



# **North Carolina Crisis System of Care Advisory Committee**

## ***Meeting #1***

**September 2, 2026**

# Welcome & Introductions

**The North Carolina Crisis System of Care Advisory Committee meetings are open to the public and subject to North Carolina [open meeting rules](#), including:**

- Members of the public may attend and observe any Advisory Committee meeting as well as record the meeting if they choose; however, members of the public will not be permitted to speak during the meeting.
- Meeting dates and times must be posted at least 48 hours in advance on the Secretary of State's [website](#).
- Meeting minutes must be recorded and made available at the public's request.

In addition, following each Advisory Committee meeting, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) will publish meeting materials on its [website](#).

- **Welcome & Introductions.....9:00-9:50 am**
- **Overview of the Advisory Committee & NC Crisis System.....9:50-10:35 am**
- *Break.....10:35-10:50 am*
- **IVC in North Carolina & Opportunities for Reform.....10:50 am-12:40 pm**
- **Wrap Up & Next Steps.....12:40-1:00 pm**



1. Align on the purpose and scope of the North Carolina Crisis System of Care Advisory Committee
2. Develop a shared understanding of North Carolina's crisis system, including involuntary commitment (IVC)
3. Discuss initial feedback about opportunities to improve IVC

## NC Crisis System of Care Advisory Committee

### Co-Chairs

- **Kelly Crosbie**, Assistant Secretary, Division of Mental Health, Developmental Disabilities, & Substance Use Services (DMH/DD/SUS), North Carolina Department of Health & Human Services (NC DHHS)
- **Sherry Hunter**, Deputy Secretary for Professional Standards, North Carolina Department of Public Safety (NC DPS)

### Members

- **Joe Amos**, Chief of Police, City of Middlesex
- **Ashley Barber**, Director of Behavioral Health, Alamance County Department of Health
- **Greg Berry**, Statewide Director of Law Enforcement Assisted Diversion & Deflection Programs, North Carolina Harm Reduction Coalition
- **Mark Botts**, Associate Professor of Public Law & Government, UNC School of Government
- **Robert Broughton**, Associate General Counsel, UNC Health Care System
- **Cherene Caraco**, Chief Executive Officer, Promise Resource Network
- **Kimberly Clement**, Assistant Chief of Preparedness & Strategic Operations, NC Office of Emergency Medical Services
- **Marisa Cornell**, Executive Director, Mediation & Restorative Justice Center
- **Lauren Earnhardt**, Executive Vice President, NC Sheriffs' Association
- **Kevin FitzGerald**, Senior Fellow, MDC; NC Collaboratory
- **Dr. Sonja Frison**, Clinical Manager, Division of Juvenile Justice and Delinquency Prevention, NC DPS
- **Sen. Jonah Garson**, Senator, NC General Assembly
- **Allison Gosda**, Chief of Clinical Services, Partners Health Management
- **Natasha Holley**, Chief Executive Officer, Integrated Family Services
- **Dr. Ariana Huselid**, Chief Medical Officer, Central Regional Hospital, Division of State Operated Healthcare Facilities, NC DHHS
- **Nicholle Karim**, Vice President of Policy Development, NC Healthcare Association
- **Colleen Kochanek**, Executive Director, NC College of Emergency Physicians
- **Laura McIlvaine**, Behavioral Health Regional Director, RHA Health Services
- **Spencer Merriweather**, Executive Committee Member, NC Conference of District Attorneys; District Attorney, Mecklenburg County
- **Candice Moore**, Evidence Based Practices Administrator, Division of Juvenile Justice & Delinquency Prevention, NC DPS
- **Rep. Marcia Morey**, Representative, NC General Assembly
- **Tara Muller**, Policy Attorney, Disability Rights North Carolina
- **Judge Regina Parker**, Superior Court Judge, NC Second Judicial District
- **Jeff Prichard**, Project Coordinator, Stepping Up Initiative
- **Major Kelly Redmon**, Chief Deputy, Watauga County Sheriff's Office
- **Rep. Dr. Timothy Reeder**, House Deputy Majority Whip, NC General Assembly
- **Lillie Rhodes**, Legislative Council, NC Administrative Office of the Courts
- **Nidhi Sachdeva**, Director of Strategic Health & Opioid Initiatives, NC Association of County Commissioners
- **Dr. Sy Saeed**, Executive Director, NC Statewide Telepsychiatry Program (NC-STeP)
- **Dr. Marvin Swartz**, Behavioral Health Team Lead, Wilson Center for Science & Justice, Duke Law; NC Collaboratory

### Manatt Support

- Zoe Barnard
- Giuliana Del Guercio
- Tony Fiori
- Madeleine Toups Tranchina
- Arielle Traub

### DMH/DD/SUS Staff Support

- Lisa DeCiantis (Crisis Services Lead)
- Hanaleah Levy Hoberman (Policy Director)
- Becky Zornick (Policy Advisor)

# What Motivated You to Join the Advisory Committee?

The word cloud features the following text elements:

- Solve Complex Problems** (dark blue, top center)
- Lift Up Voices of Those With Lived Experience** (purple, top right)
- Help Individuals and Youth in Crisis** (dark green, middle left)
- Strengthen the Crisis System** (large orange, center)
- Identify Gaps in Services** (dark blue, middle right)
- Improve Access to Treatment** (dark blue, bottom left)
- Contribute to Solutions** (green, bottom right)
- Address the Increase in Mental Health Needs but Decrease in Services** (dark blue, bottom center)
- Personal Experience** (purple, bottom right)

- 1. For 10 minutes, Advisory Committee members will walk around the room and try to fill out the “Human Bingo Card” by asking questions based on the bingo card prompts.**
- 2. At the end of 10 minutes, we will ask some members to share a few things that they learned about others in the room.**
- 3. Continue to try and fill out your card during the day!**

*If you are unable to walk around, members will come to you.*

# Overview of the NC Crisis System of Care Advisory Committee

# Establishing the Advisory Committee

In February 2026, Governor Stein issued [Executive Order 33](#): Protecting North Carolinians Through Stronger Behavioral Health and Criminal Justice Systems. In July 2026, the NC General Assembly passed [House Bill 1104](#) ([State Law 2026-38](#)). The Advisory Committee's establishment stems from these actions.

## ***Executive Order 33:***

*"The Governor directs DHHS to convene a working group to recommend reforms to involuntary commitment ("IVC") in North Carolina.*

*The working group shall also work with mental health providers and hospitals to reliably and consistently implement existing IVC laws and any future reforms."*

## ***HB 1104 / SL 2026-38:***

*"DHHS shall establish a working group ... to identify gaps, evaluate current practices, and recommend strategies to interrupt repeated crises and reduce avoidable recidivism [for individuals with mental health/substance use needs]."*



# Advisory Committee: Purpose & Objectives



**The NC Crisis System of Care Advisory Committee is tasked with advancing recommendations and ensuring coordination across critical reforms that strengthen the State's crisis system.**

