treatment*, PSYCHIATRIC TIMES (Mar. 24, 2023), https://www.psychiatrictimes.com/view/the-traumas-of-involuntary-treatment [https://perma.cc/PZP3-NY7W] ("Involuntary treatment is a trauma . . . .").

argued for IVC reform.[35] Nevertheless, outcomes remain unacceptable, suggesting that procedural justice reform will not solve the problems created by IVC.[36] Instead, IVC law must be abolished. In its place, novel law and policy must be implemented to address the societal issues IVC law was designed to address, and to compensate for the myriad ways IVC law has failed.

While abolition may seem impracticable, a diverse array of stakeholders (including law professors)[37] have argued for abolition for at least four decades.[38] Moreover, the system of novel law and policy required to replace our current broken legal regime of IVC *already exists*.[39] Thus, the changes this Article argues for are concrete and practical. To demonstrate both the necessity and the workability of this proposed change, this Article proceeds in four parts.

Part I offers a selected legal history of behavioral health crisis interventions, the most common of which is forced psychiatric hospitalization. Part II introduces and summarizes the contemporary prevailing intervention: IVC. Part III provides a critical analysis of IVC law, demonstrating that the existing legal framework has been unsatisfactory in its treatment of people experiencing behavioral health crises. This part discusses the lack of procedural justice afforded to people subjected to IVC, and advocates for abolition rather than reform. IVC abolition is justified by the conclusion that carceral tools—use of force, confinement, police involvement, and predictive punishment—are inapposite responses to behavioral health crises. Part IV proposes a new alternative. Drawing from Durham's Holistic Empathetic Area Response Team ("HEART") model and the model Behavioral Health Response Team ("BHRT") Act drafted by Taleed El-Sabawi and Jennifer J. Carroll,[40] this part describes how changes to the law could better address the needs of people experiencing behavioral health crises and reduce the needless harm currently caused to them by our existing legal regime. A brief conclusion follows.

35. For examples of this scholarship, see James Diven, Note, *Rewriting Kendra's Law: A More Ethical Approach to Mental Health Treatment*, 43 PACE L. REV. 174, 175 (2022); David P.T. Price, *Civil Commitment of the Mentally Ill: Compelling Arguments for Reform*, 2 MED. L. REV. 321, 321 (1994); Lederer, *supra* note 1, at 910; Miller & Fiddleman, *infra* note 75, at 985–86; Stone, *infra* note 131, at 790–91; Beis, *infra* note 132, at 88; Simpson, *infra* note 137, at 242; Myers, *infra* note 144, at 368; *see also infra* Section III.A.

36. *See infra* Part III.

37. *See* Morse, *supra* note 33, *passim*.

38. For a reference to an extensive list of abolitionist scholarship, see *infra* note 193.

39. That law and policy are embodied by the HEART, which recently expanded its services to the entire City of Durham. Sharryse Piggott, *The HEART Program Expands Its Mental Health Crisis Response Services to All of Durham*, WUNC (Oct. 23, 2023, 6:28 PM), https://www.wunc.org/news/2023-10-23/heart-program-expands-mental-health-crisis-response-durham [https://perma.cc/3U28-2WSU]. For a detailed discussion of this program, see *infra* Part IV. Any formalistic or scalability issues that HEART may implicate are addressed in comprehensive detail by the model Behavioral Health Response Team ("BHRT") Act drafted by Taleed El-Sabawi and Jennifer J. Carroll. *See* El-Sabawi & Carroll, *infra* note 238, *passim*.

40. *See* El-Sabawi & Carroll, *infra* note 238, *passim*.

I. A SELECTED LEGAL HISTORY OF FORCED PSYCHIATRIC HOSPITALIZATION

Involuntary hospitalization presents healthcare providers with an ethical conundrum: how to balance beneficence with respect for autonomy.[41] While these two imperatives are usually not at odds, "[p]sychiatrists often encounter cases in which patients are in grave need of [care,] yet adamantly refuse to cooperate with the provision of the necessary treatment."[42] In these cases, the physician must decide whether to incarcerate patients against their will and forcibly treat them. In making that decision, the physician must assess how severe the mental illness is, how grossly a patient's perception has been distorted by it, and how capable the patient is of making decisions in their own best interest.[43] Ultimately, a physician may justify their decision to forcibly hospitalize a patient by determining that the patient is not truly autonomous due to the severity of their mental illness.[44] But this decision is not made by the physician alone—the physician acts according to the prevailing body of medical knowledge, within the parameters of the prevailing legal regime.[45] The balance between the authority assumed by law and by medicine has shifted over time.

Accordingly, to meaningfully analyze the current legal regime of IVC, it is necessary to reflect on the history of the various legal approaches to involuntary psychiatric hospitalization. This history is controversial, full of tension and extremes. It is valuable to trace the path of this history's pendulum, which over the centuries has swung between total neglect and total control.

41. Testa & West, *supra* note 3, at 30. Beneficence is the requirement that doctors provide patients with services that will benefit them. *Id.* at 31.

42. *Id.* "Necessary" does a lot of heavy lifting here. Without clear guidance, this is a discretionary, normative decision, one subject to explicit and implicit biases. As discussed above and further below, such guidance can come in the form of ethical rules, professional norms, regulations, and laws. *See supra* notes 12, 34 and accompanying text; *infra* notes 86, 87, 107, 112, 163, 169, 183 and accompanying text. *See* N.C. GEN. STAT. ch. 122C (2024). For examples of how the statute uses "necessary" or close synonyms, see *id.* § 122C-3(21)(a) (defining "Mental illness" in adults as "an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of the individual's affairs and social relations as to make it *necessary* or advisable for the individual to be under treatment, care, supervision, guidance, or control (emphasis added)); *id.* § 122C-3(11)(a)–(b) (defining "dangerous"); *id.* § 122C-261 (outlining petition process that may initiate forced psychiatric hospitalization for people deemed "dangerous" and/or those who are "*in need of* treatment in order to prevent further disability or deterioration that would predictably result in dangerousness" (emphasis added)); *id.* §§ 122C-262, -263 (setting forth criteria authorizing IVC and special emergency procedure for individuals *needing* immediate hospitalization); *id.* § 122C-57(e) (authorizing forced treatment when a physician deems it *necessary*).

43. Testa & West, *supra* note 3, at 31.

44. *Id.*

45. Rachel Hajar, *The Physician's Oath: Historical Perspectives*, 18 HEART VIEWS 154, 154 (2017); Jacob P. Olejarczyk & Michael Young, Patient Rights and Ethics, NAT'L INST. HEALTH, https://www.ncbi.nlm.nih.gov/books/NBK538279/ [https://perma.cc/5L7A-JZVE] (last updated May 6, 2024); *AMA Principles of Medical Ethics*, AM. MED. ASS'N CODE MED. ETHICS, https://code-medical-ethics.ama-assn.org/principles [https://perma.cc/W2N9-S6L4].

Along that path lies institutionalization, IVC, voluntary treatment, and deinstitutionalization.[46]

Early in the United States' history, people experiencing mental illness were relegated to jails and almshouses.[47] Reformers sought a more humane alternative to this practice, and asylums increased in number in the early nineteenth century.[48] This marked the beginning of the era of institutionalization.[49] During that time, the law deemed people experiencing mental illness unable to make decisions.[50] All asylum admissions were involuntary.[51] To justify psychiatric hospitalization, the legal standards during this era required only a doctor's declaration that a person was "insane" and a recommendation for treatment.[52] Judicial involvement was typically limited to endorsing such medical opinions of a person's "need" for treatment.[53]

46. A comprehensive history of forced psychiatric treatment and society's attitudes toward the mentally ill is beyond the scope of this Article. For a summary of this history in the United States beginning in the eighteenth century, see generally Christina Reardon, *Article Stirs Debate on Long-Term Psychiatric Care*, SOC. WORK TODAY, July–Aug. 2015, at 12, https://www.socialworktoday.com/archive/072115p12.shtml [https://perma.cc/D2BU-5TTD] (summarizing the history of forced psychiatric treatment and attitudes towards the mentally ill in the United States); ALBERT DEUTSCH, THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE & TREATMENT FROM COLONIAL TIMES (2d ed. 1949) (same).

47. Testa & West, *supra* note 3, at 32.

48. The first organized efforts to care for the mentally ill in America began in the mid-eighteenth century. *Timeline of Early Psychiatric Hospitals & Asylums*, NIH NAT'L LIBR. OF MED., https://www.nlm.nih.gov/hmd/topics/diseases-of-mind/timeline.html [https://perma.cc/W5F2-BFQV]. The efforts of Dorothea Dix helped catalyze the extensive construction of large psychiatric hospitals under the Kirkbride Plan between 1845–1913. *See* Mardita M. Murphy, Preserving the Kirkbride Legacy: An Analysis of the Extant State of the Plan and Challenges of Adaptive Reuse 35–36 (2016) (M.F.A. thesis, University of North Carolina at Greensboro), https://libres.uncg.edu/ir/uncg/f/Murphy_uncg_0154M_12059.pdf [https://perma.cc/7HZ2-H8D4]; Lauren Hoopes, On the Periphery: A Survey of Nineteenth-Century Asylums in the United States 31–32 (2015) (M.S. thesis, Clemson University), https://open.clemson.edu/cgi/viewcontent.cgi?article=3128&context=all_theses [https://perma.cc/QRH6-2DAK]. By 1890, every state in the United States had at least one public psychiatric hospital. Jeffrey Geller, *The Rise and Demise of America's Psychiatric Hospitals: A Tale of Dollars Trumping Decency*, PSYCHIATRIC NEWS, Mar. 1, 2019, at 8, 9.

49. Hoopes, *supra* note 48, at 47; *see also* Winnie S. Chow & Stefan Priebe, *Understanding Psychiatric Institutionalization: A Conceptual Review*, 13 BMC PSYCHIATRY, no. 169, 2013, at 1, 1; CARLA YANNI, THE ARCHITECTURE OF MADNESS: INSANE ASYLUMS IN THE UNITED STATES 5 (2007); Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment—The American Experience*, 43 ISR. J. PSYCHIATRY & RELATED SCIS. 209, 210 (2006).

50. Anfang & Applebaum, *supra* note 49, at 210.

51. *Id.*

52. *Id.* at 209.

53. *Id.* During this era, the most common IVC procedure was a hearing with a judge, who made the final decision after an examination report by two statutorily qualified physicians. *See Analysis of Legal and Medical Considerations in Commitment of the Mentally Ill*, 56 YALE L.J. 1178, 1183, 1191 (1947) [hereinafter *Analysis of Legal and Medical Considerations*] ("The relative roles played in the commitment process by expert medical judgment and the arm of the judiciary present delicate problems. In the great majority of cases the physician's opinion will be accepted, but in a borderline case the judge may assume

In asylums, chronic patients were sometimes abused and neglected, though they were also sometimes given meaningful refuge.[54] Treatment often consisted of restraint, isolation, exercise, work, crafts, sedation, experiments, and/or other interventions thought to be therapeutic.[55] These were typically ineffective in curing patients and often offered no meaningful life skills to survive outside the facilities.[56] Unsurprisingly then, patients were often warehoused in asylums for life.[57]

the burden of decision. The judgment called for here is complex, involving a knowledge of the nature of the illness, and prognosis of the benefit of hospitalization, the possibilities of cure and the likelihood of the patient becoming suddenly dangerous. Where the determination emphasizes the advisability of treatment, it would seem to call for medical rather than judicial authority."); *see also, e.g.*, Inhabitants of Naples v. Inhabitants of Raymond, 72 Me. 213, 217 (1881) ("In all cases of preliminary proceedings for the commitment of any person to the hospital, the evidence and certificate of at least two respectable physicians, based upon due inquiry and personal examination of the person to whom insanity is imputed, shall be required to establish the fact of insanity."); Wheeler v. State, 34 Ohio St. 394, 394 (1878) (similar); Bush v. Pettibone, 5 Barb. 273, 273–75 (N.Y. Gen. Term. 1848), *aff'd*, 4 N.Y. 300 (1850) (similar). One case, *Van Deusen v. Newcomer*, 40 Mich. 90 (1879), exemplified the prevalence of judicial deference to medical opinions:

> If a tribunal is needed, if this question must be passed upon . . . judicially . . . I submit that the medical superintendent of the asylum, being the hand and the instrument of the State . . . and his assistant physicians, are presumed to be competent experts, and they are to determine whether a person is a fit inmate for the asylum or not, and their judgment and conclusion is much more likely to be correct than any other tribunal you can create. They are men placed there not only for their learning in this department of medical science, but for their integrity.

Id. at 103. Beyond that, in some cases, such deference was so high that judges were completely removed from the process, as was true for "emergency commitment," which was "a summary statutory proceeding without resort to the judiciary . . . devised for the temporary commitment of mentally ill persons needing immediate hospitalization." *Analysis of Legal and Medical Considerations*, *supra*, at 1196. That said, not all in the judiciary approved of this deference: at least one nineteenth-century judge lamented the procedural injustice of forced psychiatric commitment. *See In re* Dickie, 7 Abb. N. Cas. 417, 423 (N.Y. Sup. Ct. 1879) ("There is another suggestion arising from this case and the results, and that is, that the laws should require a trial such as had herein, or a similar one, within thirty days after a subject is committed to any asylum. At present two physicians may certify that a person is insane, and on their approval by the court the supposed lunatic is sent to the asylum. His mental condition may be such as to demand instant confinement, it is true, but the right to treat him thus should be determined by some more formal and exhaustive process before his restraint should be declared indefinite. The laws require amendment."). However, as late as 1947, the practice of allowing two physicians to make a nonemergency IVC determination upon final approval by a judge still prevailed, and in a few states, judges were completely uninvolved, as in Maryland, Louisiana, Rhode Island, and Vermont, where "the formal [IVC] order is issued solely by the certification of two physicians. Here, judicial machinery is called into play only when an aggrieved party appeals directly from the certificate . . . ." *Analysis of Legal and Medical Considerations*, *supra*, at 1191.

54. *See* Oliver Sacks, *The Lost Virtues of the Asylum*, N.Y. REV. BOOKS (Sept. 24, 2009), https://www.nybooks.com/articles/2009/09/24/the-lost-virtues-of-the-asylum/ [https://perma.cc/6QTZ-NEXY (staff-uploaded, dark archive)].

55. *See* Testa & West, *supra* note 3, at 32.

56. *Id.*

57. *See id.*

Between the nineteenth and twentieth centuries, "changes to commitment laws focused almost entirely on procedures."[58] "Reformers advocated for jury trials or formal judicial hearings for persons faced with involuntary hospitalization," and sought to provide "other procedural safeguards borrowed from the criminal justice system."[59] Physicians' discretion was curtailed and states broadened the scope of psychiatric care regulations.[60] In the early twentieth century, states began to develop "special emergency commitment procedures" that bypassed judicial hearings, allowing physicians (and sometimes police) to hospitalize patients briefly without court review.[61]

Even as late as the 1950s, "the law imposed few obstacles" to IVC.[62] Statutes authorizing commitment were often vaguely worded. One law authorized IVC for people found to have a "character disorder" that rendered them so "deficient in 'judgment or emotional control' that they were 'likely to conduct [themselves] in a manner which clearly violate[d] the established . . . conventions . . . of the community.'"[63] Once committed, beyond being deprived of their freedom, a patient was also "likely to suffer constricting civil disabilities," including being barred from writing a will, marrying, contracting, voting, and even driving.[64] This status clung to the patient even after leaving the hospital, if they ever did.[65]

Exposés in the 1940s criticized the inhumane conditions in many state mental hospitals.[66] These planted seeds for reforms that would take place in the next two decades.[67] Asylum use peaked in the 1950s; by then their total

58. Anfang & Applebaum, *supra* note 49, at 210.

59. *Id.*

60. *See id.*

61. *Id.*

62. Rael Jean Isaac & Samuel Jan Brakel, *Subverting Good Intentions: A Brief History of Mental Health Law "Reform*," 2 CORNELL J.L. & PUB. POL'Y 89, 97 (1992).

63. *Id.* (omissions in original) (quoting MASS. ANN. LAWS ch. 123, § 1 (1965)). Often, "insanity" has been defined in terms of deviance from societal mores. The process of deciding those mores and how far one may deviate from them before being considered clinically insane is a highly normative process. *See, e.g.*, NICHOLAS N. KITTRIE, THE RIGHT TO BE DIFFERENT, DEVIANCE AND ENFORCED THERAPY (1971); *see also* Augustine Bala Nalah & Leku Daniel Ishaya, *A Conceptual Overview of Deviance and Its Implication to Mental Health: A Bio Psychosocial Perspective*, 2 INT'L J. HUMS. & SOC. SCI. INVENTION 1, 3 (2013) ("Deviance and mental illness often go hand-in-hand. While not all deviants are considered mentally ill, almost all mentally ill persons are considered deviant (since mental illness is not considered 'normal').").

64. Isaac & Brakel, *supra* note 62, at 97.

65. *Id.*

66. *Id.* Inhumane conditions did not cease at this time. "One must constantly remember that the right to treatment and right to rehabilitation suits that exposed the utterly shocking and inhumane conditions in state hospitals in various states were products of the 1970's, not the distant past." Morse, *supra* note 33, at 104 (footnote omitted).

