



North Carolina Crisis System of Care Advisory Committee

Pre-Read Materials for Advisory Committee on September 30, 2026

- **Meeting #1 Summary & Recap**
- **Current State of IVC in North Carolina & Revolving Door Problem**
- **Key Areas of Improvement & Proposed Solutions**
 - Dependence on Law Enforcement & Emergency Departments
 - Overreliance on IVC to Enter Care

Reminder: 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 [i.e., the "revolving door" problem] [for individuals with mental health/substance use needs]."



Reminder: 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 substance use needs, 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.

- **In 2026, the Advisory Committee's focus on the IVC process and the revolving door problem will primarily address the following:**
 - Recommend reforms to the IVC process that:
 - Promote diversion to community-based care, reducing burden on emergency departments and law enforcement
 - Create a more human-centered, efficient process for all involved
 - Inform recommendations to the “revolving door” cycle
- **For recommendations related to the IVC process, the Advisory Committee will initially focus on *adult* IVC petitions that originate in community-based settings (i.e., not a hospital or facility)**
- While the Advisory Committee may discuss other populations and settings due to some overlap with the solutions and issues being examined, the Advisory Committee will not develop targeted recommendations for these issues initially in Fall 2026, but can revisit in 2027

Recap of NC Crisis System of Care Advisory Committee 9/2 Meeting

The Advisory Committee broadly agreed that reducing unnecessary IVC use will require strengthening the continuum of community-based crisis services, improving system coordination, increasing awareness of alternatives, and using data to guide policy and investment decisions.

- **Strong consensus emerged that North Carolina's crisis system relies heavily on IVC to obtain care, with law enforcement and emergency departments as the primary responders.** Community-based alternatives to respond to crises in real time are often unavailable, inaccessible, or insufficiently resourced.
- **Advisory Committee members identified opportunities to reduce unnecessary IVC use,** including mobile crisis services, peer supports, crisis planning and advance directives, and community response models, but noted that many of these options are not currently available in many parts of North Carolina, especially on evenings and weekends.
- **Law enforcement, emergency departments, and hospitals continue to serve as default crisis responders,** particularly in rural communities. Often, law enforcement and hospitals are the only available responders to emergencies.
- **Advisory Committee members highlighted concerns about the current IVC process,** including inappropriate utilization, using IVC to obtain transportation, variation in local practices, impacts on individuals and families, and a need to balance public safety, due process, and access to treatment.
- **A critical need in North Carolina is improving cross-system coordination,** particularly among 988, 911, providers, hospitals, courts, schools, and law enforcement.
- **Advisory Committee members emphasized the importance of stronger data and system performance measurement,** including understanding sources for IVC petition initiation, why the petitions occur, demographic and geographic IVC trends, IVC use for transportation purposes, how individuals move through the crisis system, and outcomes following crisis intervention.

Pre-Read Instructions: Current State

As you review the pre-read materials, consider your **level of agreement** with how the current state is described and presented.

- Do you understand the updated process flow and data reflected in the current state? If not, what questions do you have? What else would you add? How would you modify?
- Are there any other aspects of the current state that are critical to discuss?

9/30 Advisory Committee Meeting Process

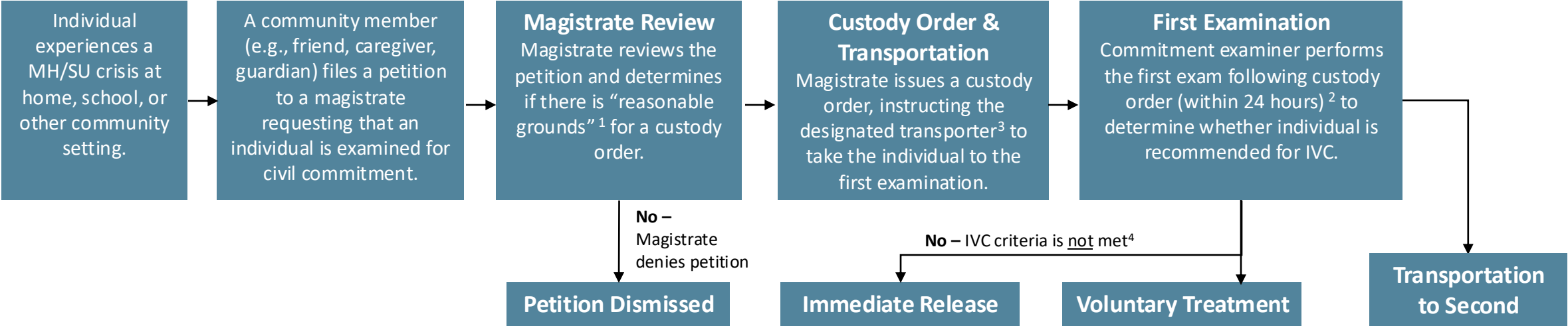
- During the 9/30 Advisory Committee meeting, Advisory Committee members will leverage the **Level of Agreement cards** to provide feedback on the current state included in the pre-read.