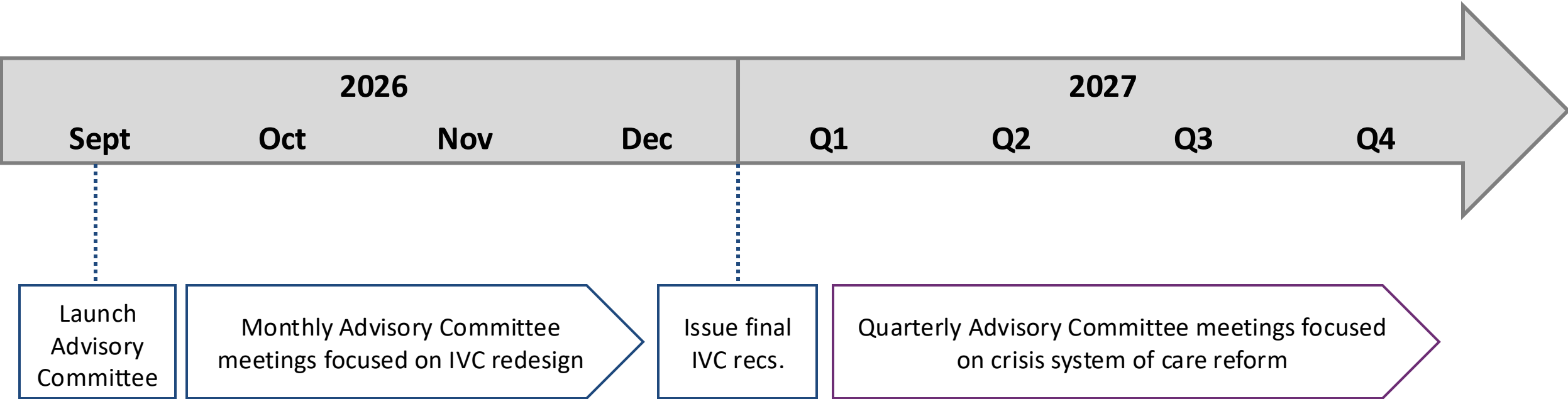
## Key Objectives

- Improve the lives of those living with mental health and/or substance use needs (MH/SUD) while protecting public safety
- Influence the building of a comprehensive crisis system in North Carolina, inclusive of voluntary and involuntary treatment
- Identify recommendations to improve North Carolina's IVC process and prevent the "revolving door" pattern
- Foster collaboration and coordination across public and private sector partners engaged in crisis system modernization efforts

**The Advisory Committee will provide recommendations and feedback to NC DHHS, NC DPS, and the Governor's Office to inform decisions related to the crisis system.**

# High-Level Advisory Committee Timeline

In 2026, the NC Crisis System of Care Advisory Committee will focus on identifying improvements to the IVC process. Beginning in 2027, the Advisory Committee will meet about other aspects of crisis reform.



# 2026 Advisory Committee Meeting Schedule\*

## Today's Focus

### Meeting #1 – Kickoff

September 2, 2026

**Agenda:**

- Introductions & Advisory Committee Overview
- Crisis System of Care Overview
- Current State of IVC
- IVC Challenge Areas & Reform Opportunities

### Meeting #2

September 30, 2026

**Proposed Agenda:**

- Review IVC Challenge 1: IVC as Default Front Door
- Review IVC Challenge 2: Over-Reliance on EDs & Law Enforcement
- Discuss IVC Potential Solutions

### Meeting #3

October 28, 2026

**Proposed Agenda:**

- Review IVC Challenge 3: Limited Integration
- Review IVC Challenge 4: Navigation Barriers
- Discuss IVC Potential Solutions

### Meeting #4

November 18, 2026

**Proposed Agenda:**

- Review IVC Challenge 5: Community Linkage
- Discuss IVC Potential Solutions

### Meeting #5

December 16, 2026

**Proposed Agenda:**

- Finalize IVC Recommendations



Prior to each of the 2026 Advisory Committee meetings focused on IVC, Advisory Committee members will receive pre-read materials 1-2 days in advance.

\*Agendas and timeline subject to change.

# Advisory Committee Norms



**Come prepared and participate actively**



**Respect confidentiality and privacy**



**Represent your role and stakeholder perspective**



**Engage respectfully and constructively**



**Adopt a solutions mindset**

**On a scale of 1 to 5, what is your level of agreement with the Advisory Committee norms?**

**1. Strongly Disagree**

**2. Disagree**

**3. Neutral**

**4. Agree**

**5. Strongly Agree**

# Overview: NC's Crisis System of Care

# History of the Public Mental Health Crisis System in the U.S.

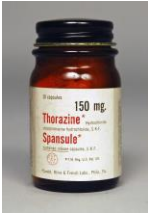
## 1860s – 1880s:

Dorothea Dix advocates for mental asylums instead of prisons



## 1954:

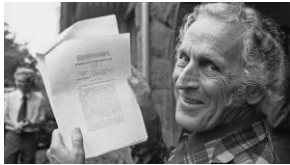
Thorazine introduced



1960s: 24/7 EDs become standard of care in the US



1975: *O'Connor v. Donaldson* changes IVC standards



1999: 911 becomes universal US emergency number



2009: First National Guidelines for Behavioral Health Crisis Care published



2014: Certified Community Behavioral Health Clinic (CCBHC) demonstrations signed into law



*Institutionalization as Mental Health Care*  
(1840s – 1950s)

*Movement to Deinstitutionalize*  
(1960s – 1970s)

*Community-Care Gap*  
(1980s – 2000s)

*Building a Modern Crisis System*  
(2010s – Present Day)



1911: Louisville City Hospital opens the country's first emergency room with police paddy wagon drop offs



1946: Life Magazine's "Bedlam" article exposes human rights abuses in institutions



1963: Community Mental Health Act signed into law



1973: National Emergency Medical Services Systems Act provides federal funding for EMS



1981: Federal block grant cuts reduce Community Mental Health Centers (CMHCs)



1988: Launch of the nation's first crisis intervention team (CIT) in Memphis



2005: National Suicide Prevention Lifeline launches



2020: Crisis Now guidelines published



2022: 988 launches



2022: Bipartisan Safer Communities Act expands CCBHCs

Foundational Elements



Someone to Contact



Someone to Respond



A Safe Place to Go

Guiding Principles

- Comprehensive, Integrated, Coordinated, & Developed Using a Systems-Based Approach
- Continuity of Care through Onset of Crisis, Stabilization, & Follow-Up
- Accessible & Responsive to All Populations
- Person-Centered, Family-Focused, Right Level of Care at the Right Time
- Responsive to Individuals’ Wholistic Needs
- Prioritize Safety
- Developmentally Appropriate
- Prioritize Quality & Effectiveness
- Resiliency- & Recovery-Oriented
- Trauma-Informed
- Evidenced-Based & Reflective of Best Practices

*North Carolina has used these guidelines to inform its crisis system reform efforts.*



## Someone to Contact

Multiple access points to seek help during mental health and substance use crises to provide real-time support, triage, safety assessment, and connection to additional crisis resources.

- Established [988](#) suicide and crisis call and text 24/7 line
- Established [Peer Warmline](#), a 24/7 crisis response service
- Launched the Crisis Services Communications [Toolkit](#)



## Someone to Respond

Community-based, in-person response services designed to stabilize individuals safely in homes, schools, shelters, and other community settings.

- Increased Medicaid [rates for mobile crisis](#)
- Deployed new [mobile crisis teams](#) and piloted improved [dispatch program](#)
- Launched [child crisis teams](#) (Mobile Outreach, Response, Engagement, & Stabilization (MORES))
- Piloted [co-response teams](#) with EMS/law enforcement responding with a crisis team
- Expanded availability of [Crisis Intervention Teams](#) (CIT) with law enforcement and mental health providers
- Invested in non-law enforcement, trauma-informed [transportation](#)



## A Safe Place to Go

Multiple levels of community-based crisis stabilization settings provide structured support while reducing reliance on emergency departments and inpatient hospitalization.

- Opened new [Behavioral Health Urgent Care Centers](#) (BHUC, or Mental Health & Substance Use Urgent Care) for immediate support
- Expanded [Facility-Based Crisis \(FBC\) centers](#) for short-term inpatient stabilization for children and adults
- Increased [rates for child and adult FBCs](#)
- Invested in [peer respite homes](#)
- Updated the [Behavioral Health Statewide Central Availability Navigator](#) (BH SCAN) for hourly updates on mental health bed registry wait times



When community-based crisis services are unavailable or difficult to access, individuals frequently **default to emergency departments, law enforcement response, or involuntary commitment pathways.**

These settings were never intended to serve as the primary front door to mental health and substance use care.

**Early, community-based crisis support helps:**

- ✓ Prevent unnecessary escalation,
- ✓ Support more appropriate care, and
- ✓ Reduce pressure on hospitals, emergency departments, and public safety systems.

# Building a Seamless, Integrated Crisis System of Care

As evidenced by recent state actions, work to further modernize the crisis system and build on existing investments remains a top priority statewide.