67. For example, in 1946, the National Mental Health Act "authorized the Surgeon General to improve the mental health of U.S. citizens through research into the causes, diagnosis, and treatment of psychiatric disorders." *See The NIH Almanac*, NAT'L INSTS. HEALTH, https://www.nih.gov/about-

population in the United States had ballooned to more than 500,000.[68] During this same time, civil rights became a prominent nationwide issue.[69] As some fought for racial justice, others looked to improve the conditions for psychiatric detainees.[70] Notably, these two struggles are not mutually exclusive, and have historically been interconnected.[71]

nih/what-we-do/nih-almanac/national-institute-mental-health-nimh [https://perma.cc/3NJQ-ZBJN] (last updated Aug. 19, 2024) (citing National Mental Health Act, ch. 538, 60 Stat. 421 (1946) (codified at 42 U.S.C. §§ 232, 242a)). The National Institute of Mental Health was established in 1949, and new laws sought better care for the mentally ill through scientific research and increased funding. *See id.* Notably, the 1951 Draft Act Governing Hospitalization of the Mentally Ill proposed streamlining commitment procedures via a modified "need for treatment" formula with a standard requiring patients to need care in a mental hospital and lack insight or capacity to make responsible decisions because of their illness. Anfang & Appelbaum, *supra* note 49, at 211. The Draft Act sought to encourage voluntary hospitalization and to address the deficient, carceral emergency commitment procedures then extant in many states; though it was adopted by a number of states after its publication, the Act never passed. Paul S. Appelbaum, *The Draft Act Governing Hospitalization of the Mentally Ill: Its Genesis and Its Legacy*, 50 PSYCHIATRIC SERVS. 190, 190–91 (2000). There was skepticism about the reality of mental illness, doubts about the benefits of mental hospitalization, and misgivings due to exposés which illuminated traumatic, inhumane treatment in asylums. *See id.* "The result . . . was a thorough re-orientation of mental health law away from the Draft Act model." *Id.* "In place of need-for-treatment criteria for [IVC], courts and legislatures substituted standards based solely on patients' dangerousness . . . ." *Id.* (citing Lessard v. Schmidt, 349 F. Supp. 1078, 1083 (E.D. Wis. 1972), *vacated*, 414 U.S. 473 (1974)). Legislative tides turned thanks in part to the Community Mental Health Centers Act of 1963, favoring outpatient care. *Id.* at 193. "Although both deinstitutionalization and community mental health would be disappointing in many ways, particularly in their neglect of patients with chronic mental illnesses, their idealistic goals reflected the hopes of the first decade of the postwar era." *See id.* at 191. It was this post-institutional idealism that would color the medico-legal landscape of IVC for the decades to come. *Id.*

68. Isaac & Brakel, *supra* note 62, at 97.

69. *Id.*

70. *Id.* at 97–98.

71. Indeed, "the stigmatization of mental illness is racialized." Mary Elisabeth John, Lone Survivor: Linking Institutionalized Racial Adversity, Lived Experiences and Mental Health Conditions Among African Americans (2018) (M.A. thesis, University of North Carolina at Greensboro), https://libres.uncg.edu/ir/uncg/f/John_uncg_0154M_12465.pdf [https://perma.cc/E2NV-ZUKY]. Moreover, "[p]atients of color [are] significantly more likely than White patients to be subjected to involuntary psychiatric hospitalization, and Black patients and patients who identified as other race or multiracial [are] particularly vulnerable . . . ." Timothy Shea, Samuel Dotson, Griffin Tyree, Lucy Ogbu-Nwobodo, Stuart Beck & Derri Shtasel, *Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment*, 73 PSYCHIATRIC SERVS. 1322, 1322 (2022). Given the historical entanglements between psychiatric detention, mental illness as a "moral" failing, racism, sterilization, eugenics, stigma, homelessness, and criminalization, some advocates for racial justice and for the civil rights of people subjected to IVC use intersectional critical analysis. The link between racial justice and justice for psychiatric detainees is not abstract or theoretical; it is a matter of life and death. Sabah H. Muhammad & J. Michael E. Gray, *An Untenable Space: The Dilemma of Black Families Caring for a Loved One with Severe Mental Illness and an Argument for a Legislative Solution*, 53 TEX. TECH L. REV. 575, 583 (2021) ("[T]he risk of death to a person with mental illness when confronted by police is 30.8% higher if the person is Black as opposed to White."). This is especially apposite to the critique of police involvement in mental health crises. *See infra* Section IV.B. Of course, all people, not just people of color, have civil rights, and people experiencing neurodivergence more broadly have struggled to secure

Senate committee hearings in the 1960s sought to protect "the rights of the mentally ill."[72] At the hearings, medical professionals and other stakeholders attempted to balance preservation of patients' constitutional rights with attendance to their medical needs, and expressed concern about the loss of civil rights as a "price paid for treatment."[73] As a result of the hearings, the committees drafted model legislation aimed at encouraging "greater use of *voluntary* treatment."[74] This model legislation required public hospitals to accept patients requesting psychiatric help, and it ended the practice of stripping patients of their civil rights as a consequence of having been hospitalized.[75]

In the late 1960s and early 1970s, legal watersheds brought the model legislation to fruition, limiting state power to subject people to IVC.[76] IVC underwent "legalization," shifting from "a clinical procedure essentially under complete control of the medical profession to a much more formalized legal

their dignity and liberty since at least the 1960s. *See* NAT'L ACAD. OF SCIS., ENG'G & MED., ENDING DISCRIMINATION AGAINST PEOPLE WITH MENTAL AND SUBSTANCE USE DISORDERS: THE EVIDENCE FOR STIGMA CHANGE 25 (2016). Advocacy from professionals greatly increased the visibility of the plight of psychiatric detainees. For example, Thomas Szasz described the destructive threats to civil liberties and a decent life posed by state "hospitals," and Erving Goffman described how the neglect and humiliation of asylums-turned-prisons made patients much more symptomatic and dysfunctional than they would be in real-life situations. *See* Allen Frances & Mark L. Ruffalo, *Mental Illness, Civil Liberty, and Common Sense*, 35 PSYCHIATRIC TIMES 14A, 14A (2018), https://www.psychiatrictimes.com/view/mental-illness-civil-liberty-and-common-sense [https://perma.cc/U9U9-6PNN].

72. Isaac & Brakel, *supra* note 62, at 97.

73. *Id.* "Many of the psychiatrists who spoke at the hearings saw an intrinsic connection between voluntary treatment and preservation of patients' civil rights. . . . For mental patients to lose their civil rights was not only practically, but also psychologically, disabling. It was *anti-therapeutic*." *Id.* at 98 (emphasis added).

74. *See id.* (emphasis added) (mentioning model legislation drafted for the District of Columbia). Note the impact that model legislation can have; compare this to the BHRT Act. *See infra* Section IV.B.

75. Isaac & Brakel, *supra* note 62, at 98. It also discouraged IVC by making it more difficult. *Id.* at 99. Here, an important shift in legal philosophy took place. Rather than relying on the "need for treatment" standard, which the committee felt "lent itself too readily to overreaching and abuse," the bill sought to base IVC solely on the police power, limiting its use to individuals who, because of mental illness, were deemed likely to injure themselves or others if allowed to remain at liberty. *Id.* This would become known as the "dangerousness" standard. *See* Robert D. Miller & Paul B. Fiddleman, *Involuntary Commitment in North Carolina: The Result of the 1979 Statutory Changes*, 60 N.C. L. REV. 985, 989 (1982) (citing Cross v. Harris, 418 F.2d 1095 (D.C. Cir. 1969); Millard v. Harris, 406 F.2d 964 (D.C. Cir. 1968); Addington v. Texas, 441 U.S. 418 (1979); O'Connor v. Donaldson, 422 U.S. 563 (1975)); *see also* Anfang & Appelbaum, *supra* note 49, at 212 (mentioning that in *Addington v. Texas*, the United States Supreme Court found that "civil commitment" differed from criminal prosecution, and accepted a "clear and convincing evidence standard" for a state to prove need for IVC (quoting *Addington*, 441 U.S. at 422)). In *Parham v. J.R.*, 442 U.S. 584 (1979), the United States Supreme Court allowed parents to authorize IVC of a nonconsenting minor without the full due process protections that adults would receive. *See id.* at 603 (citing *Parham*, 442 U.S. at 603). For a detailed critique of the "dangerousness" standard, see *infra* Part III.

76. Morse, *supra* note 33, at 55 (first citing CAL. WELF. & INST. CODE §§ 5000–5550 (2016); and then citing Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated*, 414 U.S. 473 (1974)).

process."[77] In IVC matters, courts became the principal venue, and judges and attorneys became the key decision-makers.[78] Landmark court decisions established requirements for clear criteria for commitment and a restriction of overbroad exercises of the *parens patriae* power.[79] Many "cases found state commitment laws unconstitutional and applied stringent substantive and procedural due process protections to the [IVC] process."[80]

As these legal changes took place, states legislatively reformed IVC laws, incorporating two key features: patients were considered *competent* and retained all civil rights upon IVC, and patients had to be found "dangerous" in order to be subjected to IVC.[81] The presumption of competence served an important public policy goal of preserving autonomy and dignity among patients.[82]

77. *See* Miller & Fiddleman, *supra* note 75, at 985.

78. *See id.* at 989.

79. *See id.* Specifically, "the existing criteria for commitment were held to be too vague" and "dangerousness to self or others was held to be a necessary criterion for commitment." *Id.* In the D.C. Circuit, "the court supported the necessity of a demonstration of dangerousness in Cross v. Harris, 418 F.2d 1095 (D.C. Cir. 1968), and in Millard v. Harris, 406 F.2d 964 (D.C. Cir. 1968)." *Id.* at 989 n.18. "Stronger arguments, basing requirements for dangerousness on constitutional grounds, soon were forthcoming. *Id.* (citing *Addington*, 441 U.S. at 418; *O'Connor*, 423 U.S. at 563; *Lessard*, 349 F. Supp. at 1078).

80. Morse, *supra* note 33, at 55. "[C]ourts held that the existing commitment laws and practices violated the fourteenth amendment guarantee that liberty could not be taken without due process of law and required legislatures to provide adversary counsel at all phases of the commitment process." Miller & Fiddleman, *supra* note 75, at 989 (first citing Baxstrom v. Herold, 383 U.S. 107 (1966); then citing Jackson v. Indiana, 406 U.S. 715 (1972); then citing Humphrey v. Cady, 405 U.S. 504 (1972); then citing *Lessard*, 349 F. Supp. at 1078; then citing Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974); and then citing State *ex rel.* Memmel v. Mundy, 249 N.W.2d 573 (Wis. 1977)). Notably, while reluctant to create an explicit constitutional right to treatment, courts held that people subjected to IVC could not be confined unless treatment was actually available and offered. *See id.* (first citing Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966); then citing Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971); and then citing *O'Connor*, 423 U.S. at 563).

81. Isaac & Brakel, *supra* note 62, at 99. These two features were adopted from the 1964 Senate Bill. *Id.* Another similar standard sometimes invoked required that a patient be "so gravely disabled as to present an overt danger." *Id.*

82. *Id.* at 100. Autonomy is an attribute intimately tied to dignity in American jurisprudence. *See, e.g.*, Liz Halloran, *Explaining Justice Kennedy: The Dignity Factor*, NPR (June 28, 2013, 2:42 PM), https://www.npr.org/sections/thetwo-way/2013/06/27/196280855/explaining-justice-kennedy-the-dignity-factor [https://perma.cc/23CC-9N8T] (quoting Jeffrey Rosen, president and CEO of the National Constitution Center: "At the heart of liberty is the right to define oneself, and that concept of personal autonomy 'is centrally connected to dignity in Justice Kennedy's mind.'" (referencing Justice Kennedy's majority opinion in United States v. Windsor, 570 U.S. 744 (2013)); *see also* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 11 (2019) [hereinafter CARE CONTINUUM], https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf [https://perma.cc/K3W7-HU9T (staff-uploaded archive)] ("By the late 1960's . . . a new emphasis on respect for patient autonomy in medical decision-making . . . called into question whether acutely ill psychiatric patients necessarily were incapable of providing adequate consent. In a context where respecting patient rights increasingly came to mean documenting

Forced commitment procedures underwent a revolution between 1967 and 1985.[83] This transformation was accomplished thanks in part to an emergent libertarian patients' rights bar in which lawyers challenged state IVC laws and the inadequacies of public mental health institutions in federal courts throughout the country.[84] "These changes coincided with a social trend toward deinstitutionalization . . . ."[85] Starting in the 1950s, and gaining steam in the 1960s and 1970s, the deinstitutionalization movement saw the closing of many large psychiatric hospitals and mental asylums run by centralized authorities.[86] Improvements in psychiatric medication profoundly improved outcomes for patients and made treatment outside asylum settings more practical.[87]

Cases like *Baxstrom v. Herold*[88] forced the discharge of large numbers of committed patients,[89] while new laws restricted the number of new patients committed to state hospitals.[90] The goal was to provide more localized, humane, and individualized care for people with mental disorders or developmental

one's reliable consent to or refusal of recommended treatment, the adjudication of mental incompetence—with assignment of a guardian or conservator as a substitute decision-maker—became the high standard for overriding a patient's treatment refusal.").

83. "Prior to 1973, North Carolina's [IVC] statutes and procedures were comparable to those in most other states." Miller & Fiddleman, *supra* note 75, at 993. Between 1973 and 1979 significant statutory changes took place. *Id.* "The criteria for commitment became mental illness or inebriety (with alcohol or other drugs) plus imminent dangerousness to self or others; or mental retardation plus an associated behavior disorder rendering the person dangerous to others." *Id.* For a summary of the evolution of IVC law in North Carolina between 1973 and 1981, including evidentiary standards, standards for inpatient and outpatient commitment, statutory authorizations, and procedural mechanisms, as well as the roles played by doctors, police, and the judiciary, see *id.* at 993–99; and see also N.C. GEN. STAT. § 122 (1981).

84. *See* Isaac & Brakel, *supra* note 62, at 102–05.

85. Miller & Fiddleman, *supra* note 75, at 990.

86. *Id.*; Anfang & Appelbaum, *supra* note 49, at 211; *see also* Alisa Roth, *The Truth About Deinstitutionalization*, ATLANTIC (May 25, 2021), https://www.theatlantic.com/health/archive/2021/05/truth-about-deinstitutionalization/618986/ [https://perma.cc/FK8Q-3M9Z (dark archive)] ("The population of people living in asylums dropped from a high of more than half a million in 1955 to barely more than 100,000 in the mid-1980s. (Those numbers have continued to fall in the intervening years, and today there are negligible numbers of people in long-term psychiatric facilities.)").

87. *See* Steven P. Reidbord, *A Brief History of Psychiatry*, https://www.stevenreidbordmd.com/history-of-psychiatry [https://perma.cc/T5L4-SDPF].

88. 383 U.S. 107 (1966).

89. *Id.* at 115; Henry J. Steadman, *Implications from the Baxstrom Experience*, 1 AM. ACAD. PSYCHIATRY & L. 189, 189 (1973) (observing *Baxstrom* resulted in the release or transfer to less restrictive facilities of 967 patients).

90. Miller & Fiddleman, *supra* note 75, at 990.

disabilities.[91] This new "community care"[92] approach was to take place in hospitals, clinics, transitional living spaces, and/or at home with the family. States passed updated laws designed to provide "modern solutions" to the problems posed by mental and behavioral health.[93] A key piece of legislation in North Carolina was the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, which established the current regime of IVC law still in place today.[94]

In the last few decades, IVC has continued to evolve. Some states, concerned about underinclusive IVC statutes, have broadened the definition of "grave disability" to include the prospect of severe deterioration, disabling illness, or general inability to care for oneself.[95] Scholars have argued that "this may reflect the perception . . . that IVC was too difficult to achieve with the strict dangerousness model, or that too many patients needing treatment were being excluded."[96] During the 1990s and 2000s, involuntary *outpatient* commitment began to gain currency as a less restrictive alternative to IVC.[97]

91. *See id.* ("[A]s community treatment resources developed as alternatives to the large state mental institutions that house the vast majority of committed patients, legislatures and courts began to recognize a right to treatment in the least restrictive environment. In practice this meant virtually anything other than state hospitals.").

92. *See generally* Andrew Scull, *"Community Care" a Historical Perspective on Deinstitutionalization*, 64 PERSPS. IN BIOLOGY AND MED. 70 (2021) (discussing the term and a critiquing of its implementation); *id.* at 79 ("'Community care,' after all, has turned out to be an Orwellian euphemism masking a nightmare.").

93. *See, e.g.*, GA. CODE ANN. § 37-3-93(a) (2024); Mental Health, Mental Retardation, and Substance Abuse Act of 1985, ch. 589, 1985 N.C. Sess. Laws 670 (codified at N.C. GEN. STAT. chapter 122C).

94. This legislation was first passed in 1985 under the name "the Mental Health, Mental Retardation, and Substance Abuse Act of 1985;" in 1989 the name of the law was changed to "Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985." Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, ch. 625 N.C. Sess. Laws 1682 (codified at N.C. GEN. STAT. chapter 122C) (deleting the term "mental retardation" and replacing it with "developmental disabilities" and deleting "mentally retarded" and replacing it with "developmentally disabled" throughout the bill). This legislation was further updated by mental health reform legislation in 2001. Act of Oct. 4, 2001, ch. 437, 2001 N.C. Sess. Laws 2232 (codified at scattered sections of N.C. GEN. STAT. chapter 122C). There were two central outcomes of North Carolina's 2001 reform legislation. First, it "transfer[ed], over a multi-year period, [the] management and oversight functions of mental health, developmental disability, and substance abuse programs from the existing quasi-independent local area authorities to fully governmentally accountable local management entities." Alison Gray, *The History of Mental Health Reform in North Carolina*, N.C. CTR. FOR PUB. POL'Y RSCH. (Mar. 7, 2009), https://nccppr.org/the-history-of-mental-health-reform-in-nc/ [https://perma.cc/4BXL-X9G6] And second, it "privatizat[ed] mental health services by divesting clinical services from public area authorities to private nonprofit and for-profit provider groups." *Id.*

95. *See* CARE CONTINUUM, *supra* note 82, at 9–11 (first citing ALASKA STAT. § 47.30.915(9) (2019), then citing OR. REV. STAT. § 426.005(1)(f) (2019), then citing WIS. STAT. ANN. § 51.20(1)(a) (2019), and then citing ARK. CODE ANN. § 20-47-207(c)(2)(D) (2019)).