Current State of IVC in North Carolina

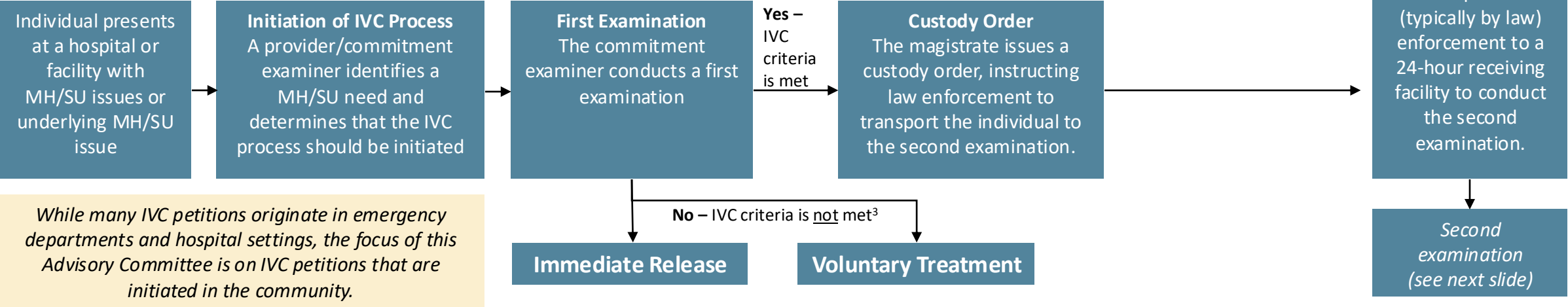
Updated to reflect 9/2 Meeting Feedback

Current IVC System Process Flow (1/2): Petition to Post-First Examination Pathways

IVC Initiated by Community-based Petition



IVC Initiated in ED



While many IVC petitions originate in emergency departments and hospital settings, the focus of this Advisory Committee is on IVC petitions that are initiated in the community.