NC DHHS' DMH/DD/SUS Division developed at [Strategic Plan for 2024 – 2029](#) in September 2024 that prioritizes strengthening the crisis system of care and IVC reform



In 2025, the NC General Assembly passed **Iryna's Law** ([State Law 2025-93](#)), mandating stricter release conditions and additional pretrial review for individuals already involved in the justice system, if an individual is believed to be a danger to self/others and/or has a history of involuntary commitment



**Governor Stein issued [Executive Order 33: Protecting North Carolinians Through Stronger Behavioral Health and Criminal Justice Systems](#)** in February 2026, directing NC DHHS to reform IVC and establish a working group to recommend and support reforms



The **NC House Select Committee on IVC & Public Safety** published a [report](#) in April 2026 summarizing the Committee's efforts to reform IVC and strengthen the crisis system of care, including dozens of experts and advocates who testified



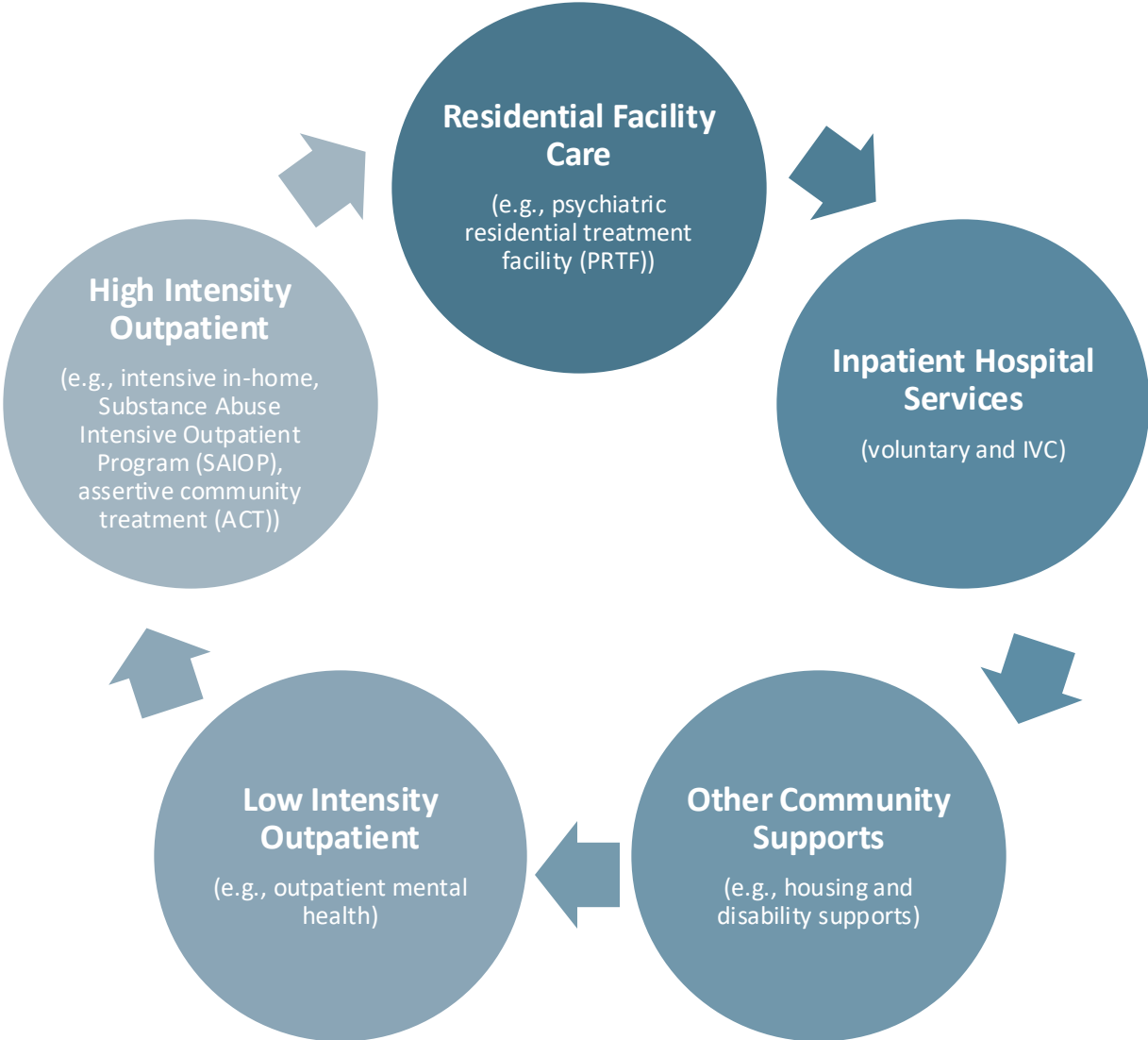
The state-funded **NC Collaboratory** issued a [preliminary report](#) in April 2026 on the intersection of North Carolina's mental health and justice systems for adults and children with future studies and final recommendations forthcoming



In July 2026, **Governor Stein signed bipartisan legislation, [State Law 2026-38 \(House Bill 1104\)](#)** intended to improve the State's crisis system, engage stakeholders, and reform the IVC process

# Crisis Services Are One Component of the Broader System of MH/SUD Care

North Carolina’s crisis system is intended to function as an entry point into the broader MH/SUD treatment continuum. An effective crisis system requires both immediate stabilization and connection to ongoing care.



**Strong community-based crisis response is essential** to reducing unnecessary escalation into emergency departments, incarceration, and involuntary commitment whenever clinically appropriate

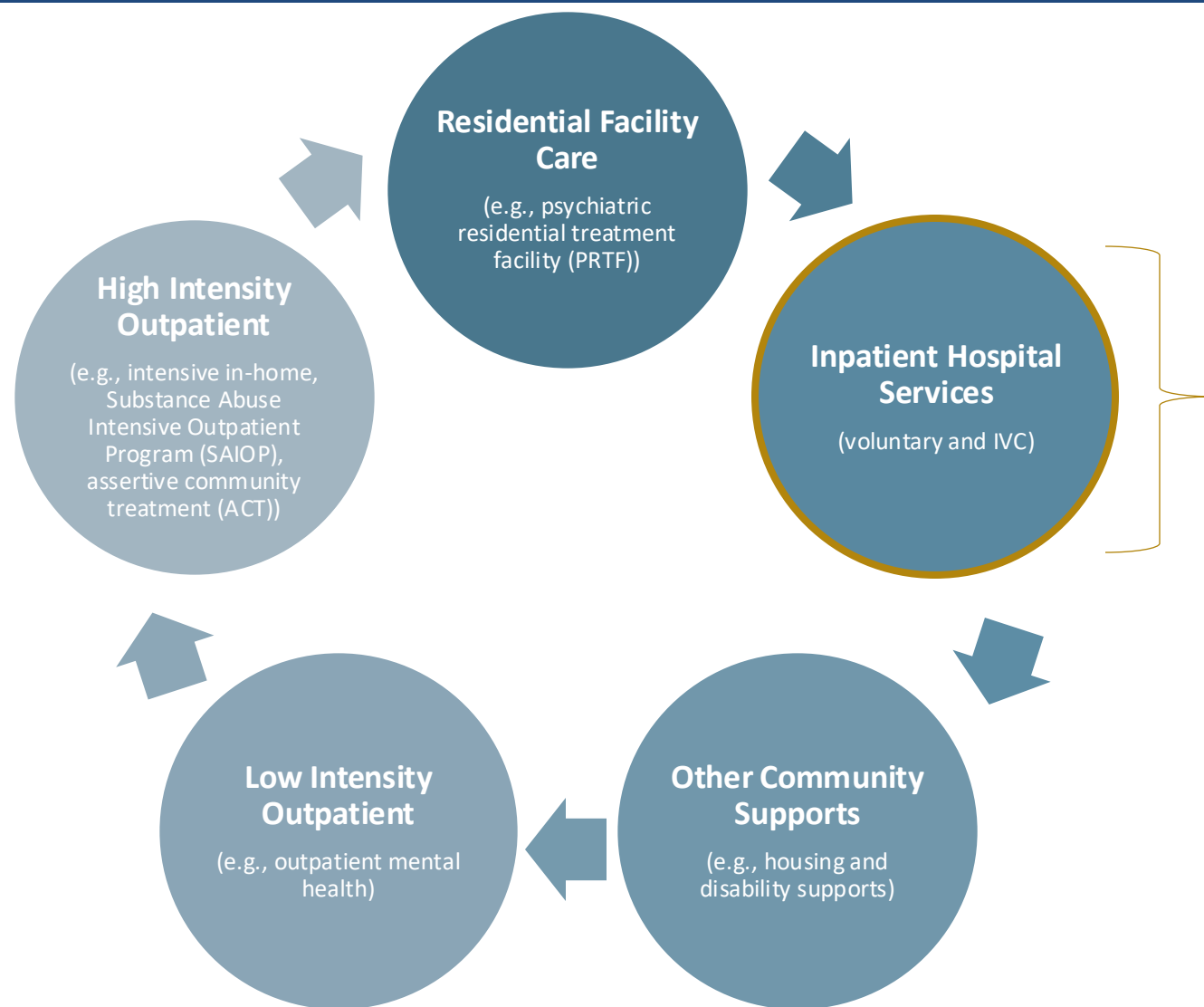


***BREAK***

***Please return to the room at 10:50am***

# Deep Dive: IVC in North Carolina

## NC DHHS & NC DPS seek to publish recommendations to reform IVC for the Governor's Office and NC General Assembly to improve North Carolina's IVC process.