96. Anfang & Appelbaum, *supra* note 49, at 212.

97. *Id.* North Carolina was one of several states to run early pilot studies to test the viability of involuntary outpatient commitment. Marvin S. Swartz, Jeffrey W. Swanson, Virginia A. Hiday, H. Ryan Wagner, Barbara J. Burns & Randy Borum, *A Randomized Controlled Trial of Outpatient*

This pushed society further toward deinstitutionalization by offering coercive treatment outside the physical confinement of a psychiatric facility.

Though deinstitutionalization has been heralded by some as our nation's most successful decarceral effort,[98] it occurred while most states adopted IVC models "grossly analogous to the criminal system."[99] The idealistic goal of community care has not come to fruition.[100] While initially federal grant money and entitlement programs were made available to reimburse community programs to care for the mentally ill, those programs never fulfilled their mandate to treat the people "freed" from psychiatric hospitals.[101] The services that have emerged in the cavity left behind by deinstitutionalization were inaccessible to the populations once served by state mental hospitals.[102] Today, many seek treatment but are turned away.[103] Some people have slipped through the cracks, others have enjoyed greater autonomy and dignity while still receiving needed care, and still others have found themselves in homeless shelters and in prisons.[104]

Perversely, then, many people experiencing mental illness today find themselves in the exact same position as their predecessors centuries ago—

Commitment in North Carolina, 25 PSYCHIATRIC SERVS. 325, 325 (2001). Some states have been celebrated for their provision of high-quality involuntary outpatient commitment. For example, Minnesota (which calls its involuntary outpatient commitment "assisted outpatient therapy") received the highest grade from a study conducted by the Treatment Advocacy Center. LISA DAILEY, MICHAEL GRAY, BETSY JOHNSON, SABAH MUHAMMAD, ELIZABETH SINCLAIR & BRIAN STETTIN, TREATMENT ADVOC. CTR. GRADING THE STATES: AN ANALYSIS OF U.S. PSYCHIATRIC TREATMENT LAWS 5 (2020), https://www.tac.org/wp-content/uploads/2023/11/Grading-the-States-2020.pdf [https://perma.cc/G5RC-ZRF5]. However, not all stakeholders value the services offered by involuntary outpatient commitment. Some groups view these laws as unconstitutional expansions of state coercive power that unduly stifles patient autonomy and tramples on the rights of people with disabilities. *See, e.g.*, ACLU OF N.Y., THE DANGERS OF KENDRA'S LAW 1 (2021), https://www.nyclu.org/uploads/2022/01/2022-nyclu-onepager-kendraslaw.pdf [https://perma.cc/VPA8-GCR2]. Forty-seven states now have involuntary outpatient commitment statutes. Amy Allbright, Frederick Levy & Nisha Wagle, *Outpatient Civil Commitment Laws: An Overview*, 26 MENTAL & PHYS. DISABILITY L. REP. 179, 179–85 (2002).

98. *See* Amber Karanikolas, Book Review, 54 J. CRIMINOLOGY 259, 259 (2021) (reviewing LIAT BEN-MOSHE, DECARCERATING DISABILITY, DEINSTITUTIONALIZATION AND PRISON ABOLITION (2020)).

99. Anfang & Appelbaum, *supra* note 49, at 21. One such analogy is the use by several states of the "beyond a reasonable doubt" standard. *Id.*

100. *See, e.g.*, Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness*, 28 HOUS. L. REV. 63, 83–84 (1991).

101. *Id.* at 84.

102. ELYN R. SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL 3 (2002).

103. *Id.*

104. *See* Anfang & Appelbaum, *supra* note 49, at 216.

warehoused in jails and almshouses.[105] This is the medicolegal landscape in which IVC exists. Whether inpatient or outpatient, involuntary treatment remains the prevailing legal intervention deployed in response to people experiencing a perceived acute behavioral health crisis. The next part summarizes how this legal regime currently operates in North Carolina.

II. THE CURRENT STATE OF NORTH CAROLINA INVOLUNTARY COMMITMENT LAW

To understand the current state of IVC law in North Carolina, it is necessary to first mention the federal framework currently in place as a result of the statutory and judicial histories outlined above. The United States Supreme Court has "repeatedly . . . recognized that [IVC] for any purpose constitutes a significant deprivation of liberty that requires due process protection."[106]

Supreme Court of North Carolina Justice Anita Earls recently wrote a dissent discussing this federal framework in which she contends that "ensuring that appropriate due process protections exist in [IVC] proceedings is paramount to guaranteeing that only those who truly require hospitalization are subjected to it against their will."[107] The hallmark of due process is "fundamental fairness,"[108]

105. Some have characterized this as "transinstitutionalization," a process "whereby large amounts of inpatients with mental illnesses moved out of psychiatric institutions, into the streets, and then into the criminal justice system." Michael Mullan, *How U.S. Society Has Treated Those with Mental Illnesses*, 24 RICH. PUB. INT. L. REV. 79, 80 (2021). This process, also known as "transcarceration," shuffles patients out of state hospitals, into general hospitals, emergency rooms, prisons, jails, nursing homes, transitional housing, and shelters—"places that are less appropriate and more expensive than long-term psychiatric institutions." Christine Montross, Opinion, *The Modern Asylum*, N.Y. TIMES (Feb. 18, 2015), https://www.nytimes.com/2015/02/18/opinion/the-modern-asylum.html [https://perma.cc/HET7-UWWB (staff uploaded, dark archive)]; *Are Mental Health Services Good?*, NEWS YOU CAN USE (Nat'l All. Mental Health N. Ky., Newport, Ky.), Apr. 2017, at 6, https://naminky.org/wp-content/uploads/sites/58/2013/09/April-Newsletter-20170405-918-AM.pdf [https://perma.cc/Q94V-TGXU] ("The elimination of psychiatric beds is creating enormous strains on law enforcement, jails, prisons and hospital ERs, where acutely ill people are essentially 're-institutionalized'—or left to live on the streets. Wherever they are, they exist in an alternate reality that deprives them of the ability to participate in life as they could with treatment."). Indeed, some have intimated that a return to institutionalization might offer a more humane alternative. *See* Sacks, *supra* note 54; Jacob Hands, *Making the Case for Re-Institutionalization*, BERKELEY POL. REV. (Oct. 31, 2017), https://bpr.berkeley.edu/2017/10/31/making-the-case-for-re-institutionalization/ [https://perma.cc/5JRU-BWUC].

106. *In re* J.R., 383 N.C. 273, 278, 881 S.E.2d 522, 525 (2022), *cert. denied sub nom*, 144 S. Ct. 75 (2023) (mem.) (first citing Addington v. Texas, 441 U.S. 418, 425 (1979) (holding that a person cannot be committed against their will without due process of law); then citing Jackson v. Indiana, 406 U.S. 715, 731 (1972) (same); then citing Humphrey v. Cady, 405 U.S. 504, 504–13 (1972) (same); then citing *In re* Gault, 387 U.S. 1, 12 (1967) (same); and then citing Specht v. Patterson, 386 U.S. 605, 608 (1967) (same)); *see also* U.S. CONST. amend XIV, § 1.

107. *In re J.R.*, 383 N.C. at 291–92, 881 S.E.2d at 534 (Earls, J., dissenting).

108. *Id.* at 285, 881 S.E.2d at 530 (citing Lassiter v. Dep't of Soc. Servs., 452 U.S. 18, 24 (1981)).

which requires a "full and fair hearing."[109] These rights are essential in guarding against erroneous IVC and are designed to give those subjected to IVC the ability to "understand the nature of what is happening" to them and to "challenge the contemplated action."[110] IVC proceedings are based on an "essentially medical" question,[111] that "turns on the meaning of the facts which must be interpreted by expert psychiatrists and psychologists."[112]

States and localities have the ultimate burden and authority to administrate IVC and care for the mentally ill.[113] "Each [state] has a unique set of laws, regulations, policies[,] and budget priorities that, collectively, make up our national mental health system."[114] State courts are bound to adhere to the federal law outlined above, but may tailor specific law and policy to their own specifications.[115] This part of the Article focuses on the IVC law of one state: North Carolina.

Our state's constitution requires that no person be imprisoned or otherwise deprived of liberty except by the law of the land.[116] Section 122C of the General Statutes of North Carolina is the law that authorizes such a deprivation via IVC. Conforming to the "dangerousness" standard outlined above,[117] section 122C permits "anyone who has knowledge of an individual who has a mental illness and is either (i) dangerous to self . . . or dangerous to others . . . or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness," to file an affidavit and petition the court to have the individual involuntarily committed."[118] "Imminency" is a key aspect of North Carolina's dangerousness standard; the perception that a person presents an imminent threat

109. *Id.* (citing Miller v. French, 530 U.S. 327, 350 (2000)). Other federal constitutional due process protections include the right to a neutral, independent decisionmaker, and to an adversarial hearing. *In re* Spivey, 345 N.C. 404, 417, 480 S.E.2d 693, 700 (1997); *see* Vitek v. Jones, 445 U.S. 480, 495 (1980). Other cases have guaranteed the due process right to a fair and impartial tribunal. *See In re* Murchison, 349 U.S. 133, 136 (1955); *see* Foucha v. Louisiana, 504 U.S. 1780, 1781 (1992); French v. Blackburn, 428 F. Supp. 1351, 1356 (M.D.N.C. 1977); *In re* Hernandez, 46 N.C. App. 265, 269, 264 S.E.2d 780, 782 (1980).

110. *In re J.R.*, 383 N.C. at 286, 881 S.E.2d at 530 (Earls, J., dissenting) (citing *Vitek*, 445 U.S. at 495–96 (holding that when a person is subjected to IVC, they experience a "massive curtailment of liberty")).

111. *Id.* (citing *Vitek*, 445 U.S. at 495).

112. *Id.* (citing Addington v. Texas, 441 U.S. 418, 429 (1979)).

113. Anfang & Appelbaum, *supra* note 49, at 211; *see* DAILEY ET AL., *supra* note 97, at 4.

114. DAILEY ET AL., *supra* note 97, at 4.

115. *See Standards for Involuntary Commitment (Assisted Treatment) State-by-State (Source Treatment Advocacy Center)*, MENTAL ILLNESS POL'Y ORG., https://mentalillnesspolicy.org/national-studies/state-standards-involuntary-treatment.html [https://perma.cc/QK68-RJ2A] (listing the statutes that govern IVC in all fifty states).

116. N.C. CONST. art. 1, § 19.

117. *See supra* notes 78–79, 88–90 and accompanying text. For a critique of the "dangerousness" standard, see *infra* Part III; *see also supra* notes 74, 93 and accompanying text.

118. N.C. GEN. STAT. § 122C-261(a) (2024); *see also In re* J.R., 383 N.C. 273, 277–78, 881 S.E.2d 522, 525 (2022), *cert. denied sub nom*, 144 S. Ct. 75 (2023) (mem.).

of danger is used to justify the use of physical restraints, seclusion, and breaches of patient confidentiality that would otherwise be illegal.[119]

A person is considered "dangerous to themselves" and can be subjected to IVC if they are deemed unable "to exercise self-control" and care for themselves, reasonably likely to suffer "physical debilitation [in] the near future" without treatment, or have "attempted or threatened suicide [and/or self-mutilation] and . . . there is a reasonable probability of suicide [and/or self-mutilation] without treatment."[120] A person is considered "a danger to others" and can be subjected to IVC if, "within the relevant past" and with "reasonable probability" of repetition in the future, they have threatened, attempted, or inflicted "serious bodily harm on another," taken actions that created "a substantial risk of serious bodily harm to another," or engaged in "extreme destruction of property."[121]

After the initial affidavit is filed, the clerk or magistrate must determine whether "reasonable grounds" exist to believe that the facts in the affidavit are true, the respondent has a mental illness, and one of the aforementioned criteria is met, before taking the individual into custody.[122] Being taken into custody can involve being restrained via handcuffs and ankle shackles, and the transportation usually takes place in a law-enforcement vehicle.[123] Once an individual is taken into custody, they must go before a commitment examiner, who determines whether the requirements for IVC are met.[124] If the examiner recommends IVC,

119. N.C. GEN. STAT. § 122C-60 (2024) ("Physical restraint or seclusion of a client shall be employed only when there is imminent danger of abuse or injury to the client or others . . . ."); *id.* § 122C-55(d) ("A responsible professional may disclose confidential information when in the responsible professional's opinion there is an imminent danger to the health or safety of the client or another individual . . . ."); *see also In re* Hatley, 291 N.C. 693, 696, 231 S.E.2d 633, 635 (1977).

120. *See* N.C. GEN. STAT. § 122C-3(11)(a) (2024).

121. *Id.* § 122C-3(11)(b) ("Within the relevant past, the individual has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another, or has acted in such a way as to create a substantial risk of serious bodily harm to another, or has engaged in extreme destruction of property; and that there is a reasonable probability that this conduct will be repeated.").

122. *Id.* § 122C-261(b); *In re J.R.*, 383 N.C. at 278, 881 S.E.2d at 525.

123. *See* Knopf, *More NC Psych Patients*, *supra* note 7.

124. N.C. GEN. STAT. § 122C-263(c), (d)(2) (2024); *In re J.R.*, 383 N.C. at 278, 881 S.E.2d at 525. At the initial hearing before a magistrate, a respondent does not have the right to counsel. *See* LOU A. NEWMAN, JOHN RUBIN & DOROTHY T. WHITESIDE, NORTH CAROLINA CIVIL COMMITMENT MANUAL §§ 2.1(A)–(B), 2.3(J) (2d ed. 2011); *see also* N.C. GEN. STAT. § 122C-261 (2024). However, "[i]n the majority of proceedings for [IVC], respondents are represented by appointed attorneys." NEWMAN ET AL., *supra*, § 2.1(A). Section 122C-270(a) of the General Statutes of North Carolina provides that special counsel represents "all indigent respondents at all hearings, rehearings, and supplemental hearings" held at state facilities. *Id.* "A respondent has the right to counsel through all stages of the proceedings for [IVC]. On appeal from a district court [IVC] order, counsel is assigned by the Office of the Appellate Defender." *Id.* "An indigent person is entitled to counsel in a proceeding for [IVC] for either mental health or substance abuse." *Right to Council*, NAT'L COAL. FOR CIV. RIGHT TO COUNCIL, https://civilrighttocounsel.org/major_developments/right-to-counsel-327/

the individual must be admitted to a twenty-four-hour facility where they must be examined by a physician to again determine if the criteria for IVC are met.[125]

If the physician recommends IVC, a hearing must take place within ten days before the trial court.[126] An individual may be subjected to IVC if the trial court finds "by clear, cogent, and convincing evidence" that the respondent is mentally ill and dangerous.[127] Persons subjected to IVC have the right to access commitment reports and other relevant documents shared with the trial court[128] and to cross-examine witnesses during an IVC hearing.[129]

North Carolina statutes, Supreme Court of North Carolina decisions,[130] and United States Supreme Court decisions emphasize the importance of due process rights for psychiatric detainees. Nevertheless, as the next part demonstrates, people experiencing IVC are consistently deprived of the legal

[https://perma.cc/QT5F-KQLH] (citing N.C. GEN. STAT. § 7A-451(a)(6) (2024)). "N.C. GEN. STAT. § 7A-451(b) specifies that 'entitlement to the services of counsel begins as soon as feasible after the indigent is taken into custody or service is made upon him of the charge, petition, notice or other initiating process' and 'entitlement continues through any critical stage of the action or proceeding.' *Id.*; *see also* N.C. GEN. STAT. § 122C-286 (2024) (providing for appointed counsel for substance abuse IVC); *id.* § 122C-224.1 (same for juvenile detainees); *id.* § 122C-268(d) (entitling respondents who are not indigent to be represented by privately-retained counsel of choice and providing for appointment of counsel pursuant to Indigent Defense Services rules if a nonindigent respondent refuses to hire counsel).

125. N.C. GEN. STAT. §§ 122C-263(d)(2), -266 (2024); *In re J.R.*, 383 N.C. at 278, 881 S.E.2d at 525.

126. § 122C-268(a); *In re J.R.*, 383 N.C. at 278, 881 S.E.2d at 525. Counsel for the State must appear at any hearing concerning IVC at a state facility, but when a person is held in custody for treatment at a private facility, counsel for the State is under no statutory obligation to appear. § 122C-268(b)–(d); *id.* § 122C-270(f); *In re J.R.*, 383 N.C. at 282, 881 S.E.2d at 527–28 (Earls, J., dissenting).

127. § 122C-268(j); *In re J.R.*, 383 N.C. at 278, 881 S.E.2d at 525. The "clear, cogent, and convincing" evidentiary standard is lower than "beyond a reasonable doubt" evidentiary standard afforded to criminal defendants. *Clear and Convincing Evidence*, CORNELL L. SCH. LEGAL INFO. INST., https://www.law.cornell.edu/wex/clear_and_convincing_evidence [https://perma.cc/298L-X2JK] (last updated July 2022).

128. § 122C-266(c); *In re J.R.*, 383 N.C. at 278, 881 S.E.2d at 525.

129. § 122C-268(f); *In re J.R.*, 383 N.C. at 278, 881 S.E.2d at 525.