While ongoing crisis system improvements aim to avoid the use of unnecessary IVC, the work of the Advisory Committee will also endeavor to improve the IVC process for those who need it.

### **The Advisory Committee will:**

- Identify challenges in the IVC system in North Carolina.
- Identify solutions and recommendations rooted in principles of person-centered, trauma-informed, and least-restrictive care to improve the IVC process.
- Inform final IVC recommendations with pathways for policy actions to improve the IVC process, for publication in late 2026/early 2027.

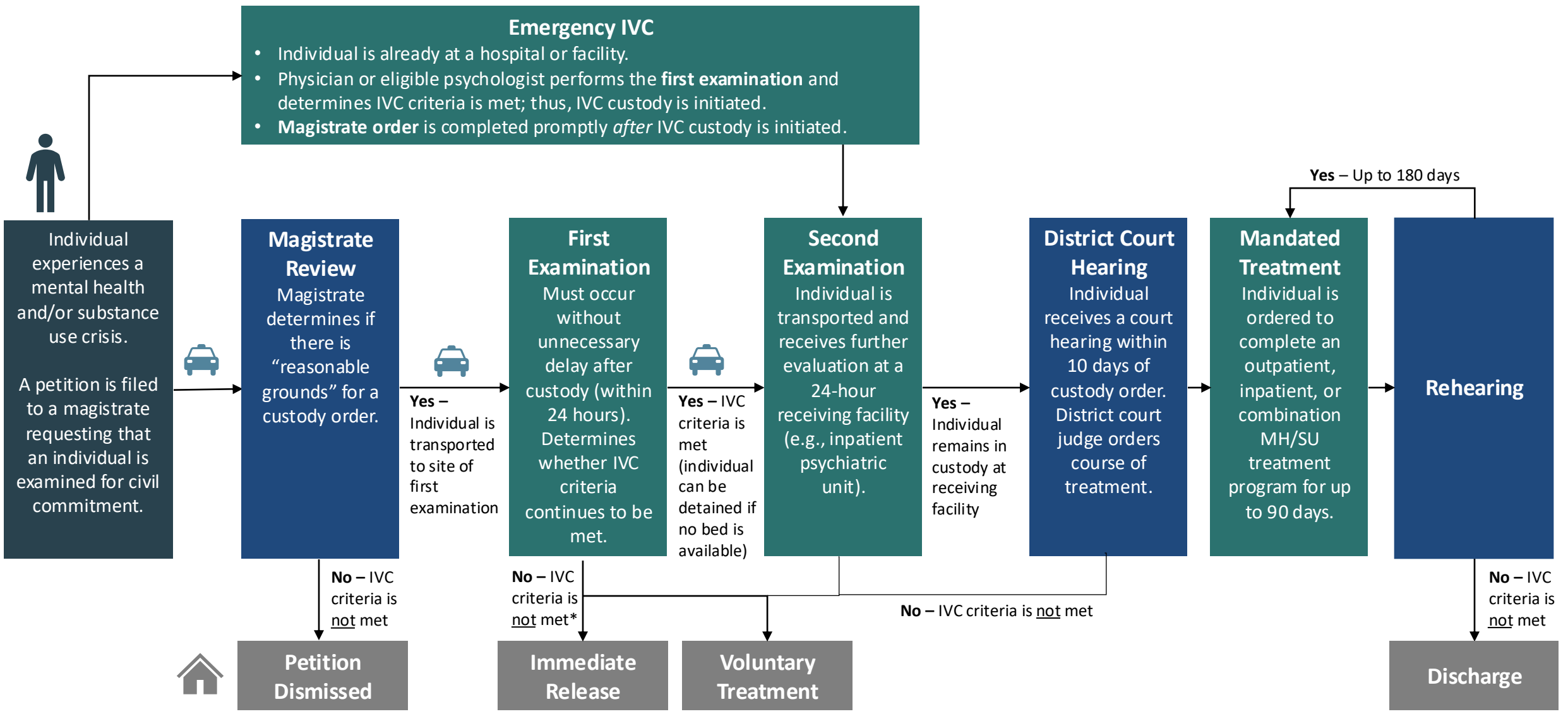
# What is IVC in North Carolina?

IVC is a *civil* legal process, defined in state law ([Chapter 122C](#)), where an individual’s civil liberties are temporarily suspended so that a person can be temporarily detained, evaluated, and treated during a MH and/or SUD crisis when deemed a danger to self or others and voluntary care cannot be safely accessed.

| Statutory IVC Component                             | Description                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Who may “qualify” for IVC?                          | <ul style="list-style-type: none"><li>IVC is allowed <b>only</b> when a person has a mental illness or substance use disorder <b>AND</b> is considered dangerous to self (e.g., inability to care for basic needs, attempts at suicide) or to others (e.g., threatening harm, extreme property destruction).<sup>1</sup></li></ul>                                                                                                |
| How does a person petition for IVC?                 | <ul style="list-style-type: none"><li>Any person (e.g., clinician, law enforcement officer, family member) may file an affidavit and petition alleging a person needs IVC, has a mental illness or substance use disorder, and meets criteria for involuntary commitment.<sup>2</sup></li><li>A clerk or magistrate can order an IVC examination upon petition based on probable cause.<sup>3</sup></li></ul>                     |
| What happens once an IVC petition is accepted?      | <ul style="list-style-type: none"><li>Law enforcement or designated transporters take the respondent promptly for a health screening and <b>first examination</b> to a setting with an available commitment examiner.<sup>4</sup></li><li>The examiner recommends outpatient commitment, inpatient commitment, or termination of IVC proceedings.<sup>5</sup></li></ul>                                                           |
| What happens if the first examiner recommends IVC?  | <ul style="list-style-type: none"><li>The individual is transported to a 24-hour facility where a physician or eligible psychologist delivers a <b>second examination</b> within 24 hours after arrival, with telehealth examinations allowed under specified conditions.<sup>6</sup></li></ul>                                                                                                                                   |
| What happens if the second examiner recommends IVC? | <ul style="list-style-type: none"><li>The individual is held at the 24-hour receiving facility until the hearing at a district court.<sup>7</sup></li></ul>                                                                                                                                                                                                                                                                       |
| What happens at the district court hearing?         | <ul style="list-style-type: none"><li>A district court schedules a hearing within 10 days of custody to determine whether inpatient commitment is warranted.<sup>8</sup></li><li>The court determines if the individual is mandated to inpatient commitment.<ul style="list-style-type: none"><li>The maximum commitment period is 90 days,<sup>9</sup> which may be renewed for up to 180 days.<sup>10</sup></li></ul></li></ul> |

State law encourages voluntary admission and that individuals under an IVC order are discharged to a less restrictive care setting as soon as appropriate. Voluntary admission does not abdicate a person’s civil liberties.<sup>11</sup>

# Current IVC System Process Flow



\*A commitment examiner could recommend outpatient commitment and the individual could be released prior to the court hearing.

## Overview of IVC in North Carolina Today



**Growth increase:** IVC petitions have increased in North Carolina in recent years; increases in civil commitments have occurred in about 20% of states nationally.