130. *In re J.R.* is primarily relied on here since it is a recent and well-written opinion that touches on the aspects of IVC law most pertinent to this Article. But a litany of Supreme Court of North Carolina cases have addressed the due process rights of persons subjected to IVC. *See, e.g.*, *In re* C.G., 383 N.C. 224, 236, 881 S.E.2d 534, 543–44 (2022) (discussing the due process right to an impartial trial); *In re* Q.J., 278 N.C. App. 452, 458–60, 863 S.E.2d 424, 429–30 (2021), *aff'd per curiam*, 383 N.C. 333, 330, 880 S.E.2d 675, 675 (2022) (discussing the due process right to impartial tribunal by eliciting evidence when no counsel for state was present); *In re* R.S.H., 383 N.C. 334, 338–39, 881 S.E.2d 480, 483–84 (2022) (discussing the due process right to confrontation of witnesses); *In re* E.D., 372 N.C. 111, 121–22, 827 S.E.2d 450, 457–58 (2019) (discussing whether the right to a speedy examination is preserved automatically); *see also* State v. Hammonds 370 N.C. 158, 162, 804 S.E.2d 438, 441 (2017) (finding that IVC constituted "in custody" for *Miranda* purposes); State v. Sides, 376 N.C. 449, 461–62, 852 S.E.2d 170, 179 (2020) (discussing IVC documentation as it pertained to later competency hearing).

process they are due.[131] Though noble, attempts to reform IVC and to protect due process rights have ultimately failed our neighbors subjected to this harrowing process. Accordingly, procedural reform is inadequate. Instead, IVC must be abolished and replaced with HEART and BHRT. The next part provides a detailed critique of IVC law to support this proposed alternative.

III. A CRITIQUE OF NORTH CAROLINA INVOLUNTARY COMMITMENT LAW

A. *Traditional Critiques of Involuntary Commitment*

Traditionally, assessments of IVC have been articulated like this: "[T]he emphasis in mental health law is focusing more and more upon the task of ensuring that no individual will be involuntarily committed without being provided full due process rights."[132] It would be understandable if a reader mistook this for a quote from a recent law review article. But this quote is *fifty*

131. *See, e.g.*, Lederer, *supra* note 1, at 903–04 (calling for greater judicial intervention, active advocacy by counsel, increased space for comment by respondents, quicker probable cause hearings, explicit statutory role definition for counsel representing people subjected IVC, and state-mandated mental health board monitoring of the IVC process to increase compliance and transparency); Donald Stone, *There Are Cracks in the Civil Commitment Process: A Practitioner's Recommendations to Patch the System*, 43 FORDHAM URB. L.J. 789, 790 (2016) (noting the lack of criminal procedural protections like the right to remain silent and the right against self-incrimination, questioning whether the adversarial hearing process is best suited to address the need for in-patient hospitalization, and criticizing other aspects of IVC law, including the applicability of evidence and the burden of proof standard, *inter alia*); *see* Simpson, *infra* note 137, at 242. *But see* Miller & Fiddleman, *supra* note 75, at 1021–22 (arguing that libertarian patients' rights advocacy excessively focused on reducing involuntary hospitalization may provide false liberty by depriving people who need help from accessing treatment). Indeed, opinions on "liberty" differ.

> Notably, it was civil rights attorneys—not mental health professionals—that started the movement of preferring "liberty" to in-patient treatment. Mental health professionals argue that a preference for liberty at the expense of treatment does not result in the mentally ill enjoying their liberty; rather, they are left afraid and alone. The resulting effect of the involvement of civil rights attorneys in the field of mental health is that the mentally ill are "dying with their rights on."

Victor E. Ramos, Note, *Saving Homeless Lives Through Established Mental Health Laws*, 25 ANNALS HEALTH L. ADVANCE DIRECTIVE 95, 103 (2016) (footnotes omitted) (quoting Meredith Karasch, *Where Involuntary Commitment, Civil Liberties, and the Right to Mental Health Care Collide*, 54 HASTINGS L.J. 493, 497 (2003)).

> Clinicians have argued for years that the real choice for patients with severe mental illnesses (who make up a majority of state mental hospital populations) is not freedom versus incarceration in a mental hospital. Rather, the choice is between a chronic loss of internal freedom due to the illness itself versus periods of hospitalization and treatment followed by enhanced ability to utilize the external freedom after discharge.

Miller & Fiddleman, *supra* note 75, at 1021.

132. Edward B. Beis, *Civil Commitment: Rights of the Mentally Disabled, Recent Developments and Trends*, 23 DEPAUL L. REV. 42, 88 (1973).

years old. Indeed, the focus of legal scholarship over the past six decades has been on criticism of the inadequate due process rights conferred to people subjected to IVC.[133] These critiques are valuable; they identify real problems with IVC. Though this Article ultimately concludes that the best solution is abolition, not reform, it is nevertheless worthwhile to first retrace the contours of the prevailing procedural justice critiques to demonstrate the many shortcomings of IVC law.

As described above, in North Carolina and more broadly, "dangerousness" is the primary criterion for subjecting people to IVC.[134] However, attorneys have "pointed to a number of studies that conclusively stated that neither clinicians nor anyone else could predict future dangerousness with sufficient reliability."[135] Some practitioners have claimed this standard made it more difficult to commit respondents,[136] some have argued that the dangerousness standard is overinclusive,[137] and others have suggested it may be unconstitutionally vague.[138] Indeed, "widespread disagreement exists among courts and psychiatrists as to the ability of psychiatrists to predict dangerousness. Most studies suggest that such predictions are highly inaccurate."[139] But since psychiatrists have "neither time nor training to investigate the petitioners' allegations," their only option is to "trust

133. *See supra* note 35 and accompanying text.

134. Miller & Fiddleman, *supra* note 75, at 993.

135. *Id.* at 991; *see infra* Section III.B. (critiquing the "dangerousness" standard further).

136. Miller & Fiddleman, *supra* note 75, at 990–91.

137. *See generally* David T. Simpson, Jr., *Involuntary Civil Commitment: The Dangerousness Standard and Its Problems*, 63 N.C. L. REV. 241 (1984) (suggesting legislation be enacted requiring dangerousness to be proven beyond a reasonable doubt).

138. Alexander D. Brooks, *Notes on Defining the "Dangerousness" of the Mentally Ill*, *in* DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH 37, 39–40 (Calvin Frederick ed., 1978). Brooks exhaustively outlines many of the potential consequences that can cascade from a legal determination of dangerousness:

> A finding of dangerousness can result in an indeterminate and lengthy involuntary confinement in a civil mental hospital. If the civilly committed, mentally ill person is found to be too dangerous for safe confinement in the civil hospital to which he has been committed, he may be transferred to a correctional hospital for the so-called "criminally insane," even though he has committed no crime. In some [s]tates, a 'dangerous' civil patient, though guilty of no offense, can be transferred to, and placed in, a prison. For the mentally ill offender, the consequences of a finding of dangerousness are likely to be even harsher. A finding of dangerousness applied to a defendant accused of crime, but ruled incompetent to stand trial, may result in confinement in a correctional or maximum security hospital, rather than in a civil hospital, regardless of the seriousness of the original charge. . . . A mentally disturbed prisoner, who is otherwise able to withhold his consent to being drugged, may be subjected to drugs against his will if a consulting psychiatrist finds him to be dangerous. A prisoner who becomes mentally ill can be transferred to, and retained in, a correctional mental hospital if he is found to be dangerous. Even juvenile offenders, in many ways members of a protected group, may, if confined, be subjected to invidious transfers if found to be mentally ill and dangerous.

Id. at 37.

139. Chris Michael Kallianos, *Psychiatrists' Liability to Third Parties for Harmful Acts Committed by Dangerous Patient*, 64 N.C. L. REV. 1534, 1540–41 (1986).

the truth and accuracy of those allegations and use them in making recommendations to the court."[140] "Attorneys who defer to psychiatrists are thus relying on opinions based on hearsay."[141] Ultimately, "dangerousness" is amorphous, nebulous, and dubious—not a "standard" at all.[142] Similarly, the legal theory of "competence" in IVC has also proven difficult and at times unworkable in practice.[143]

Other procedural justice critiques involve the quality and qualification of key decision-makers in the IVC process. At least one court has questioned the validity of involving judicial personnel like magistrates and clerks in making medical psychiatric judgments.[144] Others have critiqued the lack of cooperation between medical and legal professionals and the inadequate funding available to connect people subjected to IVC to the treatment and resources they need.[145] Still others have lamented the inadequate time, dedication, and expertise among lawyers to attend to the needs of clients subjected to IVC and to properly advocate for them.[146] Similar critiques have been leveled against doctors

140. Virginia Aldigé Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C. L. REV. 1027, 1046 (1982).

141. *Id.*

142. In fact, some scholars have argued that dangerousness is *under*inclusive, providing for needed coerced care too late in the experience of an acute mental health crisis. *See* Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 66 CASE W. L. REV. 657, 658. While this Article disagrees with that conclusion, its existence further discredits dangerousness as a coherent standard.

143. Specifically, "competency" as a standard has been criticized because it is an outdated, inconsistent, subjective, relatively unenforceable, ambiguous concept that may not be a meaningful criterion in making psychiatric treatment decisions. *See* CARE CONTINUUM, *supra* note 82, at 16 n.19, 24; *see also* Elyn R. Saks & Dilip V. Jeste, *Capacity to Consent to or Refuse Treatment and/or Research: Theoretical Considerations*, 24 BEHAV. SCI. & L. 411, 426 (2006) ("It is clear . . . that many mentally ill people—indeed, many seriously mentally ill people—are not incompetent on most measures of incompetency."). Scholars have argued that the concept is problematic for other reasons. For one, "competence" is overinclusive, in that it enables some profoundly mentally ill people who are involuntarily committed to refuse beneficial treatment. Dora W. Klein, *When Coercion Lacks Care: Competency To Make Medical Treatment Decisions and* Parens Patriae *Civil Commitments*, 45 U. MICH. J.L. REFORM 561, 563 (2012). For another, "*in*competence" is also overinclusive, in that it can result in unjustly protracted incarceration for psychiatric detainees, hampering their chances for meaningful recovery. Joseph D. Bloom & Scott E. Kirkorsky, *Incompetent to Stand Trial, Not Restorable, and Dangerous*, 48 J. AM. ACAD. PSYCHIATRY L. 1, 5 (2020). Others argue that judges and attorneys often fail to grasp the contours of "incompetence" and how it can be restored, impeding just legal outcomes. *See* Haleigh Reisman, *Competency of the Mentally Ill and Intellectually Disabled in the Courts*, 11 J. HEALTH & BIOMEDICAL L. 199, 234 (2015).

144. *See* Parham v. J.R., 442 U.S. 584, 607 (1979) ("[N]either judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments.") (citation omitted). However, it should be noted that other legal scholars have countered that "[e]xperience teaches that the delicate balance between state and individual interests can be accomplished best in the context of adversarial proceedings in which a judge retains decision making authority." John E.B. Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV. 367, 426 (1983).

145. Myers, *supra* note 144, at 433.

146. Hiday, *supra* note 140, at 1048–49.

involved in the IVC process, who too often are "burnt out" and thus unable to properly make the delicate discretionary determinations involved in IVC hearings.[147]

One final strident procedural justice critique comes from a recent federal lawsuit filed by the American Civil Liberties Union, which challenged the District of Columbia's practice of sending police officers to respond to mental health emergencies.[148] The lawsuit alleges that "the disparity in how the District responds to physical and mental health emergencies violates the Americans with Disabilities Act and the Rehabilitation Act."[149] The lawsuit also contends that "the District discriminates against people with mental health disabilities by failing to ensure that mental health providers, *instead of police officers*, are available to provide timely responses to mental health emergencies."[150]

Besides procedural justice, some have leveled policy critiques. In a recent dissent, Justice Earls argued that "overreliance on institutional treatment is generally more expensive and less effective than community-based alternatives" and that "data also shows that certain groups are more likely to be subjected to care in psychiatric hospitals, namely males and African Americans, and this likely correlates to their limited access to community-based services."[151] She concluded that "a lack of access to community-based services should not render . . . [IVC] the only available form of treatment."[152] Justice Earls goes on to powerfully articulate the externalities of IVC:

> [IVC] . . . comes with serious collateral consequences such as restrictions on a parent's . . . right to custody and control of their children, being

147. *See* Richard F. Summers, Tristan Gorrindo, Seungyoung Hwang, Rashi Aggarwal & Constance Guille, *Well-Being, Burnout, and Depression Among North American Psychiatrists: The State of Our Profession*, 177 AM. J. PSYCHIATRY 955, 955 (2020) ("Psychiatrists experience burnout and depression at a substantial rate."); ASHISH K. JHA, ANDREW R. ILIFF, ALAIN A. CHAOUI, STEVEN DEFOSSEZ, MARYANNE C. BOMBAUGH & YAEL R. MILLER, A CRISIS IN HEALTH CARE: A CALL TO ACTION ON PHYSICIAN BURNOUT 6 (2018), https://www.hsph.harvard.edu/wp-content/uploads/sites/21/2019/01/PhysicianBurnoutReport2018FINAL.pdf [https://perma.cc/T4JD-WUNZ] ("Physician burnout is a public health crisis that urgently demands action by health care institutions, governing bodies, and regulatory authorities. If left unaddressed, the worsening crisis threatens to undermine the very provision of care, as well as eroding the mental health of physicians across the country."); *see also* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., ADDRESSING BURNOUT IN THE BEHAVIORAL HEALTH WORKFORCE THROUGH ORGANIZATIONAL STRATEGIES 2 (2022), https://store.samhsa.gov/sites/default/files/pep22-06-02-005.pdf [https://perma.cc/3HMT-3EP5] (discussing the distinct but related phenomena of moral injury, vicarious trauma, compassion fatigue, and second victim syndrome).

148. *Bread for the City v. District of Columbia*, ACLU, https://www.aclu.org/cases/bread-for-the-city-v-district-of-columbia [https://perma.cc/Y6E4-LKLZ] (last updated July 6, 2023).

149. *Id.*

150. *Id.* (emphasis added); *see also* Complaint at 1–2, Bread for the City v. District of Columbia, Case 1:23-cv-01945 (D.D.C. July 7, 2023).

151. *In re* J.R., 383 N.C. 273, 291, 881 S.E.2d 522, 529 (2022) (Earls, J., dissenting) (citations omitted), *cert. denied sub nom.*, 144 S. Ct. 75 (2023) (mem.).

152. *Id.* at 291, 881 S.E.2d at 534.

> forbidden from owning a firearm, and being prohibited from obtaining several types of professional licenses, including a license to practice law. Indeed, a person's [IVC] is "always an ominous presence" that may be used to attack their competence, credibility, and character whenever there is "any interaction between the individual and the legal system." Our society can also be unkind to people with mental illness . . . [and can stigmatize them]. Accordingly, the United States Supreme Court has acknowledged that "an erroneous commitment is sometimes as undesirable as an erroneous conviction."[153]

Further collateral consequences have been identified in studies finding that psychiatric hospitalization can do more harm than good. "A 2016 report suggested that 'adverse experiences associated with hospitalization' caused the high number of post-discharge suicide attempts."[154] That report found that IVC was associated with an "increased risk of suicide both during the hospitalization itself and afterward."[155] A 2017 article found that immediately after being released from a hospital, the risk of suicide was *100 times greater* than average immediately after being released from a hospital.[156] And a 2023 study found that areas that do not frequently utilize IVC do not see more adverse events among people experiencing serious mental disorders.[157] These findings tend to undermine the assumption that IVC protects patients from negative outcomes.[158]

Ultimately, traditional critiques generally support a more judicious use of IVC. This Article contends that such an approach, while noble, is inadequate.

153. *Id.* at 284–85, 881 S.E.2d at 529.

154. Peter Simons, *Involuntary Hospitalization Increases Risk of Suicide, Study Finds*, MAD AM. (June 24, 2019), https://www.madinamerica.com/2019/06/involuntary-hospitalization-increases-risk-suicide-study-finds/ [https://perma.cc/WE3C-WFY7] (citation omitted).

155. *Id.* (citing Daniel Thomas Chung, Christopher James Ryan & Matthew Large, *Commentary: Adverse Experiences in Psychiatric Hospitals Might Be the Cause of Some Postdischarge Suicides*, 70 BULL. MENNINGER CLINIC 371, 372 (2016)). Likewise, a 2019 study suggested that forced hospitalization increases the risk of suicide. Joshua T. Jordan & Dale E. McNiel, *Perceived Coercion During Admission into Psychiatric Hospitalization Increases Risk of Suicide Attempts After Discharge*, 50 SUICIDE & LIFE-THREATENING BEHAV. 180, 186 (2019).

156. Simons, *supra* note 154 (citing Daniel Thomas Chung, Christopher James Ryan, Dusan Hadzi-Pavlovic, Swaran Preet Singh, Clive Stanton & Matthew Michael Large, *Suicide Rates After Discharge from Psychiatric Facilities: A Systematic Review and Meta-analysis*, 74 JAMA PSYCHIATRY 694, 699 (2017)).

157. Olav Nyttingnes, Jūratė Šaltytė Benth, Tore Hofstad & Jorun Rugkåsa, *The Relationship Between Area Levels of Involuntary Psychiatric Care and Patient Outcomes: A Longitudinal National Register Study from Norway*, 23 BMC PSYCHIATRY 1, 1 (2023), https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-023-04584-4 [https://perma.cc/WDN3-E5VJ].

158. *Id.* To make an empirical utilitarian assessment of the value of IVC, studies like these would need to be contrasted with studies that provide data on how many people have positive experiences as a result of IVC. A meta-analysis of how many suicides were averted thanks to IVC would be ideal. Unfortunately, I could find no such data extant in the literature. The lack of data is understandable; this sort of qualitative positive outcome would be hard to quantify, and, as noted below, personal narratives of positive IVC outcomes are sparse.

Instead, since IVC tends to cause significantly more harm than good, it must be abolished. The next section offers a variety of qualitative approaches to further justify this claim.

B. *Humanizing Involuntary Commitment via Narrative Medicine*

Traditional critiques of IVC law are useful but incomplete. While statistics make clear that more people than ever are being subjected to IVC, the texture and humanity of those experiences are better captured qualitatively through narratives.[159] This presents a tension in academic literature, where empirical data is often given pride of place.[160] Nevertheless, Narrative Medicine—the application of narrative ideas to the practice of medicine—has recently gained currency.[161]

Such narrative application is also apposite to law.[162] Accordingly, as a foundation for its critique, this Article draws on narratives to emphasize how

159. *See, e.g.*, Alexandra Lynne Adame, Recovered Voices, Recovered Lives: A Narrative Analysis of Psychiatric Survivors' Experiences of Recovery (2006) (M.A. thesis, Miami University), https://etd.ohiolink.edu/acprod/odb_etd/ws/send_file/send?accession=miami1152813614&disposition=inline [https://perma.cc/4PQ8-P65G (staff-uploaded archive)] ("[T]he psychiatric survivor movement created a counter-narrative of protest in opposition to the medical model's description and treatment of psychopathology. Since then, the movement has moved beyond the counter-narrative and has constructed an alternative narrative; one that is not defined in opposition to the master narrative but instead participates in an entirely different discourse.").

160. "The healing power of narrative is repeatedly attested to but the scientific evidence is sparse." George Zaharias, *What Is Narrative-Based Medicine?*, 64 CAN. FAM. PHYSICIAN 176, 176 (2018). "Wouldn't you want someone to tell your story? Ultimately, it's the best proof there is that we mattered. And what else is life from the time you were born but a struggle to matter, at least to someone?" *Id.* at 177 (quoting Elliot Perlman).

161. *Id.* While there is no universally accepted definition of Narrative Medicine, George Zaharias describes it this way:

> Stories are our life's blood. We like to listen to stories, and it is through stories that we make sense of the world, that identity is shaped, and that we attempt to communicate what matters to us. This is well recognized by psychology, the social sciences, and the humanities, where narrative ideas originated. . . . [Narrative Medicine] is the application of narrative ideas to the practice of medicine.

Id.

162. *See, e.g.*, Andrew Benjamin Bricker, *Is Narrative Essential to the Law?: Precedent, Case Law and Judicial Emplotment*, 15 LAW, CULTURE & HUMS. 319, 319, 327 (2016) ("Storytelling pervades almost every aspect of the law. . . . Narrative *is* essential to the law."); Robert M. Cover, *Foreword: Nomos and Narrative*, 97 HARV. L. REV. 4, 5 (1983) ("Law and narrative are inseparably related."); Anne E. Ralph, *Narrative-Erasing Procedure*, 18 NEV. L.J. 573, 584 (2018) ("'[L]aw lives on narrative' and 'the law is awash in storytelling.' . . . [Law and narrative are] inextricably intertwined.") (citations omitted); ROBIN WEST, NARRATIVE, AUTHORITY, AND LAW 419 (1993) ("Simply put, stories are a part, and seemingly an indispensable part, of the law with which rights are protected, and as a consequence, storytelling and rights construction inevitably intertwine."); JAMES BOYD WHITE, JUSTICE AS TRANSLATION: AN ESSAY IN CULTURAL AND LEGAL CRITICISM 17 (1990) (thinking of law as a narrative or literary activity allows us "a range of remarkable opportunities not otherwise available" for

being subjected to IVC can be harrowing. These narratives evince that IVC experiences range from gently stabilizing to profoundly traumatizing.[163] People subjected to IVC may find themselves stripped of autonomy, stripped of their clothing, deprived of their belongings, stigmatized, destabilized, financially stymied, unable to work, disrespected, humiliated, degraded, dehumanized, violated, or—perhaps worst of all—forgotten.[164] Psychiatric survivors may be skeptical about diagnoses that precede IVC and those received after forced hospitalization.[165] They may feel betrayed, especially in situations where the petitioner whose call resulted in their commitment was a loved one.[166] Some

interpretation); Peter Brooks, *Narrative and Rhetoric in the Law*, *in* LAW'S STORIES: NARRATIVE AND RHETORIC IN THE LAW 14, 17 (Peter Brooks & Paul Gewirtz eds., 1996) (describing narratology as offering "some hypotheses, distinctions, and analytic methods that could be useful to legal scholars, if they were to pay attention"); Catharine A. MacKinnon, *Law's Stories as Reality and Politics*, *in* LAW'S STORIES: NARRATIVE AND RHETORIC IN THE LAW 232, 235 ("Storytelling can be a strategy for survival when one dare not argue. But it can ask too little. Dominant narratives are not called stories. They are called reality.").

163. *See, e.g.*, Morgan True, *Patients, Families Share Wrenching Stories of Involuntary Hospitalization*, VTDIGGER (Jan. 13, 2014), https://vtdigger.org/2014/01/31/patients-families-share-wrenching-stories-of-involuntary-hospitalization/ [https://perma.cc/U448-86CD].

164. *See* Simons, *supra* note 154.

165. *See, e.g.*, Awais Aftab, *Reconsidering Care and Coercion in Psychiatry: Kathleen Flaherty, JD*, PSYCHIATRIC TIMES (Apr. 21, 2021), https://www.psychiatrictimes.com/view/care-coercion-psychiatry [https://perma.cc/B7G5-2NZY] (describing attorney's skepticism of bipolar disorder diagnosis in the context of a conversation about forced psychiatric treatment). Notably, the attorney interviewed in this article provided this excellent summary of the problems surrounding the medicolegal landscape of IVC:

> The systemic difficulties and obstacles experienced by our clients subjected to the state actions of involuntary treatment and [IVC] are longstanding and pervasive. Systemic inequity and poverty are layered over discrimination that stems from disability. Many police departments reflect the larger prejudices of their communities and use infractions and laws to criminalize disability, instead of providing accommodations and diversion into health care and meeting basic needs. Systemic problems within the state judicial action of [IVC] include ineffective assistance of counsel, lack of adequate due process, lack of access to independent expert witnesses, and treating judicial hearings like treatment team meetings in how they look at behavior and outcomes. The judicial system does not have a realistic and accurate understanding of mental health conditions, which results in almost complete deference to *proffered diagnosis and risk assessments, both of which lack a robust foundation in empirical science*. The judicial system has limited awareness of the complicated efficacy (to the extent that it exists) of psychiatric treatment and medication, especially for the cohort of patients subjected to [IVC]. Once committed, the problems include unsafe conditions of confinement, police presence at hospitals, inadequate system response to allegations of patient abuse and neglect, and forced psychiatric treatment. The system often fails to provide adequate information about the risks and benefits of psychiatric medication so that patients can give truly informed consent. Finally, discharge planning is inadequate; patients' rights to be discharged into the most integrated setting as soon as they are stable and ready for discharge is routinely violated.

Id. (emphasis added).

166. *See, e.g.*, David McGuinness, Kathy Murphy, Emma Bainbridge, Liz Brosnan, Mary Keys, Heike Felzmann, Brian Hallahan, Colm McDonald & Agnes Higgins, *Individuals' Experiences of*

people who feel harmed by IVC may engage in advocacy to seek systemic change for greater dignity and rights.[167] Others may feel powerless, defeated, resigned, and, too often, suicidal.[168]

The law of IVC also takes a toll on healthcare providers.[169] Doctors who aspire to ethically heal patients can be seen as jailers; patients' experience of the healthcare system may feel more like coercive control than benevolent treatment.[170] This struggle mirrors the ethical dilemma of balancing beneficence against autonomy that has vexed physicians throughout history.[171] Moreover, psychiatrists can suffer secondary or vicarious trauma as a result of working with mentally ill IVC patients.[172]

It would be remiss, however, not to mention other countervailing IVC narratives. Family and community members terrified by violent episodes of psychosis or suicidality may value IVC as an emergency resource.[173] For them, the temporary confinement and coercion of a noncriminal proceeding may seem more merciful than letting a loved one persist in an agonizing psychic crisis with no conceivable end, or subjecting them to jail or prison.[174] Likewise, there may be narratives of optimism and success from people who are glad to have been involuntarily committed.[175]

Involuntary Admissions and Preserving Control: Qualitative Study, 4 BJPSYCH OPEN 501, 503 (2018) ("Additionally, individuals felt betrayed when they perceived family members may have been involved in initiating their involuntary admission. As a direct consequence[] of 'feeling violated[,]' peoples' sense of loss of control was further exacerbated.").

167. *See, e.g.*, Laura McCabe, *What It's Like To Be Involuntarily Committed*, MAD AM. (Feb. 6, 2020), https://www.madinamerica.com/2020/02/what-its-like-to-be-involuntarily-committed/ [https://perma.cc/6N2D-TP7W] ("The change I would like to see in the mental health system is to never see anyone involuntarily medicated. It is the most maddening thing to have one's rights removed without a crime occurring.").

168. *See supra* Section III.A.

169. *See supra* note 147 and accompanying text.

170. Abraham Nussbaum, *Held Against Our Wills: Reimagining Involuntary Commitment*, 39 HEALTH AFFS. 898, 898 (2020).

171. *See supra* Part I.

172. *See* Joseph A. Boscarino, Richard E. Adams & Charles R. Figley, *Secondary Trauma Issues for Psychiatrists*, 27 PSYCHIATRIC TIMES 1, 1 (2010); Summers et al., *supra* note 147.

173. *See* True, *supra* note 163.

174. *See, e.g.*, *Mentally Ill and Locked Up: Prisons Versus Inpatient Wards for Psychiatric Patients*, PSYCHCENTRAL (Apr. 1, 2015), https://psychcentral.com/pro/mentally-ill-and-locked-up-prisons-versus-inpatient-wards-for-psychiatric-patients [https://perma.cc/2PJG-FM8S] ("Advocates for more [IVC] say that at least the ill person is safe in a ward."). However, this study goes on to mention that "[i]n reality, both inmates and patients suffer from [a] lack of physical security" and are vulnerable to physical attacks and sexual assaults. *Id.*

175. Because I am friends with several people who have been subjected to IVC and voluntary psychiatric hospitalization, I have access to some colloquial narrative evidence of success after IVC and appreciative accounts of the experience. More common, however, are stories about how scary, upsetting, violent, and needlessly traumatizing being subjected to IVC was.

There are also the ambient narratives of "public safety"[176] and "civility"[177] sometimes deployed as a justification for IVC, which may be enjoyed by citizens who appreciate not having to engage with mentally ill people.[178] Others believe that addicts (a subset of the population exposed to IVC law in North Carolina)[179] will benefit from IVC because it will reduce instances of drug use and crime.[180] And, as discussed above, some proponents of IVC view it as a necessary avenue to needed treatment of which patients would be otherwise deprived.[181]

176. *See, e.g.*, Kansas v. Hendricks, 521 U.S. 346, 353–54 (1997); *see also* King, *supra* note 6, at 1427–28 (concluding that the *Hendricks* Court seemed willing to sacrifice individual liberty in return for public safety in its decision to subject the defendant to IVC).

177. *See* Peter Stastny, *Involuntary Psychiatric Interventions: A Breach of the Hippocratic Oath?*, 2 ETHICAL HUM. SCIS. & SERVS. 21, 32 (2000) (discussing paternalism, authoritarianism, and the power to control as it pertains to psychiatric confinement); *see also* Robert Teir & Kevin Coy, *Approaches to Sexual Predators: Community Notification and Civil Commitment*, 23 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 405, 426 (1997) (arguing that IVC is a reasonable tool to keep communities safe from sexual predators).

178. The desire to keep mentally ill people out of sight requires some ideological rationalization that their being banished and/or vanished is somehow just. This can be understood in terms of what Allegra McLeod has called the "fetish of finality." Allegra McLeod, *Prison Abolition and Grounded Justice*, 62 UCLA L. REV. 1156, 1211–16 (2015). Thomas Ward Frampton has described the Fetish of Finality as "our country's deeply rooted cultural acceptance of the idea that a criminal conviction marks the end of our moral concern for the offender." Thomas Ward Frampton, *The Dangerous Few: Taking Seriously Prison Abolition and Its Skeptics*, 135 HARV. L. REV. 2013, 2048 (2022). Given IVC's carceral operation and tenor, I argue that this phenomenon applies to IVC, too. *See also* Meredith Karasch, *Where Involuntary Commitment, Civil Liberties, and the Right to Mental Health Care Collide: An Overview of California's Mental Illness System*, 54 HAST. L.J. 493, 522 (2003) ("By making it easier to confine than to treat, and by failing to provide a right to adequate treatment, it appears that the [law governing IVC in California] is actually more focused on protecting the sane from the insane than achieving its goal of helping the mentally ill.").

179. "Addict" here is used as shorthand to describe a person experiencing substance use disorder; "substance abusers" are contemplated by North Carolina's IVC laws. *See generally* N.C. GEN. STAT. § 122C-281 to -300 (2024) ("Part 8. Involuntary Commitment of Substance Abusers, Facilities for Substance Abusers") (outlining procedure for seeking to have a person perceived to be a "substance abuser who is dangerous to self or others" involuntarily committed); *see also id.* § 122C-3(36) (defining "substance abuse" as "[t]he pathological use or abuse of alcohol or other drugs in a way or to a degree that produces an impairment in personal, social, or occupational functioning"). "Addict," "substance abuser," and "person experiencing substance use disorder" are arguably equivalent, but some have advocated for the use of more humane terms. *See* Lev Facher, *When It Comes to Addiction, Americans' Word Choices Are Part of the Problem*, STAT (Oct. 26, 2022), https://www.statnews.com/2022/10/26/when-it-comes-to-addiction-americans-word-choices-are-part-of-the-problem/ [https://perma.cc/J6FB-Q7GV (staff-uploaded, dark archive)].

180. *See, e.g.*, SALLY L. SATEL, DRUG TREATMENT: THE CASE FOR COERCION *passim* (1999). Satel purports to justify her support of coercion by arguing that "most addicts, given a choice, will not enter a treatment program at all." *Id.* at 2.

181. *See* Miller & Fiddleman, *supra* note 75, at 1021–22.

Ultimately, Narrative Medicine offers a portal into the lived experience and interiority[182] of people subjected to IVC. Though the web of IVC narratives is complex, most involve needless harm, violence, force, coercion, and trauma. To remedy these experiences, critiques of IVC must not be used to rationalize reform but to justify the call for abolition. That call, and the accompanying proposal for statewide implementation of HEART and BHRT, are outlined in the next section.

C. *Reforms Are Inadequate; Instead Involuntary Commitment Must Be Abolished*

Abolitionist scholars have argued that IVC is carceral and oppressive. Rafik Wahbi and Leo Beletsky contend that IVC *produces*—not reduces—harm and death.[183] They describe how IVC "links the healthcare, public health, and legislative systems to act as a *carceral-health service*" whereby the "systems, structures, practices, and policies of structural oppression and white supremacy" are reinforced while IVC masquerades as "humane and medicalized."[184] They argue that IVC's "inextricable connection to the carceral system" and extensive "history of violent social control" militate against its continued existence, and that IVC is an illegitimate alternative to criminal legal responses to behavioral health challenges.[185] They conclude that IVC must be abolished.[186] Tristan Campbell makes a similar claim, arguing that IVC is an instance of structural oppression that increases the power of the carceral state and interferes with communities' capacity to "address behavioral and mental health crises without involving the police."[187] He concludes that IVC must be abolished as a key piece of infrastructure in the "healthcare-to-prison-pipeline."[188]

Further proof of the carcerality of IVC is provided by the fact that the Prison Policy Initiative ("PPI") counts people subjected to IVC among the incarcerated. As of 2024, PPI found that 25,000 people are involuntarily detained or committed

182. *See, e.g.*, Keally McBride, *Incarceration and Imprisonment*, 6 LAW, CULTURE & HUMS. 341, 343 (2010) (describing interiority as "an ability to construct a sense of self and reality outside of established frameworks of social categories, experience and interactions" and "interiority inside a prison" as "the ability to create and sustain a definition and sense of self outside of the one offered to you by the very fact of incarceration"). Because IVC is a civil regime of incarceration, I find McBride's discussion of interiority particularly resonant here.

183. Rafik Wahbi & Leo Beletsky, *Involuntary Commitment as "Carceral Health Service": From Healthcare-to-Prison Pipeline to a Public Health Abolition Praxis*, 50 J.L. MED. & ETHICS 23, 28 (2022) (emphasis added). Rafik Wahbi, M.P.H., is an educator, student, and scholar of abolition and harm reduction. *Id.* at 23. Leo Beletsky, J.D., M.P.H., is a professor of law and of medicine and directs the Health in Justice Action Lab at Northeastern University. *Id.*

184. *Id.* (internal quotation marks omitted) (emphasis added).

185. *Id.*

186. *Id.* at 25.

187. Tristan Campbell, *Involuntary Civil Commitment as Mass Incarceration*, 79 NAT'L LAWS. GUILD REV. 32, 32 (2023).

188. *Id.* at 46.

to state psychiatric hospitals and IVC centers.[189] PPI concluded that although these facilities "aren't typically run by departments of correction, *they are in reality much like prisons*."[190] At least thirty-eight states (including North Carolina) allow IVC to be used as a consequence for "dangerous" substance use, and, often, "people are sent to actual prisons and jails, which are inappropriate places for treatment."[191] It has even been argued that medical professionals should face liability for false imprisonment and other civil rights violations for seeking to keep a person committed beyond the terms of their psychiatric advanced treatment directive.[192]

To the extent that IVC is carceral, justification for its abolition can be found among the broad corpus of scholarship advocating for prison abolition.[193] Groups like the Movement for Black Lives include IVC among the forms of confinement that must be abolished.[194] Furthermore, a diverse array of legal scholars, medical personnel, healthcare providers, peer support specialists, and disability justice organizers have spoken out against IVC and called for its

189. Wendy Sawyer & Peter Wagner, *Mass Incarceration: The Whole Pie 2024*, PRISON POL'Y INITIATIVE (Mar. 14, 2024), https://www.prisonpolicy.org/reports/pie2024.html [https://perma.cc/T8SU-LESJ] ("Many of these people are not even convicted, and some are held indefinitely. These 'forensic patients' include people being evaluated or treated for incompetency to stand trial, as well as those found not guilty by reason of insanity or guilty but mentally ill, who may remain hospitalized for decades or for life. Roughly 6,000 are people convicted of sex-related crimes who are involuntarily committed or detained after their prison sentences are complete.").