**System impacts:** Increases in IVC commitments impacts the health system, law enforcement, and justice system, and can create a financial burden.



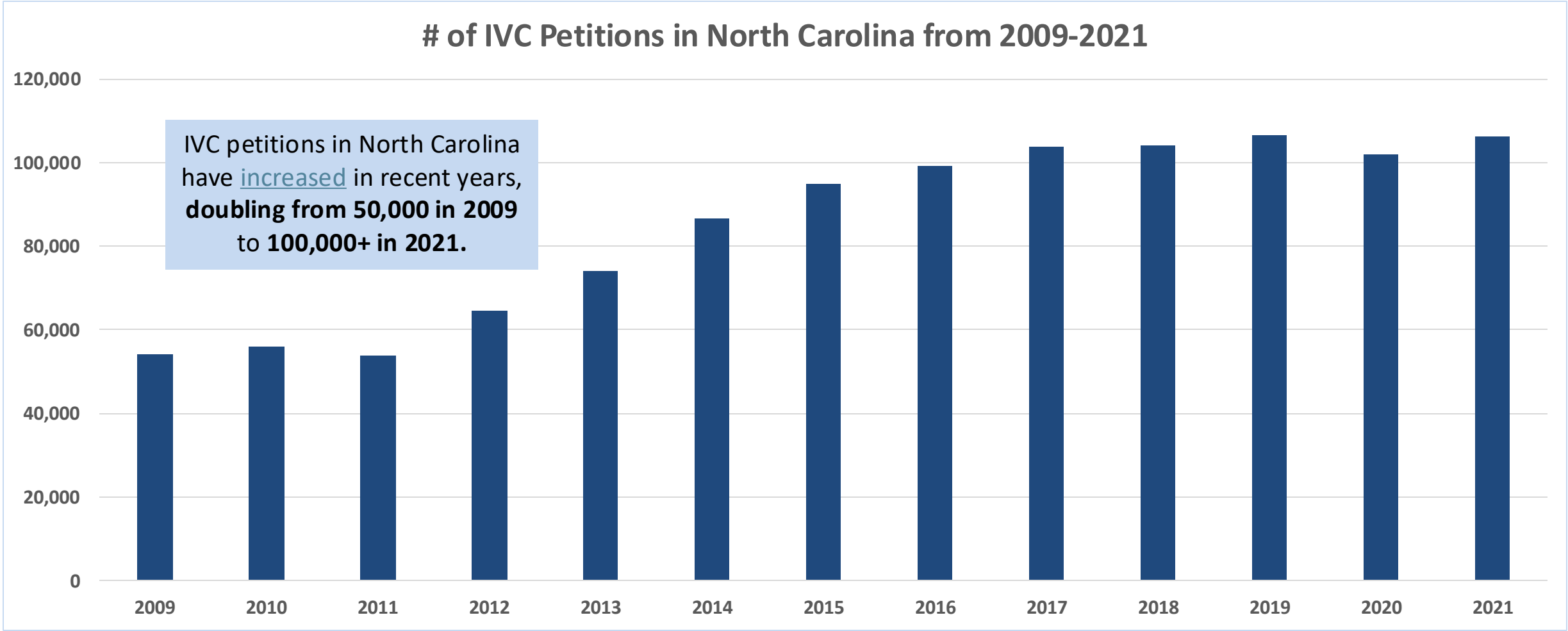
**Access gaps:** Accessing crisis care can be challenging in North Carolina; families often turn to IVC to expedite access to needed crisis, mental health, and substance use services.



**Better alternatives:** Other care alternatives – including voluntary commitment and other crisis services – can better support North Carolinians in need of treatment.

# IVC in North Carolina (1 of 4)

Some see IVC as the fastest way to address urgent MH/SU needs. IVC petitions have increased in recent years, though the majority of petitions are dismissed. This puts a strain on the health system and law enforcement and signifies a need for access to voluntary crisis services and other levels of care.



Source: [NC Health News](#) (August 2022)

### Emergency departments are frequently used as holding environments for people experiencing a mental health crisis



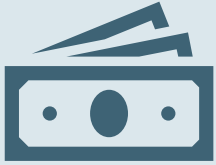
- A person in crisis visits an emergency department in North Carolina every 2.5 minutes.
- **Patients experiencing MH/SU crises tend to wait longer in emergency departments to receive services** (e.g., 12 days vs. 3 hours).
- **~ 27% of all emergency department visits for a primary mental health issue were repeat, rather than first visits, in North Carolina.**

### Heavy reliance on law enforcement for transportation during the IVC process diverts resources



- **Over 20% of law enforcement staff time is spent responding to MH/SU concerns/crises nationally.**
- **68% of individuals were transported by law enforcement for second evaluations in North Carolina.**
- By comparison, people with physical health needs rarely rely on law enforcement for transportation.

## IVC can have substantial financial impacts



- A 10-day hold prior to court hearing and a 30-day commitment could result in **\$60,000 in medical bills.**
- Inpatient stays at a psychiatric hospital can be more than **\$1,000 per day.**

## Support for children and youth in crisis is limited



- Every week, children sleep in North Carolina's emergency departments due to lack of available or accessible MH/SU services.

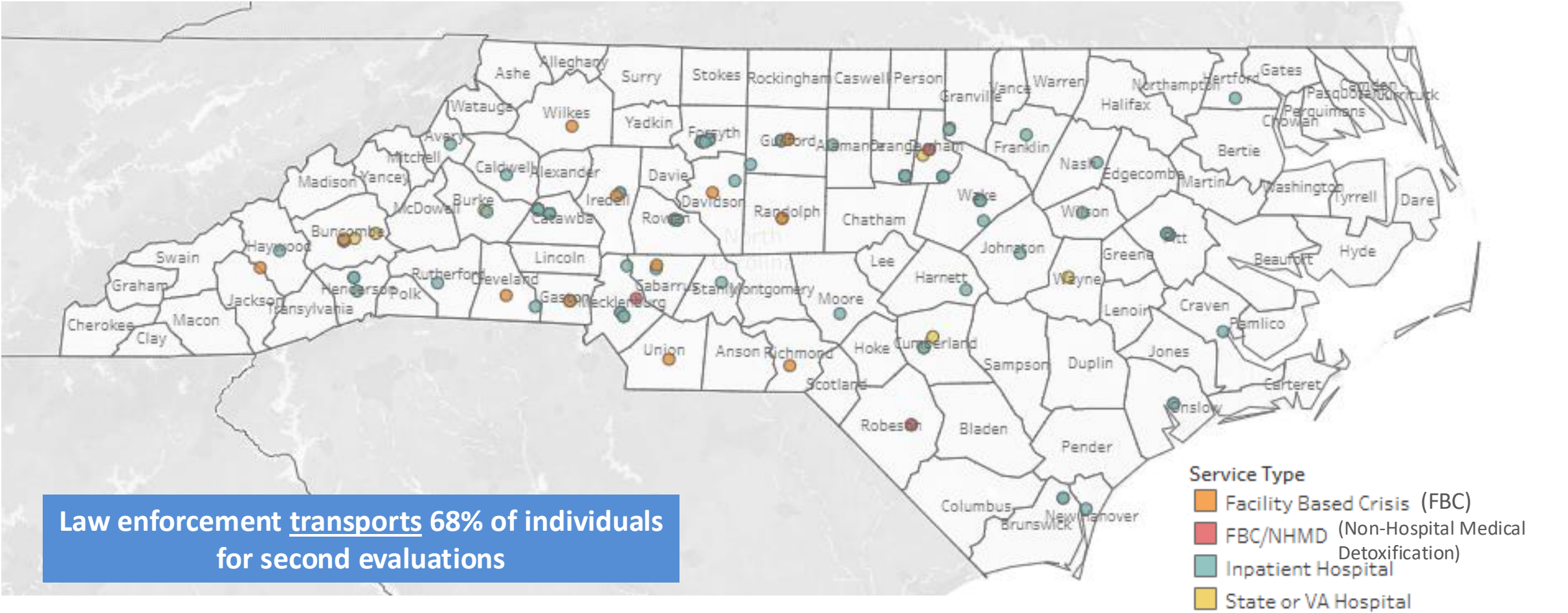
## People involved in the justice system often need MH/SU supports



- The “**revolving door**” of people cycling in and out of arrest, detention, and IVC, with limited stabilization/services, is **compounded by unmet mental health and substance use needs.**
- **Over 50% of people in North Carolina's prisons/jails have a mental health need** and 75% identify as having a SUD.
- Nearly 100% of juveniles in North Carolina's Juvenile Justice & Delinquency Prevention centers has one or more mental health diagnosis (with an average of 4.7 diagnoses).
- Among North Carolina youth with detention admissions, those awaiting behavioral health placement **spent an average of 71 days in juvenile detention** (nearly 3x the typical stay).