190. *Id.* (emphasis added).

191. *Id.* (citation omitted). IVC has also been described as part of the "shadow carceral state," which "expands penal power through institutional annexation and legal hybridity." *See* Katherine Beckett & Naomi Murakawa, *Mapping the Shadow Carceral State: Toward an Institutionally Capacious Approach to Punishment*, 16 THEORETICAL CRIMINOLOGY 221, 221 (2012).

192. Samantha M. Caspar & Artem M. Joukov, *You Can Check-in Any Time You Like, but You Can Never Leave: Forced Mental Health Treatment and Advance Directives*, 40 QUINNIPIAC L. REV. 395, 460 (2022). "Psychiatric advance directives [("PADs")], introduced in the 1980s, permit mental health patients to retain some control over their mental health treatment during periods of decisional incapacity." *Id.* at 423. Many adults with SMIs have fluctuating decisional capacity and choose to "take advantage of . . . times of lucidity to create a plan for future crises." *Id.* PADs help people communicate preferences for care and may help them avoid the trauma of IVC in some cases. *See id.* However, PADs are trumped by IVC law and may also be legally overridden or ignored by clinicians who believe them "to be inconsistent with accepted clinical standards of care." *Id.* at 423. Importantly, many "laws provide legal immunity to doctors who decline to follow patients' advance treatment instructions." *Id.* at 424. Thus, though PADs are in high demand and sometimes provide for meaningful restoration of autonomy and dignity in the IVC process, their relative weakness leads me to conclude they are among the noble but ultimately ineffective attempts to reform procedural justice in IVC.

193. A detailed analysis of abolitionist literature is beyond the scope of this Article; for a litany of legal-scholastic support for the project of abolition, see Frampton, *supra* note 178, at 2015 & nn.10, 11.

194. *End to All Jails, Prisons, and Immigration Detention*, MOVEMENT FOR BLACK LIVES, https://m4bl.org/policy-platforms/end-jails-prisons-detention [https://perma.cc/2AWG-VPVP] (demanding "[a]n end to all jails, prisons, immigration detention, youth detention *and civil commitment facilities* as we know them and the establishment of policies and programs to address the current oppressive conditions experienced by people who are imprisoned" (emphasis added)).

abolition.[195] Public health scholars have added passionate critiques to this chorus, lamenting the inequitable disparities that currently exist in IVC law, which fall along lines of race, class, gender identity, and disability.[196] Likewise, other thinkers in abolition medicine[197] have critiqued healthcare practices as racist.[198]

This critique is not limited to the United States—even the United Nations ("UN") condemns IVC and seeks its abolition. In 2013, Juan Méndez, the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, called for a ban on forced psychiatric interventions.[199]

195. For examples of such calls for abolition, see Wahbi & Beletsky, *supra* note 183, at 25; Stella Akua Mensah *Abolition Must Include Psychiatry*, DISABILITY VISIBILITY PROJECT (June 22, 2020), https://disabilityvisibilityproject.com/2020/07/22/abolition-must-include-psychiatry/ [https://perma.cc/4FHD-GQ92]; Jenny Logan, *Undoing the Healthcare-to-Prison Pipeline with Abolitionist Practice*, MAD AM. (June 1, 2022), https://www.madinamerica.com/2022/06/undoing-healthcare-prison-pipeline/ [https://perma.cc/K96J-7J5S]; Stefanie Lyn Kaufman-Mthimkhulu, *We Don't Need Cops To Become Social Workers: We Need Peer Support + Community Response Networks*, MEDIUM (June 6, 2020), https://medium.com/@stefkaufman/we-dont-need-cops-to-become-social-workers-we-need-peer-support-b8e6c4ffe87a [https://perma.cc/EWY8-JQWM]; Liat Ben-Moshe, *Dis-epistemologies of Abolition*, 26 CRITICAL CRIMINOLOGY 341, 344–45 (2018). Another related critique has been that welfare programs serve as tools of social control that offer little therapeutic value or meaningful material assistance. Norman N. Goroff, *Social Welfare as Coercive Social Control*, 2 J. SOCIO. & SOC. WELFARE 19, 19 (1974).

196. *See* Wahbi & Beletsky, *supra* note 183, at 27–28.

> With regards to [IVC], an integrated evidence-based health and social service model in tandem with non-carceral community-based emergency and crisis response teams has the potential to respond to the wide range of crises that individuals can be in. By responding with compassion and practices that do not further harm the individual (punishment and incarceration), these alternative approaches exceed involuntary commitment because they actually address the issues, instead of caging them away.

Id. at 28. They note that Black people in particular are disproportionately subjected to violence and trauma via IVC. *Id.* at 26.

197. Hala Baradi, *Advocating for Abolition in Health Law: A Theory and Praxis to Liberate Black Incarcerated Women*, 51 J.L. MED. & ETHICS 196, 196, 205 (2023) (arguing that the carceral state functions as a structural determinant of health and that legacies of oppression have facilitated the abridgment of incarcerated women's reproductive capacities, and concluding: "Abolition is more than a tool to dismantle prisons. Abolition is a medicine that can heal us all.").

198. Zahra H. Khan, Yoshiko Iwai & Sayantani DasGupta, *Abolitionist Reimaginings of Health*, 24 AMA J. ETHICS 239, 241 (2022) ("If the emphasis of medicine is to 'first, do no harm' then we must contend with medicine's history of systemic racism and redefine how we understand health and safety . . . abolition medicine calls for deconstructing and divesting from practices within health care that perpetuate systemic racism and criminalize the lives of marginalized people[,] and for reinvesting in life-affirming systems that address structural harm. Abolition medicine means linking medicine to public safety by redirecting resources away from policing structures and towards services that invest in the welfare of all people . . . . It also means removing police presence in places like the emergency room and safeguarding health care settings as sanctuaries. By placing abolition in conversation with medicine, we ask: What healthier possibilities can emerge when social systems reduce violence and reimagine collective care?").

199. Juan E. Méndez (Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), *Rep. of the Special Rapporteur on Torture and Other Cruel, Inhuman or*

Méndez "warned member countries, including the United States, that the practice of involuntary hospitalization is prohibited and should be *abolished* since it consists of the restraint and imprisonment of people who have neither been accused of nor convicted of a crime."[200]

This line of IVC criticism is not new. Decades before this call for abolition by the UN, Law Professor Stephen J. Morse crafted an elegant, persuasive call for the abolition of IVC. In his 1982 law review article, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, Morse noted that while some may attempt to critique IVC for being unconstitutional, such an approach is ultimately unpersuasive.[201] Instead, Morse argued that IVC is "a gravely unwise social institution, regardless of its constitutionality," and that it must be abolished.[202]

Morse contended that "[t]he system, as now constituted, does not alleviate substantially the ills of the disordered; rather, it only removes disordered persons and their problems from the consciousness and conscience of our society at an enormous cost in liberty."[203] There, Morse anticipated a phenomenon later articulated by Allegra McLeod as "the fetish of finality," whereby incarceration functions as a tool to put persons accused of deviance out of sight and out of mind.[204] Morse went on to say that "[i]f there is a solution, however partial, it lies in providing the resources to ensure that decent food, shelter, clothing, and treatment are provided in the community *in the least restrictive manner* to those who need them."[205] There, Morse anticipated a liberatory conception of neurodiversity whose etiology lies not in ineluctable dysfunction, but rather material deprivation.[206]

Morse proceeded to warn of a tripartite phenomenon that threatens to thwart progress made toward justly treating people subjected to IVC. That threat consists of (1) a "false vision of the quality of care" that IVC is supposedly providing,[207] (2) a societal unwillingness to "pay the price in terms of caring and

Degrading Treatment or Punishment, ¶¶ 67–70, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013), https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf [https://perma.cc/T7CB-JXEZ].

200. Simons, *supra* note 154 (internal quotation marks omitted) (emphasis added). "The UN group clearly stated that this infringes on the rights of people with psychosocial disabilities." *Id.* Similarly, in 2016, Dainius Pūras, a psychiatry professor and the UN Special Rapporteur on the Right to Health, denounced involuntary treatment. *See* Justin Karter, *United Nations Report Calls for Revolution in Mental Health Care*, MAD AM. (June 9, 2017), https://www.madinamerica.com/2017/06/united-nations-report-calls-revolution-mental-health-care/ [https://perma.cc/YES5-AXAD].

201. Morse, *supra* note 33, at 57.

202. *Id.*

203. *Id.* at 105.

204. *See* McLeod, *supra* note 178, at 1211–16.

205. Morse, *supra* note 33, at 105 (emphasis added).

206. *See id.*

207. *Cf.* Wahbi & Beletsky, *supra* note 183, at 23 (characterizing IVC as "masquerading as . . . humane and medicalized").

tolerance," and (3) inadequate funding for proper treatment.[208] Morse concluded that in the face of this phenomenon, "Persons who are concerned with treating disordered persons with dignity and humanity must combat these problems and should strive to *abolish*, or at least severely restrict, [IVC] and to encourage the provision of adequate care in the community."[209]

Abolition will mean that some people will occasionally be dangerous and that IVC will not be an option for recourse.[210] The key, Morse said, is to trust that voluntary treatment will adequately meet individuals' psychiatric care needs, and that the criminal system will adequately meet society's public safety needs.[211] On this point, Morse concluded, "[I]f the social climate of liberty is increased and if mentally disordered persons are finally treated as dignified and autonomous human beings, then abolition of the [IVC] system is well worth any costs that are likely to result."[212]

Morse presented a bold and unflinching vision of IVC abolition. Accepting his argument does not mean the law should abandon people experiencing behavioral health crises. Rather, the cavity created by IVC abolition can be filled with a novel legal regime that provides nonviolent emergency response resources and solutions. That legal regime currently exists as HEART in Durham, which could easily be scaled up, codified, and implemented statewide via the BHRT. Implementing HEART statewide would provide robust, compassionate, and tolerant protection for people who are currently subjected to IVC. HEART would effectively address the needs IVC law was originally designed to address, without the attendant violence, force, trauma, and suffering currently embedded in IVC.

208. Morse, *supra* note 33, at 106. See *infra* Part IV, for more on funding.

209. Morse, *supra* note 33, at 106 (emphasis added).

210. *See id.* ("No public policy, no matter how beneficial, is entirely cost free.").

211. *Id.* ("If care and treatment services are voluntary and reasonably provided to disordered persons and if social control is left primarily to the criminal justice system, our society, the mentally disordered, and even the mental health professions will benefitted. Hospitals will still exist: some people will want treatment there and perhaps some can best—or only—be treated in such an environment. A vast number of citizens, however, will for the first time be able to obtain needed services in an atmosphere of dignity and liberty. Professionals will be freed to devote their full time to the tasks of diagnosis and treatment for which they are truly trained. There will be more than enough work, prestige, and power for mental health professionals who treat only willing patients."). One thing Morse does not address that is worth mentioning here is that the repeal of the legal regime of IVC will actually result in *increased* procedural justice protections to some people, to the extent that they are exposed to the criminal justice system rather than being deprived of due process as currently permitted by civil IVC law. *See* Stone, *supra* note 131, at 790.

212. Morse, *supra* note 33, at 106.

IV. AN ALTERNATIVE PROPOSAL: ABOLISH 122C AND REPLACE IT WITH HEART & THE BHRT

A. *How HEART Works*

In 2022, the City of Durham introduced its new crisis response program, HEART.[213] The program, administered by the Durham Community Safety Department ("DCSD"), is designed to "connect people experiencing non-violent mental health crises or quality of life concerns with the right care by sending new responses that better match residents' needs."[214] To do so, it has built infrastructure and hired personnel in two key areas: rerouting 911 call dispatch and providing alternative first response.

213. *Community Safety*, CITY OF DURHAM, https://www.durhamnc.gov/4576/Community-Safety [https://perma.cc/G5DV-SJGZ] [hereinafter *Community Safety*]. Recently, community members have requested that HEART be brought to Raleigh, North Carolina's capital and its second-most-populous city. Julian Grace, *Raleigh Advocates Push for HEART Program to Come to the City*, WRAL NEWS, https://www.wral.com/story/raleigh-advocates-push-for-heart-program-to-come-to-the-city/20907204/ [https://perma.cc/X2KK-BYFY] (last updated June 13, 2023, 2:08 AM). Social justice advocates believe HEART could have prevented needless deaths of individuals suffering mental health crises. *See id.* These advocates believe HEART would be a superior alternative to Raleigh's current Co-Response team program, Addressing Crises through Outreach, Referrals, Networking and Service ("ACORNS") program. *Id.* Critics of ACORNS say it is ineffective because it responds after crises have already happened rather than attempting to preemptively intervene in the way that HEART does. *Id.* HEART does not yet exist in Durham's municipal code of ordinances. Zoom Call Interview with Sofia Hernandez, Senior Assistant City Attorney at City of Durham (Nov. 14, 2023) (notes on file with the North Carolina Law Review) [hereinafter Hernandez Zoom Call]. Notably, I helped draft several model ordinances and resolutions for HEART for a pro bono project with Ms. Hernandez in 2022. While there is currently no indication that any plans exist to adopt those, the Durham City Clerk does have on file the 2020–21 resolutions that initialized HEART. *Id.* Currently HEART operates pursuant to section 160A of the General Statutes of North Carolina. These statutes broadly authorize a municipality's city council to organize its local government. N.C. GEN. STAT. § 160A-146 (2024) ("The council may create, change, abolish, and consolidate offices, positions, departments, boards, commissions, and agencies of the city government and generally organize and reorganize the city government in order to promote orderly and efficient administration of city affairs . . . ."). That authority includes the power conferred to the city council to create new departments (the Durham Community Safety Department ("DCSD")), and the duty conferred to the city manager to operate programs within that department (HEART). *Id.* § 160A-148(a) ("The manager shall be the chief administrator of the city. The manager shall be responsible to the council for administering all municipal affairs placed in the manager's charge by the council . . . ."). Finally, one notable development is that Durham is currently in the process of amending the transportation agreement between the Durham County Sheriff's Office, Duke Health, Alliance Health Care, and the City of Durham to authorize transports for IVC in certain situations to be done by HEART rather than by law enforcement personnel in police vehicles. Hernandez Zoom Call, *supra*.

214. *Community Safety*, *supra* note 213. DCSD aims to prioritize racial and cultural competence and experience in community. CITY OF DURHAM, COMMUNITY SAFETY DEPARTMENT: DURHAM ENGAGEMENT SUMMARY 5 (2022), https://www.durhamnc.gov/DocumentCenter/View/42869/CSD_engagement-summary_June2022 [https://perma.cc/9A2T-YW7Y].

HEART is the first program of its kind in North Carolina.[215] It operates in Durham, seven days a week, for about twelve hours per day.[216] In fall 2023, HEART expanded from serving a small sector of Durham to being available citywide.[217] HEART is comprised of four crisis response units: Crisis Call Diversion, Community Response Teams, Co-Response, and Care Navigation.[218]

Crisis Call Diversion "embeds mental health clinicians into Durham's 911 Call Center to triage, assess, and respond to behavioral and mental health related calls for service."[219] Its goals are to connect people "experiencing mental or behavioral health crises to the right response and care based on their needs," to "*divert* appropriate behavioral and mental health related *calls* for service *away from unnecessary* in-person responses or *interactions with the criminal justice system*," and to "reduce risk of harm when responding in-person to mental health crises."[220]

215. Notably, other cities in the United States have similar programs. El-Sabawi and Carroll discuss the Crisis Assistance Helping Out On The Streets ("CAHOOTS") model in Eugene, Oregon—"a nonpolice first response service for emergent behavioral health crises"—as an exemplary approach. *See* El-Sabawi and Carroll, *infra* note 238, at 22–24. Wahbi and Beletsky point to Los Angeles's JusticeLA, and Re-imagine LA, which worked to shift "the city's dollars and investment away from police and prisons and into community-based systems of care." *See* Wahbi & Beletsky, *supra* note 183, at 28. These groups helped propose plans "to fund the services and programs it needs to better respond to substance use or mental health related crises," to increase "non-carceral crisis mobile response teams," to create "an alternate crisis response system," and more. Houston, Austin, Charleston, and Philadelphia all have their own forms of crisis call diversion; San Francisco, Portland, Denver, and Albuquerque all have their own forms of community response teams; Denver, Houston, and Raleigh all have their own forms of Co-Response; and Raleigh, Greensboro, and San Francisco have their own forms of care navigation. *Community Safety*, *supra* note 213. Additionally, Chapel Hill has a Crisis Unit that functions similarly to HEART's Co-Response model. Michelle Cassell, *CHPD Crisis Unit a Pioneer and National Model*, LOCAL REP. (July 21, 2022), https://thelocalreporter.press/chpd-crisis-unit-a-pioneer-and-national-model/ [https://perma.cc/NG7Q-E9FS].

216. *Community Safety*, *supra* note 213. Crisis Call Diversion operates from 9 AM to 9 PM; Community Response Teams operate from 9:15 AM to 11:45 PM; Co-Response operates from 6 AM to 9 PM; and Care Navigation operates from 9 AM to 9 PM. *Id.*

217. *Id.*

218. *Id.* HEART responders wear bright T-shirts that read "HEART" on the front and "COMPASSIONATE CARE RESPONSE" on the back. *Id.* This is an important aesthetic function, clearly distinguishing them from law enforcement personnel. HEART currently has some employees who speak fluent Spanish, and the team "uses an interpretation service that allows them to immediately connect with an interpreter over phone and video in over 240 languages, including ASL." *Id.*

219. *Id.* Suicide threats, mental health crises, and "other calls involving behavioral health concerns" are eligible for response by Crisis Call Diversion. *Id.*

220. *Id.* (emphasis added). According to the City of Durham, Crisis Call Counselors embedded in the 911 call center serve eight major functions:

> 1. Assess 911 callers' needs, complete safety plans, and help identify the appropriate response. 2. Divert non-emergent crisis calls that do not require an in-person response. 3. Connect people to resources to support with future mental health-related needs. 4. Dispatch Community Response Teams as appropriate. 5. Consult with 911 dispatchers, providing information that can support better outcomes. 6. De-escalate situations prior to the arrival of first responders. 7. Support first responders in the field as unanticipated mental health related

Community Response Teams are "*unarmed*, skilled, [and] compassionate" three-person teams of peer support specialists, mental health clinicians and emergency medical technicians ("EMT") dispatched as first responders to nonviolent behavioral health and quality-of-life calls for service.[221] Their goals are to: (1) "provide rapid, trauma-informed care for 911 calls for service"[222] and (2) "*reduce law enforcement encounters*" by sending "the right response based on people's needs."[223]

Co-Response pairs clinicians with police officers who have been trained to work as a part of a Crisis Intervention Team "to respond to certain calls for service that pose a greater potential safety risk."[224] The goals of Co-Response are to "send the right response to a wider range of crisis calls regardless of priority level" and to "more safely explore some call[] types to see if they might be appropriate for

> issues arise. 8. Follow up with callers after a crisis to check in and help connect them to any services that might be needed.

Id.

221. *Id.*; *Have a Heart Campaign*, PTP, https://haveaheart.ourpowerbase.net/civicrm/petition/sign?sid=14&reset=1 [https://perma.cc/4UYB-2G5N] (emphasis added).

222. *Community Safety*, *supra* note 213. This includes calls "involving non-violent behavioral and mental health needs and quality-of-life concerns, including calls involving the needs of people who are unsheltered." *Id.*

223. *Id.* According to the City of Durham, Community Response Teams serve five major functions:

> 1. Identify appropriate 911 calls that will receive an unarmed response. 2. Dispatch teams of three unarmed, skilled responders through 911. 3. Arrive on the scene in less than 30 minutes from time of dispatch. 4. Deliver person-centered, trauma-informed care. 5. Transport neighbors to the appropriate community-based care, when necessary.

Id. The following kinds of calls are eligible for response by Community Response Teams: suicide threat, mental health crisis, trespass, welfare check, intoxicated person, panhandling, nuisance, prostitution, public indecency, and lost person calls where the person is not in possession of a weapon or physically violent toward others. *Id.*

224. *Id.* It is worth noting that a 2022 study argues that the leadership of crisis intervention team programs like HEART must include psychiatrists. Mark R. Munetz & Natalie Bonfine, *Crisis Intervention Team Program Leadership Must Include Psychiatrists*, 24 AMA J. ETHICS 154, 154 (2022). Currently, no psychiatrists are employed by HEART. *See Community Safety*, *supra* note 213.

unarmed responses in the future."[225] IVC is among the types of call currently eligible for Co-Response.[226]

Care Navigators are "two-person teams of a Peer Support Specialist and Licensed Clinician."[227] After an initial HEART encounter, Care Navigators follow up with people "to help connect [them] to the community-based care they need and want."[228] Their goals are to "increase the likelihood that people connect with community-based care, reduce unnecessary use of the emergency room, and decrease the number of people who experience multiple crises."[229]

Detailed statistical data are kept on the clientele,[230] personnel, calls, and outcomes of HEART's response units. As of January 2025, HEART had received more than 80,000 eligible calls and tallied more than 20,000 responses.[231] Of those, HEART responders reported feeling safe ninety-nine percent of the time.[232] Nearly 9,000 responses were successfully diverted away from law enforcement.[233] Co-Response teams responded to more than 300 IVC calls.[234] The

225. *Community Safety*, *supra* note 213. According to the City of Durham, Co-Response, which entails a joint response from Durham Police and Community Safety departments, serves six major functions:

> 1. Dispatch: 9-1-1 dispatches a DPD CIT-trained officer and a licensed clinician from DCSD, where there is a higher risk of violence. DCSD is interested in eventually adding a peer support specialist to this model, which would add capacity to support our neighbors. 2. Assess: CIT officers assess the scene for safety. 3. De-escalate: The clinician supports the CIT officer in de-escalation. 4. Deliver: The clinician delivers therapeutic de-escalation and trauma-informed responses to neighbors in crisis. 5. Connect: The clinician works to assess needs and connect neighbors in crisis to community-based care where appropriate. 6. Support: In a situation like an involuntary commitment, the clinician may also support family members present and continue to support the neighbor in crisis throughout the process.

Id.

226. *Id.* The other types of call that are eligible for Co-Response are attempted suicide, custody issue, and any of the following situations where there is an increased risk of violence and/or where a weapon is present: trespass, intoxicated person, panhandling, nuisance, indecency, lewdness, prostitution, physical or verbal disturbance, harassment, threat, reckless activity, abuse, threat, and domestic violence. *Id.*

227. *Id.*

228. *Id.*

229. *Id.* Care Navigators may also follow up with families, check in multiple times to offer support to affected neighbors, and work to ensure a smooth handoff that minimizes the need for individuals to retell their story, thereby linking them to the necessary care. *Id.*

230. *Id.* HEART calls the people it serves "neighbors." *Id.*

231. *Calls*, HEART, https://app.powerbigov.us/view?r=eyJrIjoiMWQ1YzViMGYtYmI1MC00NWM3LTg1NWUtMjdjNzk3NWNlYzU0IiwidCI6IjI5N2RlZjgyLTk0MzktNDM4OC1hODA4LTM1NDhhNGVjZjQ3ZCJ9 [https://perma.cc/DE4K-Y5SP] (under "By Program" and "Eligible Calls" tabs; reflecting responses occurring between the date range June 28, 2022, and October 14, 2024). HEART defines "responses" as "calls to which HEART responders were dispatched." *About*, HEART, *supra* (under "Definitions" tab).

232. *Overview*, HEART, *supra* note 231; *see also infra* note 237 and accompanying text (providing more information on how neighbors felt during HEART encounters).

233. *Overview*, HEART, *supra* note 231 (hover over the "Divert" ring in the first column).

234. *Id.* (third column, under "Top Call Types").

majority of Community Response Team and Co-Response calls were resolved,[235] and nearly all Crisis Call Diversion encounters were met with follow-up, support, or diversion.[236] Among the data collected are "Stories from the HEART," which provide narratives of the conditions leading up to a HEART encounter, the encounter itself, and the aftermath.[237]

Undoubtedly, HEART is a remarkable improvement, and it has almost certainly reduced the demand (real or perceived) for IVC in Durham. Still, there is room for further improvement. That improvement can be accomplished by reconciling HEART with the BHRT.

B. *Reconciling HEART with the BHRT*

As the prior section demonstrates, HEART is a fully functional, caring, well-documented, data-driven, community-supported model that assists people in Durham experiencing behavioral health crises. It should be further scaled up and implemented statewide. Doing so would obviate the need for the current regime of IVC law in North Carolina and would ultimately pave the way for its abolition.

IVC abolition and implementation of HEART statewide finds comprehensive support in the work of Taleed El-Sabawi and Jennifer Carroll.[238] This change would begin to address what El-Sabawi and Carroll call the "desperate need for strategic reconsideration of the scope of duties assigned to law enforcement."[239] Rather than reforming the law via additional police training or oversight of police agencies, this Article proposes that police be

235. *Outcome*, HEART, *supra* note 231 (under "Close Codes" tab, pie charts for Community Response Teams and Co-Response). Reporting showed that 56.85% of calls were resolved for Community Response, and 58.36% of calls resolved for Co-Response. *Id.*

236. *Id.* (under "Close Codes" tab, pie chart for Crisis Call Diversion). 96.73% in total. *Id.* 3.08% were listed as "unable to contact," and only 0.19% were listed as "redirected to police." *Id.*

237. *Stories*, HEART, *supra* note 231. This sort of qualitative statistical data helps support a Narrative Medicine perspective and approach. One example:

> Over the course of several weeks, HEART was dispatched to 911 calls about a neighbor sleeping in a parking garage stairwell. Some of the callers expressed that the neighbor exhibited mean and aggressive behavior. When HEART arrived, the responders approached the neighbor from a safe spot, careful not to overwhelm the neighbor, who was sleeping. They were able to engage, and let him know of the need to relocate. However, since it was not HEART's job at that moment to require him to leave, they [came] back for several days in a row to check in and help the neighbor keep in mind the need to find a better place to stay. The Clinician reflected, "Once I said, 'It sounds like you need a place to stay where people aren't bothering you,' something clicked in how he engaged with us." The next time HEART came by, the neighbor let them know that he had found a new location to move, and was able to do so without further support from HEART.

Id.

238. Taleed El-Sabawi & Jennifer J. Carroll, *A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response*, 94 TEMP. L. REV. 1 *passim* (2021).

239. *Id.* at 6.

altogether removed from mental health crisis response. This approach diverges from the HEART approach because police are involved in the Co-Response unit. To reconcile this apparent tension, further discussion of the viability of police as mental-health first responders is needed.

Our healthcare system is broken.[240] Our police system is well-funded.[241] Law enforcement personnel have become de facto first responders to all sorts of events, including mental health crises.[242] But the police are ill-equipped for this role;[243] in fact, some do not want to play this role at all.[244] Moreover, psychiatrists have argued that police involvement in mental health crises and IVC increases the risk of racial injustice, disproportionately exposing racially marginalized individuals—particularly Black people—to inhumane treatment.[245] The primary expertise of the police is the use of force.[246] Their main purpose is

240. *See, e.g.*, Denise Meyer & Michael Greenwood, *Reforming Health Care in America*, YALE SCH. MED. (Apr. 9, 2012), https://medicine.yale.edu/news-article/reforming-health-care-in-america-1/ [https://perma.cc/9MEN-GSFK]; Gordon Chen, *To Fix a Broken Health Care System, First Innovate Your Mindset*, NEW ENG. J. MED. CATALYST (July 24, 2020), https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0445 [https://perma.cc/H7FE-M29A (staff-uploaded, dark archive)].

241. *See Criminal Justice Expenditures: Police, Corrections, and Courts*, URBAN INST., https://www.urban.org/policy-centers/cross-center-initiatives/state-and-local-finance-initiative/state-and-local-backgrounders/criminal-justice-police-corrections-courts-expenditures [https://perma.cc/P7FE-A7Y8] ("From 1977 to 2021, in 2021 inflation-adjusted dollars, state and local government spending on police increased from $47 billion to $135 billion, an increase of 189 percent."); *see also* Thijs Jeursen, *"Cover Your Ass": Individual Accountability, Visual Documentation, and Everyday Policing in Miami*, 45 POL. & LEGAL ANTHROPOLOGY REV. 186, 189 (2022) ("Disenfranchised residents understand police incursions into their neighborhoods as threatening not just because of the way the police behave and criminalize residents . . . but also because *the police are well-funded and omnipresent*: it is the main state institution that is persistently present in their lives and neighborhoods." (emphasis added)).

242. *See* El-Sabawi & Carroll, *supra* note 238, at 6.

243. *See* Complaint, *supra* note 150, at 1–2.

244. Taylor Knopf, *Sheriffs Want to Turn Transport of Psych Patients Over to Mental Health Workers*, NC HEALTH NEWS (May 23, 2022), https://www.northcarolinahealthnews.org/2022/05/23/sheriffs-want-out-of-involuntary-commitment/ [https://perma.cc/SB36-8JMF].

245. Ashley Bobak, *Police Involvement a Major Racial Justice Issue in Psychiatry*, MAD AM. (Dec. 7, 2020), https://www.madinamerica.com/2020/12/police-involvement-major-racial-justice-issue-psychiatry/ [https://perma.cc/MQ37-MMKA].

246. This is my own original contention, so I do not purport to directly substantiate it with citations. However, certain related claims have been made. *See, e.g.*, Dara Lind, *How Do Police Departments Train Cops how to Use Force?*, VOX, https://www.vox.com/2014/9/5/6105373/police-allowed-to-force-shoot-taser-training-policy [https://perma.cc/HX5Q-J9F4] (last updated May 6, 2015, 11:23 AM) ("The law gives police incredibly wide latitude to use force against civilians if they feel they're under threat."); Ronald Tyler, Suzanne A. Luban & Sharon Driscoll, *Police Use of Force, Training, and a Way Forward After the Death of George Floyd*, STAN. L. SCH. (June 4, 2020), https://law.stanford.edu/2020/06/04/police-use-of-force-training-and-a-way-forward-after-the-death-of-george-floyd/ [https://perma.cc/TJ99-2Z57] ("A serious flaw in the training of officers is the philosophy that the degree of force called for is the 'amount of effort required by police to compel compliance by an unwilling subject.' [As defined by the International Association of Chiefs of Police, quoted in https://nij.ojp.gov/topics/articles/overview-police-use-force.] Police may end up using more

to monitor communities and control behavior through the use or threat of force and punishment,[247] not to offer medical treatment, care, or compassion, which are what people in mental health crises need.[248] Force and punishment tend to make mental health crises worse, not better.[249] El-Sabawi and Carroll make the case persuasively:

> [Police] constitute an extremely poor choice when selecting first responders for emergent behavioral health crises. They lack the training,

severe or damaging force than warranted by the nature of the crime suspected or the type of noncompliance. Another grave risk of such a policy is that police may employ force to 'punish' a suspect for resisting." (alteration in original)); Andrew Cohen, *Excessive Police Use of Force: Experts Push for Legal Solutions Focused on Training and Culture*, BERKELEY L. (May 8, 2023), https://www.law.berkeley.edu/article/excessive-police-use-of-force-experts-push-for-legal-solutions-focused-on-training-and-culture/ [https://perma.cc/QQ5U-HZEB] ("[T]he biggest hurdle to accountability is the police themselves: department culture, internal politics, and police unions resisting reforms, [John Burris said]. California officers are trained on how to use force, but the problem is they often don't follow that training. What we see is a lack of respect for the community itself.").

247. *See supra* note 246 and accompanying text; *see also* Otis S. Johnson, *Two Worlds: A Historical Perspective on the Dichotomous Relations Between Police and Black and White Communities*, 42 HUM. RTS. 6, 7 (2016) ("Police power includes the legitimized use of force. This legitimized use of force is to maintain law and order . . . ."); Amna Akbar's attention to the racialization in policing and her perspective on "abolitionist horizons" help situate this analysis; she states that "reform rooted in an abolitionist horizon aims to contest and then to shrink the role of police, ultimately seeking to transform our political, economic, and social order to achieve broader social provision for human needs." Amna A. Akbar, *An Abolitionist Horizon for (Police) Reform*, 108 CALIF. L. REV. 1781, 1787 (2020). She goes on to say:

> Calls for democratic inputs on the theory that new laws and regulations will better regulate police discretion sidestep deeper questions of racialized ordering and the central role of police and prisons in maintaining the raced and classed status quo. Powerful segments of the populace have consented to a democratic system that empowers police to punish poor, Black, and brown people. Fundamentally, our democratic institutions produce police violence, however shallow, captured, raced, and classed our democracy may be.

Id. at 1804. The fundamental hope behind my critique and proposed changes to the law is to contest and shrink the role of police for the express purpose of providing broader, more compassionate social support for people in psychic crisis.

248. *See* Nicholas Turner, *We Need to Think Beyond Police in Mental Health Crises*, VERA INST. JUST. (Apr. 6, 2022), https://www.vera.org/news/we-need-to-think-beyond-police-in-mental-health-crises [https://perma.cc/4STH-ZURT]; VERA INST. OF JUST., INVESTING IN EVIDENCE-BASED ALTERNATIVES TO POLICING: CIVILIAN CRISIS RESPONSE 1 (2021), https://www.vera.org/downloads/publications/alternatives-to-policing-civilian-crisis-response-fact-sheet.pdf [https://perma.cc/3R56-ZS6L] ("When people experience a behavioral health crisis, they need special care and attention to reach a resolution. Yet police responses to these crises often worsen the situation. Civilian first responders are better equipped to effectively handle and de-escalate behavioral health situations.").

249. *See, e.g.*, *Corporal Punishment and Health*, WORLD HEALTH ORG. (Nov. 23, 2021), https://www.who.int/news-room/fact-sheets/detail/corporal-punishment-and-health [https://perma.cc/EZ2R-NM6R]; Katie Rose Quandt & Alexi Jones, *Research Roundup: Incarceration Can Cause Lasting Damage to Mental Health*, PRISON POL'Y INITIATIVE (May 13, 2021), https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/ [https://perma.cc/2U9U-C8BK].