# IVC in North Carolina (4 of 4)

Fewer than 50 counties have a facility that provides IVC custody and treatment. Transportation to reach such facilities can take several hours, with some data indicating 3 hours of travel.



# Discussion: Key Challenges & Potential Solutions to IVC Reform

# Key Opportunity Areas to Reform IVC in North Carolina

Below are initial challenges identified within North Carolina's current IVC process for discussion today:

 **Challenge 1: Involuntary Commitment as the Default Front Door to Care**

 **Challenge 2: Over-Reliance on Emergency Departments & Law Enforcement**

 **Challenge 3: Limited Integration of Crisis System into IVC Evaluation**

 **Challenge 4: Court & Operational Processes are Difficult to Navigate**

 **Challenge 5: Weak Follow-Up & Community Linkages Contribute to Repeat Crises**

# Overview of Pre-Meeting Survey Feedback

Nearly all Committee members responded to the pre-meeting survey



Generally, members supported the description of the key challenges and potential solutions, and raised opportunities to further refine challenge descriptions and consider additional solutions



We will use this feedback to review each challenge area, elevate initial member feedback, and prepare for diving deeper during subsequent meetings



## **Challenge 1: Involuntary Commitment as the Default Front Door to Care**



## **Challenge 2: Over-Reliance on Emergency Departments & Law Enforcement**



## **Challenge 3: Limited Integration of Crisis System into IVC Evaluation**



## **Challenge 4: Court & Operational Processes are Difficult to Navigate**



## **Challenge 5: Weak Follow-Up & Community Linkages Contribute to Repeat Crises**

## Key Issues Identified in North Carolina's IVC Process:

- IVC is perceived as the fastest or only way to access care
- Individuals are often routed into a legal process before clinical assessment occurs
- Early opportunities for voluntary intervention are missed
- Current pathways reinforce the perception that care requires IVC

## Potential Solutions:



### Strengthen Clinically Led Crisis Access Points

Expand and normalize access to 988, mobile crisis teams, behavioral health urgent care centers (BHUCs), facility-based crisis (FBC) centers, and outpatient providers



### Create Clear Pathways to Voluntary Care

Establish statewide referral pathways that connect individuals to voluntary crisis services before legal escalation, whenever clinically appropriate



### Ensure Timely Clinical Input Into Court Processes

Ensure courts and law enforcement receive timely clinical information to assist IVC decision making



### Expand Public Awareness of Non-IVC Options

Educate families and communities on how to access voluntary crisis services before a crisis escalates

## Advisory Committee Pre-Meeting Survey Results

### Level of Support for How Challenge 1's Problem Is Framed (IVC as Default Front Door)

- About half **support** description (58%)
- Approximately 2/5 have **mixed reactions** (38%)

### Level of Support for Potential Solutions

- Majority **support** all solutions (83%, on avg.)
  - 73% (Solution 3: Timely Input) - 96% (Solution 4: Expand Public Awareness)
  - 15% "need more information" on Solution 3 (Timely Input)

*"Distinguishing between lack of access, misunderstanding of IVC, and attempts to overcome an individual's refusal of voluntary treatment is important when considering potential solutions."*

### Respondent Feedback

- In some instances, IVC is the *only* option for accessing care
- Families and law enforcement are not aware of other options for care, especially for SUD
- Strengthening the crisis system of care without meaningful partnerships will result in an underutilization of services
- Rural communities lack trust in statewide mandates



**How should the State build awareness of options for crisis services and trust in communities to utilize other pathways?**



**Challenge 1: Involuntary Commitment as the Default Front Door to Care**



**Challenge 2: Over-Reliance on Emergency Departments & Law Enforcement**



**Challenge 3: Limited Integration of Crisis System into IVC Evaluation**



**Challenge 4: Court & Operational Processes are Difficult to Navigate**



**Challenge 5: Weak Follow-Up & Community Linkages Contribute to Repeat Crises**

## Key Issues Identified in North Carolina's IVC Process:

- Emergency departments and law enforcement have become default responders to mental health and substance use crises
- Individuals and families often experience trauma, delays in care, and unnecessary system involvement
- Hospitals and public safety systems face operational strains from mental health and substance use crises

## Potential Solutions:



### Expand Alternative Transport Options

Reduce reliance on law enforcement transport by expanding clinically appropriate transport options before and after IVC decisions are made



### Increase Crisis Facility Capacity

Expand the ability of behavioral health urgent care centers (BHUCs) and facility-based crisis (FBC) centers to receive and stabilize individuals under IVC



### Standardize Trauma-Informed Transport

Develop statewide transport protocols that emphasize trauma-informed practices and least restrictive interventions for those involved in IVC transports (e.g., EMTs, law enforcement)



### Reserve Law Enforcement for Safety Risks

Reserve law enforcement involvement for situations involving acute safety concerns that cannot be mitigated through clinically-led services

## Advisory Committee Pre-Meeting Survey Results

### Level of Support for How Challenge 2's Problem Is Framed (Over-Reliance on ED & LE)

- Majority **support** description (88%)
- No one raised concerns

### Level of Support for Potential Solutions

- Respondents had more **mixed reactions** to these solutions than other key challenges
- Majority **support** all solutions (75%, on avg.)
  - 73% (Solutions 1 & 4: Reduce Reliance & Reserve Law Enforcement Use) - 77% (Solutions 2 & 3: Expand Crisis Centers & Develop Standardized Transport)
- At least 4% of respondents raised concerns with 3 of 4 solutions

*"Family will call law enforcement for someone who has years of drug or alcohol abuse, the officers can really only [recommend] IVC [for] the person and they will be back out in around a day with no follow [up] help for their issues."*

### Respondent Feedback

- People should not be discouraged from using law enforcement if there is potential for harm
- Facilities for crisis services may lack the appropriate security measures to keep people safe
- Law enforcement should play a secondary role, but may be necessary in violent situations to protect patient and provider well being
- Need for more specificity regarding transportation protocols and trauma-informed care



**In what situations is it appropriate for law enforcement involvement? What guidelines are necessary for law enforcement involvement, especially for transportation?**



**Challenge 1: Involuntary Commitment as the Default Front Door to Care**



**Challenge 2: Over-Reliance on Emergency Departments & Law Enforcement**



**Challenge 3: Limited Integration of Crisis System into IVC Evaluation**



**Challenge 4: Court & Operational Processes are Difficult to Navigate**



**Challenge 5: Weak Follow-Up & Community Linkages Contribute to Repeat Crises**

## Key Issues Identified in North Carolina's IVC Process:

- Community crisis providers are not consistently authorized or staffed to perform IVC-related evaluations, delaying timely recommendations for care
- Emergency departments and inpatient settings are considered the primary sites for evaluation and stabilization
- Access to specialized behavioral health evaluators varies across communities, resulting in a lack of options and awareness when seeking care
- Duplicative evaluations and fragmented coordination among providers contributes to inefficiencies and delays

## Potential Solutions:



### Increase IVC Evaluation Capacity

Require mobile crisis teams, behavioral health urgent care centers (BHUCs), and facility-based crisis (FBC) centers to maintain trained IVC-designated evaluators



### Expand Telehealth Evaluations

Expand telehealth evaluation capacity, including child and adolescent specialty telepsychiatry services in settings that may not have an evaluator on site



### Enable Community-Based Evaluation

Allow clinically appropriate IVC evaluations and stabilization to occur outside emergency departments, whenever medically appropriate



### Streamline Care Coordination

Reduce unnecessary duplication in evaluations and strengthen coordination between crisis providers and hospitals