> the institutional support, the infrastructure, the culture, the freedom, and the public image to respond to such calls for service effectively. . . . [P]roviding a meaningful, safe, and effective response to behavioral crises via law enforcement response requires law enforcement to be something that they are not. Therefore, first responders to behavioral-health-related calls for service should not be law enforcement. First responders should consist of a different set of service professionals entirely.[250]

Accordingly, this Article contends that police should not be involved in responding to mental health crises, especially those related to a potential IVC, even as partners in co-response.[251] Instead, peer support specialists, social workers, licensed mental health clinicians, EMTs, counselors, and/or therapists should be involved. To facilitate this shift, funding to the police should be decreased and funding to HEART should be increased commensurately.[252]

250. El-Sabawi & Carroll, *supra* note 238, at 21–22.

251. *See id.* at 8 (refuting the claim that crisis intervention teams and co-responder models that include police present a reasonable alternative to full police divestment from crisis mental health intervention). This proposal would not forbid police from intervening in behavioral and/or mental health crises that involve the commission of a crime. If, for example, a 911 call were made in Durham about a person who appeared to be having a behavioral health crisis and had not initially appeared to be involved in a crime, the matter was routed to HEART, HEART personnel responded, determined that the person was experiencing highly disordered thoughts, that they presented an imminent danger to themselves or others, and that they had committed some sort of crime (e.g. communicating threats, assault, etc.), they could notify the police, who could intervene as is otherwise permitted by our regime of criminal law. Indeed, this is the premise of HEART's existing Co-Response Teams, which are deployed when the initial 911 call mentions both a behavioral health crisis and the possibility of certain crimes and/or violence. The same would be true outside the 911 rerouting scheme, where if, say, police had probable cause to believe a person committed a crime in their presence but who also manifested signs of mental illness, that person would be subject to traditional policing.

252. The goal of this Article is to show how we can take practical steps to care for our neighbors experiencing psychic crises. Carrying out this goal does not require affiliation with any ideology. It requires only a commitment to compassion and basic human dignity. That said, there is an abundance of scholarship discussing the entanglement of civil rights, money, flows of power, the consequences of supporting police institutions with capital, and the expressive function behind fund allocation. For further discussion of disbanding police agencies, defunding the police, and reimagining the role of police in our communities, see, for example, *id.* at 6 (citing Akbar, *An Abolitionist Horizon for (Police) Reform*, *supra* note 247, at 1781) (explaining why calls to defund the police are more than just requests for budget reductions but are instead greater calls for social reform); Anthony O'Rourke, Rick Su & Guyora Binder, *Disbanding Police Agencies*, 121 COLUM. L. REV. 1327, 1351–52 (2021) (arguing that police agencies should be reformed into more democratic institutions with public oversight); V. Noah Gimbel & Craig Muhammad, *Are Police Obsolete? Breaking Cycles of Violence Through Abolition Democracy*, 40 CARDOZO L. REV. 1453, 1453 (2019); *Police Reform Through a Power Lens*, 130 YALE L.J. 778, 778 (2021); Michelle S. Jacobs, *The Violent State: Black Women's Invisible Struggle Against Police Violence*, 24 WM. & MARY J. WOMEN & L. 39 (2017); ANDREA J. RITCHIE, INVISIBLE NO MORE: POLICE VIOLENCE AGAINST BLACK WOMEN AND WOMEN OF COLOR 13–18 (2017); K. Sabeel Rahman & Jocelyn Simonson, *The Institutional Design of Community Control*, 108 CALIF. L. REV. 679, 730 (2020); Jordan Blair Woods, *Traffic Without the Police*, 73 STAN. L. REV. 1471, 1472 (2021) (proposing a new system of traffic enforcement divorced from policing agencies).

Alternatively, in the event that this proposal is substantively supported but its implementation via defunding the police is not, a massive source of funding is available elsewhere. In the fall of 2023, a bill passed the North Carolina General Assembly that "appropriates $60 billion across two years and triggers Medicaid expansion."[253] One lawmaker called the bill "the most significant budget we have seen in North Carolina."[254] A small fraction of this appropriation would likely suffice to implement HEART statewide. Moreover, because ineffective crisis care is wasteful and expensive, the transfer from IVC to HEART is likely to save money as well.[255]

Regardless of funding, "law can be used to incrementally reallocate responsibilities [away] from police agencies to other government agencies or service providers."[256] To that end, anticipating criticisms about the workability of a nonpolice behavioral health crisis response team, El-Sabawi and Carroll drafted a model statute, the BHRT Act.[257] They accompanied the BHRT Act with policy guidance for implementation.[258] Far from being detached, abstract, or academic, this approach is grounded, concrete, and practical, developed by integrating input from a variety of stakeholders in North Carolina.[259] Accordingly, this Article

253. Luciana Perez Uribe Guinassi & Avi Bajpai, *NC Budget Approved After Midnight; Final Vote Coming Friday Morning*, NEWS & OBSERVER, https://www.newsobserver.com/news/politics-government/article279594854.html [https://perma.cc/9389-RUFT (staff-uploaded, dark archive)] (last updated Sept. 22, 2023, 2:14 AM); *see also* Current Operations Appropriations Act of 2023, ch. 134, § 9E.23.(c1), 2023 N.C. Sess. Laws __, __ (codified as amended at N.C. GEN. STAT. § 108A-54.3A).

254. Will Doran, Paul Specht & Travis Fain, *'Most Significant Budget' in NC to Become Law After Senate Vote, Cooper Decision*, WRAL NEWS, https://www.wral.com/story/most-significant-budget-in-nc-to-become-law-after-senate-vote-cooper-decision/21060779/ [https://perma.cc/8YU3-2W56] (last updated Sept. 23, 2023, 8:56 AM) (quoting Senate Majority Leader Phil Berger).

255. *See In re* J.R., 383 N.C. 273, 291, 881 S.E.2d 522, 533 (2022) (Earls, J., dissenting), *cert. denied sub nom.*, 144 S. Ct. 75 (2023) (mem.); *see also supra* note 151 and accompanying text.

256. El-Sabawi & Carroll, *supra* note 238, at 6–7.

257. *See id.* at 44–47 (providing text of the entire model statute). The statute is intended to develop and implement local, county-wide, regional *nonpolice-administered* crisis call centers ("CCC") and behavioral health mobile crisis response teams to respond to calls regarding crises that arise due to mental health, substance use, or homelessness. *Id.* Notably, it calls for the establishment of the CCC and BHRT program to "occur in partnership with a consumer-led advisory board that is comprised of at least 51% behavioral health consumers, persons who have experienced or are experiencing houselessness, members of local immigrant communities, sexual minorities, persons with disabilities, and racial or ethnic minorities." *Id.* at 45. The statute then outlines detailed, concrete steps for authorizing, staffing, advising, and implementing the law and procedure necessary to support the CCCs and BHRTs. *Id.* at 46. It also includes recommended protocols for administration of the CCCs and BHRTs, including routing 911 calls, marketing and rolling out the services, directing behavioral-health consumers to resources, data collection, setting program requirements, structuring, and funding, with sections on rules and regulations, severability and setting an effective date. *Id.* at 46–47.

258. *Id.* at 7.

259. *Id.* ("The provisions in the [BHRT Act] were designed according to several considerations: feedback received from community leaders and members of underrepresented groups in North Carolina; legal considerations encountered in assisting groups advocating for the incremental dismantling of police; our own expertise in mental health and addiction policy history and evidence-

proceeds under the premise that this model statute and its accompanying policy guidance is workable, especially for our state.[260]

However, as mentioned above, the BHRT Act conflicts with HEART to the extent it calls for completely removing police from crisis mental health response calls because one of HEART's three units, Co-Response, currently includes police officers as one-half of a unit sent out to respond to events that suggest mental health crisis where there is a weapon or the threat of violence.

There are several solutions to this conflict. The first would be to simply remove police from the Co-Response team. This is the solution that this Article recommends.[261] They could be replaced by an EMT or another person trained as a first responder to the standards HEART requires of its police Co-Response members. But crucially, these responders should be *unarmed*, reducing their propensity and capability to use lethal force.

A second option is to keep police involved with HEART's Co-Response team, but to prohibit them from carrying guns, thus reducing our neighbors' exposure to the risk of death or injury by gunshot. Similarly, police might be allowed to participate but asked not to wear traditional uniforms and asked not to bring tasers, handcuffs, or other weapons. The mere presence of these traditional signifiers of forceful, potentially violent authority can cause provocation, and removing them might help prevent crisis situations from being needlessly escalated.[262] This Article does not recommend this option, because even outside of uniform, the too-often-lethal police culture of force and militarization, along with attitudes of ignorance, insensitivity, bias, and hostility—compounded by the potential lack of expertise in caring for mentally

based behavioral health treatment; the political process; current understandings of mechanisms of interest group mobilization and policy change; and comments received by national experts in policing, mental health, and addiction policy.").

260. *See id.* at 44–47 (providing the full text of the entre model statute).

261. For a justification see *supra* Section III.C. To reiterate that section's major points: first, the Article worked to humanize IVC. To do so, it took seriously and metabolized the perspectives gleaned from an array of invested voices and stakeholders, including Narrative Medicine, abolitionist medicine, the United Nations, critical-race and critical-legal scholarship, and the clear-eyed, comprehensive critique propounded by Professor Stephen J. Morse. From there, the Article concluded that, while noble, reforms are ultimately inadequate and that instead, IVC must be abolished. The Article concluded that this is so because, as Rafik Wahbi and Leo Beletsky argue, the current regime of IVC is carceral and oppressive, *producing* rather than reducing harm and death for people in psychic crisis. Moreover, the Article reasoned, IVC is racialized, and it disproportionately harms marginalized people. The Article concluded that rather than succumbing to the fetish of finality in the realm of IVC, the abolitionist approach should be taken seriously, and that if it were, we could improve our chances of preserving the safety, dignity and humanity of our neighbors in psychic crisis.

262. *See, e.g.*, *Lethal in Disguise 2: How Crowd-Control Weapons Impact Health and Human Rights*, PHYSICIANS FOR HUM. RTS. 1, 18 (Mar. 22, 2023) ("For some weapons, the methods and contexts of use can exacerbate injuries, escalate tensions and compound rights violations. As a result, their methods of use must be restricted . . . ."). Exposing vulnerable and disabled populations to weapons is especially unadvisable. *See id.*

ill people and the absence of meaningful crisis intervention skills—might well still permeate, toxify, and jeopardize these encounters.[263]

A third option is to argue that HEART has actually already accomplished what is called for by the BHRT. This argument would contend that the Crisis Call Diversion, Community Response Teams, and Care Navigation have effectively removed police from the most critical encounters with people experiencing mental health crises, and that the amount of diversion already accomplished by those three units vindicates the rights of those people and discharges the duty El-Sabawi and Carroll called for. The fact that police are still involved in some Co-Response calls could be construed not as police involvement in mental health calls, but the involvement of mental health personnel in calls that were previously under the sole authority and purview of police.

Ultimately, it should be left to those most directly involved in this work to make determinations about which personnel are the most capable and appropriate to provide emergency mental health care. One of the things that makes HEART so uniquely effective is that it was designed by reaching out to members of the community and collaborating with them in discussions over a period of several years to get a sense of their needs, preferences, values, and goals.[264] This preserved community members' dignity, culture, humanity, and agency, and communicated real respect and compassion for everyone involved. A similar effort to reach a community-informed policy decision with the BHRT should be made to involve neighbors and other stakeholders in determining what the best implementation options would be.

263. *See supra* notes 243–45 and accompanying text; *see also* Cara McClellan & Jamelia Morgan, *Toward Abolitionist Remedies: Police (Non)Reform Litigation After the 2020 Uprisings*, 51 FORDHAM URB. L.J. 635, 673–74 (2024) (recommending, as an "abolitionist remedy," the development of an alternate responder program that functions as a replacement for police, rather than a co-responder program that collaborates with police); Edward Randall Ornstein, *Disproportionate Police Militarization at Standing Rock Violated International Law*, 12 ARIZ. J. ENV'T. L. & POL'Y 65, 68–69 (2021) (providing historical context of the militarization of American Police Culture); JEROME H. SKOLNICK & JAMES J. FYFE, ABOVE THE LAW: POLICE AND THE EXCESSIVE USE OF FORCE 24, 90–92 (1993) (noting that police participated in at least half of the lynchings in the 1930s and arguing that the "fundamental culture of policing" involves "danger, authority, and the mandate to use coercive force"); Alexa Sardina & Alissa R. Ackerman, *Restorative Justice in Cases of Sexual Harm*, 25 CUNY L. REV. 1, 9 (2022) (discussing police insensitivity as it pertains to gender and sexual assault—"Police culture, which is typically masculine and authoritarian, generally facilitates the continued acceptance of rape myths."); Linda Sheryl Greene, *Before and After Michael Brown—Toward an End to Structural and Actual Violence*, 49 WASH. U. J.L. & POL'Y 1, 16–17 (2015) (connecting the police culture of bias, racially discriminatory policing, and lethal force against unarmed Black people); Judy Ann Clausen & Joanmarie Davoli, *No-One Receives Psychiatric Treatment in a Squad Car*, 54 TEX. TECH L. REV. 645, 658 (2022) ("Some officers are trained to respond to an individual suffering from a psychiatric crisis. Such training includes recognizing psychosis as well as de-escalation tactics. However, many officers are untrained, and those who are trained might not respond appropriately. Sometimes, officers misinterpret symptoms of a psychiatric crisis as malingering or worse.").

264. *See Community Safety*, *supra* note 213.

Relatedly, part of HEART's efficacy comes from its commitment to providing evidence-based care in its response encounters.[265] The current data being kept on Co-Response encounters explicitly notes that HEART's goal is to explore whether some call types may be better served by *unarmed* responses in the future.[266] As the program continues to operate, more quantitative data and stories will be collected about the effectiveness of the different response units to different types of calls. So long as these data and narratives are scrutinized in good faith by a diverse array of stakeholders, there will be an opportunity to update HEART as needed and to harmonize it with the BHRT in replacing IVC.

The purpose of HEART, after all, is to "enhance public safety through community-centered approaches to prevention and intervention as *alternatives to policing and the criminal legal system*."[267] Accordingly, involvement of law enforcement personnel in mental health crises should be iteratively lessened over time. While it may not comport with the more hardline vision enshrined in the BHRT Act, this vision more realistically reflects how law often changes incrementally. In any event, once HEART is implemented statewide, there will be ample evidence that the law of IVC in North Carolina has become obsolete, and its repeal should come swiftly afterward.

CONCLUSION

Law and medicine have long been intimately involved in administering care for neurodiverse people.[268] In North Carolina, the need for mental health care is growing.[269] People are experiencing unprecedented rates of mental illness both chronically and acutely.[270] For about four decades, section 122C, the law governing IVC in North Carolina, has been used as a legal tool to attempt to connect people in acute mental health crisis with needed treatment.[271] It has consistently failed those people in manifold ways.[272]

Accordingly, stakeholders from diverse walks of life have attempted to improve the procedural and substantive rights afforded to people subject to

265. *See id.*

266. *Id.* (emphasis added).

267. *Id.* (emphasis added).

268. *See supra* Part I.

269. *See, e.g.*, Richard Craver, *Mental Health Advocates Say North Carolina Is Headed Toward Crisis. They're Asking Lawmakers for Help*, WINSTON SALEM J. (June 21, 2021), https://journalnow.com/news/local/mental-health-advocates-say-north-carolina-is-headed-toward-crisis-they-re-asking-lawmakers-for/article_ec710aa6-d2cc-11eb-8033-03936e2cbdab.html [https://perma.cc/M2P6-3Q6D (staff-uploaded, dark archive)] (discussing the "historic unmet need" and "skyrocketing demand for mental health services" currently being experienced in North Carolina).

270. *See id.*

271. *See supra* Part II.

272. *See supra* Part III.

IVC.[273] Scholars have sought to reform IVC or to use it more judiciously.[274] But thanks to the fetish of finality, stories of the sick and suffering tend to be shunted to an oubliette of amnesia or disregard.[275] While some progress has been made, it is ultimately inadequate.[276] People subjected to IVC still suffer needless trauma and are exposed to force and coercion that too often make things worse, not better.[277]

Accordingly, section 122C must be abolished.[278] The needs section 122C was designed to meet can instead be better met by the HEART model.[279] But HEART only currently operates in Durham, so it must be expanded statewide.[280] While ambitious, this can be accomplished via the model BHRT Act.[281] The BHRT Act provides precise statutory language and comprehensive policy guidelines that make its implementation practical and workable.[282]

Implementing the BHRT will scale back police as mental health first responders, replacing them with more qualified personnel.[283] This, in turn, would reduce the force and violence experienced by people in crisis.[284] Beyond that, it would also improve long-term outcomes by not exposing our neighbors to the cascading collateral consequences and judiciarization associated with IVC.[285] This would ultimately serve to better care for our neighbors and reduce the total suffering in our state. It is the duty and responsibility of legal and medical health professionals to bring about this change.[286]

273. *See supra* Section III.A.
274. *See supra* Section III.A.
275. *See supra* Section III.B.
276. *See supra* Section III.C.
277. *See supra* Section III.C.
278. This is the statutory regime that provides for IVC in North Carolina. *See supra* Part IV.
279. *See supra* Section IV.A.
280. *See supra* Part IV.
281. *See supra* Section IV.B.
282. *See supra* Section IV.B.
283. *See supra* Section IV.B.
284. *See supra* Section IV.B.
285. *See supra* Section IV.B.
286. Stuart A. Anfang and Paul S. Appelbaum nicely sum up the considerations worthy of keeping in mind moving forward:

> [W]hen writing new [IVC] statutes, it would be naïve to think that legal changes alone will address desired social goals without adequate alternative resources and consistent implementation. From the clinical perspective, improved treatment options and better clinical risk prediction and management would also help serve both the *parens patriae* and police power functions of [IVC]. Whatever changes are made in [IVC] processes, there is the challenge of good empirical studies of the impact of these changes. It would be ideal to devise and fund an effective prospective evaluation process in tandem with any proposed legal changes. Balancing the desire to help the unfortunate and the fear of restricting personal liberty, American [IVC] law has evolved over the past 200 years—but we have not yet developed [IVC] statutes that are consistently fair, reasonable and compassionate.

Anfang & Appelbaum, *supra* note 49, at 217.