## Advisory Committee Pre-Meeting Survey Results

### Level of Support for How Challenge 3's Problem Is Framed (Limited Integration)

- Majority **support** description (81%)
- One fifth have **mixed reactions** (19%)

### Level of Support for Potential Solutions

- Majority **support** all solutions (80%, on avg.)
  - 69% (Solution 2: Expand Telehealth) - 88% (Solution 4: Reduce Duplication)
- About 15% had mixed reactions on Solution 1 (Increase IVC Evaluation Capacity) and 23% had mixed reactions on Solution 2 (Expand Telehealth)

*"Establishing additional sites for first evaluations addresses only one part of the problem. Expanding IVC evaluation capacity does not address the larger system issue of insufficient inpatient and other appropriate placement capacity."*

### Respondent Feedback

- Finding credentialed providers is difficult and they are often not available during nights and weekends
- Concerns that increased use of telehealth will increase the use of IVC
- Limitations of telehealth and worry of replacing services that are better in-person, especially support services
- Skeptical of the viability of implementation due to staffing and reimbursement constraints



**Where and in what situations would telehealth be beneficial in increasing access to evaluations?**



**Challenge 1: Involuntary Commitment as the Default Front Door to Care**



**Challenge 2: Over-Reliance on Emergency Departments & Law Enforcement**



**Challenge 3: Limited Integration of Crisis System into IVC Evaluation**



**Challenge 4: Court & Operational Processes are Difficult to Navigate**



**Challenge 5: Weak Follow-Up & Community Linkages Contribute to Repeat Crises**

## Key Issues Identified in North Carolina's IVC Process:

- Families often struggle to understand IVC processes and available alternatives
- Procedures, coordination, and operational practices vary across counties
- Individuals and families experience confusion regarding evaluations, hearings, and discharge decisions, and there is limited information and transparency sharing among patients, caregivers, courts, providers, and law enforcement

## Potential Solutions:



### Standardize Training & Guidance

Develop statewide guidance and training for courts, law enforcement, EMS, and mental health and substance use health care providers



### Improve Education

Create clear educational materials explaining voluntary crisis care, IVC Chapter 122C processes, Iryna's Law procedures, hearings, and discharge processes



### Promote Least Restrictive Alternatives

Strengthen use of community-based stabilization and least restrictive treatment options, whenever clinically appropriate



### Strengthen Cross-System Coordination

Improve coordination among courts, hospitals, crisis providers, and community services across the system of care

## Advisory Committee Pre-Meeting Survey Results

### Level of Support for How Challenge 4's Problem Is Framed (Navigation Barriers)

- Majority **support** description (88%)

### Level of Support for Potential Solutions

- Majority **support** all solutions (88%, on avg.)
  - 85% (Solution 1: Develop Guidance & Solution 3: Strengthen Alternatives) - 96% (Solution 4: Improve Coordination)
- No respondents raised concerns with the solutions

*"Consistency while preserving community culture is appropriate. Rural processes cannot always be the same as urban processes ... creating consistency will help with confusion but still allowing autonomy of each community for the process."*

### Respondent Feedback

- More clarification is needed between IVC as a civil process and Iryna's Law
- The system is complex and difficult to navigate, and individuals often lack support outside of a public defender
- Many individuals view IVC as a quick solution to their problems



**How can the IVC process be more transparent and standardized for all parties involved (e.g., families and caregivers, clinicians)?**



**Challenge 1: Involuntary Commitment as the Default Front Door to Care**



**Challenge 2: Over-Reliance on Emergency Departments & Law Enforcement**



**Challenge 3: Limited Integration of Crisis System into IVC Evaluation**



**Challenge 4: Court & Operational Processes are Difficult to Navigate**



**Challenge 5: Weak Follow-Up & Community Linkages Contribute to Repeat Crises**

## Key Issues Identified in North Carolina's IVC Process:

- Many individuals cycle repeatedly through crisis services, hospitalization, emergency departments, or IVC
- Follow-up and treatment engagement after crisis stabilization are often inconsistent
- Connections to community-based supports may be delayed or incomplete
- Opportunities to prevent future crises are frequently missed

## Potential Solutions:



### Ensure Rapid Post-Crisis Follow-Up

Require timely outpatient follow-up and discharge planning after crisis stabilization or hospitalization



### Leverage Peer Support Services

Increase access to peer support and post-crisis navigation programs that help individuals remain engaged in care



### Strengthen Care Coordination

Use crisis responders and existing care management systems to coordinate ongoing treatment engagement and service linkage



### Expand Community-Based Alternatives

Strengthen community-based alternatives such as Assisted Outpatient Treatment (AOT), peer supports, and intensive outpatient services

## Advisory Committee Pre-Meeting Survey Results

### Level of Support for How Challenge 5's Problem Is Framed (Community Linkage)

- Majority **support** description (96%)

### Level of Support for Potential Solutions

- Majority **support** all solutions (82%, on avg.)
  - 77% (Solution 1: Require Outpatient Follow-Up) - 85% (Solution 2: Leverage Crisis Responders & Care Management & Solution 3: Strengthen Community-Based Alternatives)
- Respondents had **mixed reactions** (12%) to Solutions 1 & 2

*"A referral alone is not necessarily a successful connection ... Housing and other practical supports are also important to consider, since gaps there can drive repeated use of crisis, hospital, and criminal justice services."*

### Respondent Feedback

- North Carolina lacks adequate outpatient and community supports, especially after an individual is hospitalized
- Referrals should account for transitions in care, which would involve warm hand-offs, rapid follow-up, strategies to reach certain populations, etc.
- Clearer guidelines for payment of crisis episodes
- Improved communication and transparency upon discharge with all entities involved



**What are the biggest barriers you observe that get in the way of successful follow-up and involvement in community-based care?**

# Wrap Up & Next Steps

Please turn to your neighbors (in groups of 2-3) and reflect on the questions below. We will spend 5 minutes reporting out to the group here today.



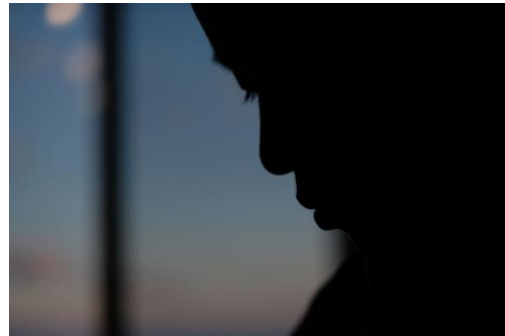
**What additional information would help you inform your participation in the upcoming meetings (e.g., detailed description of IVC court processes)?**

*Write your group's answer on a sticky note and place it on the sheet at the front of the room*

Please turn to your neighbors (in groups of 2-3) and reflect on the questions below. We will spend 5 minutes reporting out to the group here today.



What image best represents how you're feeling about the work ahead for this Advisory Committee and why?



# 2026 Advisory Committee Meeting Schedule\*

|                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                        |                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Next Meeting's Focus</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                        |                                                                                                                                                                 |
|  <b>Meeting #1 – Kickoff</b><br><br><i>September 2, 2026</i><br><br><b>Agenda:</b> <ul style="list-style-type: none"><li>• Introductions &amp; Advisory Committee Overview</li><li>• Crisis System of Care Overview</li><li>• Current State of IVC</li><li>• IVC Challenge Areas &amp; Reform Opportunities</li></ul> | <b>Meeting #2</b><br><br><i>September 30, 2026</i><br><br><b>Proposed Agenda:</b> <ul style="list-style-type: none"><li>• Review IVC Challenge 1: IVC as Default Front Door</li><li>• Review IVC Challenge 2: Over-Reliance on EDs &amp; Law Enforcement</li><li>• Discuss IVC Potential Solutions</li></ul> | <b>Meeting #3</b><br><br><i>October 28, 2026</i><br><br><b>Proposed Agenda:</b> <ul style="list-style-type: none"><li>• Review IVC Challenge 3: Limited Integration</li><li>• Review IVC Challenge 4: Navigation Barriers</li><li>• Discuss IVC Potential Solutions</li></ul> | <b>Meeting #4</b><br><br><i>November 18, 2026</i><br><br><b>Proposed Agenda:</b> <ul style="list-style-type: none"><li>• Review IVC Challenge 5: Community Linkage</li><li>• Discuss IVC Potential Solutions</li></ul> | <b>Meeting #5</b><br><br><i>December 16, 2026</i><br><br><b>Proposed Agenda:</b> <ul style="list-style-type: none"><li>• Finalize IVC Recommendations</li></ul> |

\*Agendas and timeline subject to change.

# Reminder: Post-Meeting Survey & Contact Information

North Carolina Crisis System of  
Care Advisory Committee - IVC  
Focus: Post-Meeting #1 Survey



- Please use the QR code to complete the post-meeting survey now.



**For any questions/comments, please feel free to contact the following facilitators:**

## NC DHHS

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# Appendix

# Relevant NC General Statutes on IVC (1 of 2)

## Article 5. Procedure for Admission and Discharge of Clients.

### *General Provisions.*

- [§ 122C-3\(11\). Definitions.](#) Defines danger to self or others as person who has made threats to the health and safety of themselves and/or others.
- [§ 122C-201. Declaration of policy.](#) Specifies that individuals shall not be involuntarily committed to a 24-hour facility “unless that individual is mentally ill or a substance abuser and dangerous to self or others.” Individuals who have been involuntarily committed shall be discharged to a less restrictive setting if appropriate.

### *Part 6. Involuntary Commitment – General Provisions.*

- [§ 122C-251. Custody and transportation.](#) Cities or counties are responsible for the transportation of individuals under voluntary commitment; law enforcement and other affected agencies (e.g., hospitals) must have agreements and procedures in place to receive individuals under involuntary commitment.

### *Part 7. Involuntary Commitment of the Mentally Ill; Facilities for the Mentally Ill.*

- [§ 122C-261. Affidavit and petition before clerk or magistrate when immediate hospitalization is not necessary; custody order.](#) An affidavit must be presented to a magistrate or clerk, who then determines if the individuals must be examined by a commitment examiner. Upon the result, the magistrate must then issue a custody order to law enforcement to place the individual under involuntary commitment.

## Relevant NC General Statutes on IVC (2 of 2)

- [§ 122C-263. Duties of clerk of superior court and the district attorney](#). Upon receipt of the commitment examiner's findings, the clerk must schedule the hearing and administer and maintain records of the petition.
- [§ 122C-265. Outpatient commitment; examination and treatment pending hearing](#). If a respondent does not follow through on the outpatient commitment treatment, then the clerk shall order law enforcement to take the respondent into custody and transport the individual to the outpatient facility for evaluation.
- [§ 122C-266. Inpatient commitment; second examination and treatment pending hearing](#). The respondent shall be examined within 24 hours upon arrival at the facility. Upon the second examination, the commitment examiner may recommend immediate release, outpatient commitment, or that the individual be held until the court hearing under IVC.
- [§ 122C-267. Outpatient commitment; district court hearing & § 122C-268. Inpatient commitment; district court hearing](#). Hearings shall take place at a district court within 10 days of being taken into custody.
- [§ 122C-271. Disposition](#). The court may decide an individual is discharged, be committed to outpatient treatment, inpatient treatment, or a combination of inpatient and outpatient treatment for a period no longer than 90 days.
- [§ 122C-273. Duties for follow-up on commitment order](#). If a person under an outpatient commitment order fails to comply with treatment or becomes a danger to themselves or others, then a supplemental hearing may be ordered or a new petition can be issued.
- [§ 122C-281. Affidavit and petition before clerk or magistrate; custody order](#). If a commitment examiner makes a petition to a magistrate and it is granted, then the individual can be taken to a 24-hour receiving facility by law enforcement for a qualified professional to perform the second examination.

# Advisory Committee Pre-Meeting Survey Results

## Level of Support for Key Challenge Description and Potential Solutions

|                                          | Green<br>(Support) | Yellow<br>(Mixed Reaction) | Red<br>(Concerns) | Need More<br>Information |
|------------------------------------------|--------------------|----------------------------|-------------------|--------------------------|
| Description of Key Challenge #1          | 58%                | 38%                        | 4%                | 0%                       |
| Solution 1: Strengthen Access Points     | 81%                | 15%                        | 0%                | 4%                       |
| Solution 2: Create Volunteer Pathways    | 81%                | 15%                        | 0%                | 4%                       |
| Solution 3: Ensure Timely Clinical Input | 73%                | 12%                        | 0%                | 15%                      |
| Solution 4: Expand Public Awareness      | 96%                | 0%                         | 0%                | 4%                       |

Results reflected survey responses as of August 26, 2026

# Advisory Committee Pre-Meeting Survey Results

## Level of Support for Key Challenge Description and Potential Solutions

|                                                      | Green<br>(Support) | Yellow<br>(Mixed Reaction) | Red<br>(Concerns) | Need More<br>Information |
|------------------------------------------------------|--------------------|----------------------------|-------------------|--------------------------|
| Description of Key Challenge #2                      | 88%                | 12%                        | 0%                | 0%                       |
| Solution 1: Alternative Transport Options            | 73%                | 15%                        | 4%                | 8%                       |
| Solution 2: Increase Crisis Capacity                 | 77%                | 15%                        | 4%                | 4%                       |
| Solution 3: Standardize IVC Transport                | 77%                | 15%                        | 0%                | 8%                       |
| Solution 4: Reserve Law Enforcement for Safety Risks | 73%                | 15%                        | 4%                | 8%                       |

Results reflected survey responses as of August 26, 2026

# Advisory Committee Pre-Meeting Survey Results

Level of Support for Key Challenge Description and Potential Solutions

|                                                | Green<br>(Support) | Yellow<br>(Mixed Reaction) | Red<br>(Concerns) | Need More<br>Information |
|------------------------------------------------|--------------------|----------------------------|-------------------|--------------------------|
| Description of Key Challenge #3                | 81%                | 19%                        | 0%                | 0%                       |
| Solution 1: Increase IVC Evaluation Capacity   | 77%                | 15%                        | 4%                | 4%                       |
| Solution 2: Expand Telehealth Evaluations      | 69%                | 23%                        | 4%                | 4%                       |
| Solution 3: Enable Community-Based Evaluations | 85%                | 8%                         | 4%                | 4%                       |
| Solution 4: Streamline Care Coordination       | 88%                | 4%                         | 0%                | 8%                       |

Results reflected survey responses as of August 26, 2026

# Advisory Committee Pre-Meeting Survey Results

## Level of Support for Key Challenge Description and Potential Solutions

|                                                    | Green<br>(Support) | Yellow<br>(Mixed Reaction) | Red<br>(Concerns) | Need More<br>Information |
|----------------------------------------------------|--------------------|----------------------------|-------------------|--------------------------|
| Description of Key Challenge #4                    | 88%                | 12%                        | 0%                | 0%                       |
| Solution 1: Standardize Training & Guidance        | 85%                | 12%                        | 0%                | 4%                       |
| Solution 2: Improve Education                      | 88%                | 8%                         | 0%                | 4%                       |
| Solution 3: Promote Least Restrictive Alternatives | 85%                | 12%                        | 0%                | 4%                       |
| Solution 4: Strengthen Cross-System Coordination   | 96%                | 0%                         | 0%                | 4%                       |

Results reflected survey responses as of August 26, 2026

## Advisory Committee Pre-Meeting Survey Results

### Level of Support for Key Challenge Description and Potential Solutions

|                                                 | Green<br>(Support) | Yellow<br>(Mixed Reaction) | Red<br>(Concerns) | Need More<br>Information |
|-------------------------------------------------|--------------------|----------------------------|-------------------|--------------------------|
| Description of Key Challenge #5                 | 96%                | 4%                         | 0%                | 0%                       |
| Solution 1: Ensure Rapid Follow-Up              | 77%                | 12%                        | 0%                | 12%                      |
| Solution 2: Leverage Peer Support Services      | 85%                | 4%                         | 4%                | 8%                       |
| Solution 3: Strengthen Care Coordination        | 85%                | 8%                         | 0%                | 8%                       |
| Solution 4: Expand Community-Based Alternatives | 81%                | 12%                        | 0%                | 8%                       |

Results reflected survey responses as of August 26, 2026