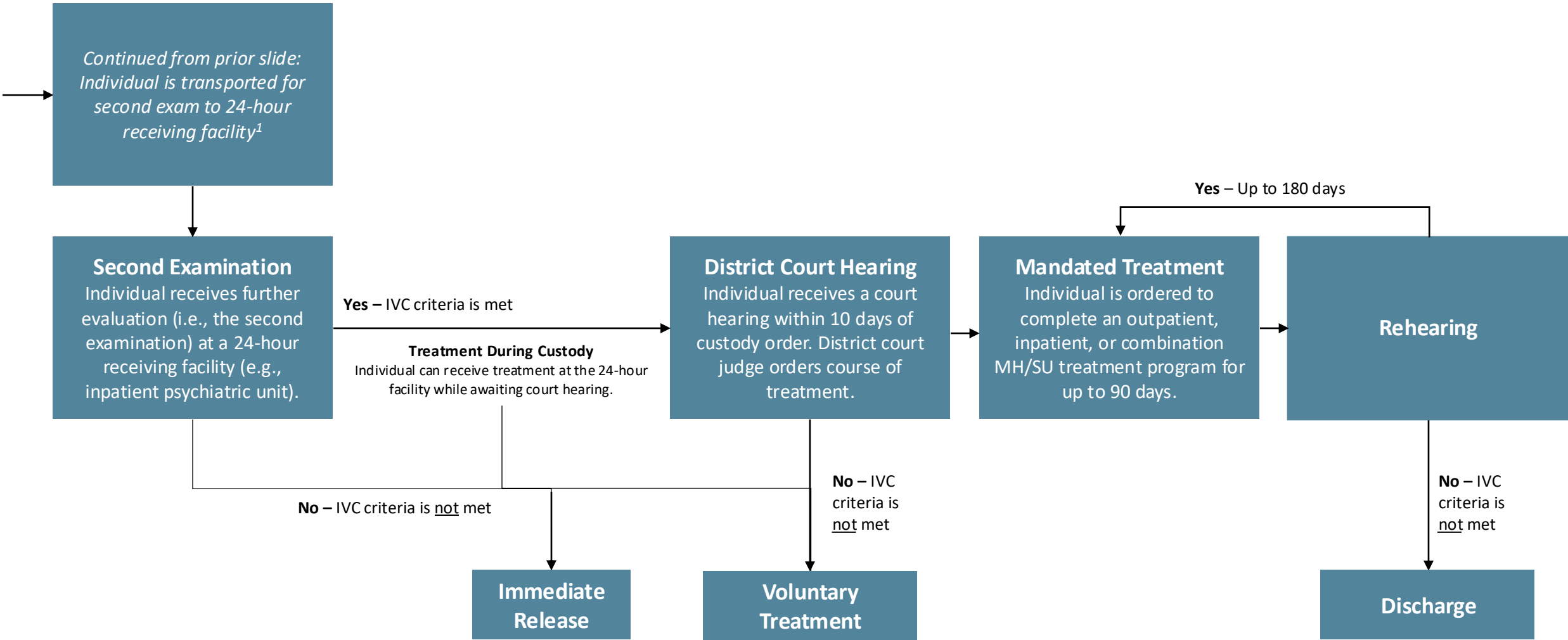
1. [Chapter 122C-261](#) uses both “probable cause” and “reasonable grounds” interchangeably as the basis for a magistrate’s decision to issue a custody order. More information can be found in the Appendix.

2. If an individual is detained and a 24-hour receiving facility is not available within 7 days after issuance of the custody order, then proceedings are terminated. Commitment examiners can issue a new IVC proceeding prior to the 7-day expiration period.

3. [Chapter 122C-251](#) requires counties to be responsible for transportation of individuals under IVC orders and allows for county discretion when selecting the transportation providers.

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

Current IVC System Process Flow (2/2): Second Examination to Court Hearing



1. A second exam may occur in the same location as a first exam if that first exam occurs at a hospital/facility designated as a 24-hour receiving facility (IVC designated facility)

What Are the Legal Requirements with IVC in NC?

IVC is a *civil* legal process, defined in North Carolina 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 an MH and/or SUD crisis when deemed a danger to self or others and treatment is not sought voluntarily.

Statutory IVC Component	Description *
Who may “qualify” for IVC?	IVC is allowed only when a person has a mental illness or substance use disorder, 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), AND whose condition would continue to deteriorate without treatment.¹
How does a person petition for IVC?	- 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.² - A clerk or magistrate can order an IVC examination upon petition based on “reasonable grounds”.³
What happens once an IVC petition is accepted?	- Law enforcement or designated transporters take the respondent promptly for a health screening and first examination to a setting with an available commitment examiner.⁴ - The commitment examiner must include an individual’s capacity to make an informed decision concerning treatment in the assessment, although it is unclear how decisions related to voluntary treatment are obtained. - The examiner recommends outpatient commitment, inpatient commitment, or termination of IVC proceedings.⁵
What happens if the first examiner recommends IVC?	The individual is transported to a 24-hour facility where a physician or completes a second examination within 24 hours after arrival, with telehealth examinations allowed under specified conditions.⁶
What happens if the second examiner recommends IVC?	- The individual is held at the 24-hour receiving facility until the hearing at a district court.⁷ - At the facility, the individual also receives treatment while waiting for the hearing.
What happens at the district court hearing?	- A district court schedules a hearing within 10 days of custody to determine whether inpatient commitment is warranted.⁸ - The court determines if the individual is mandated to inpatient commitment. - The maximum commitment period is 90 days,⁹ which may be renewed for up to 180 days.¹⁰

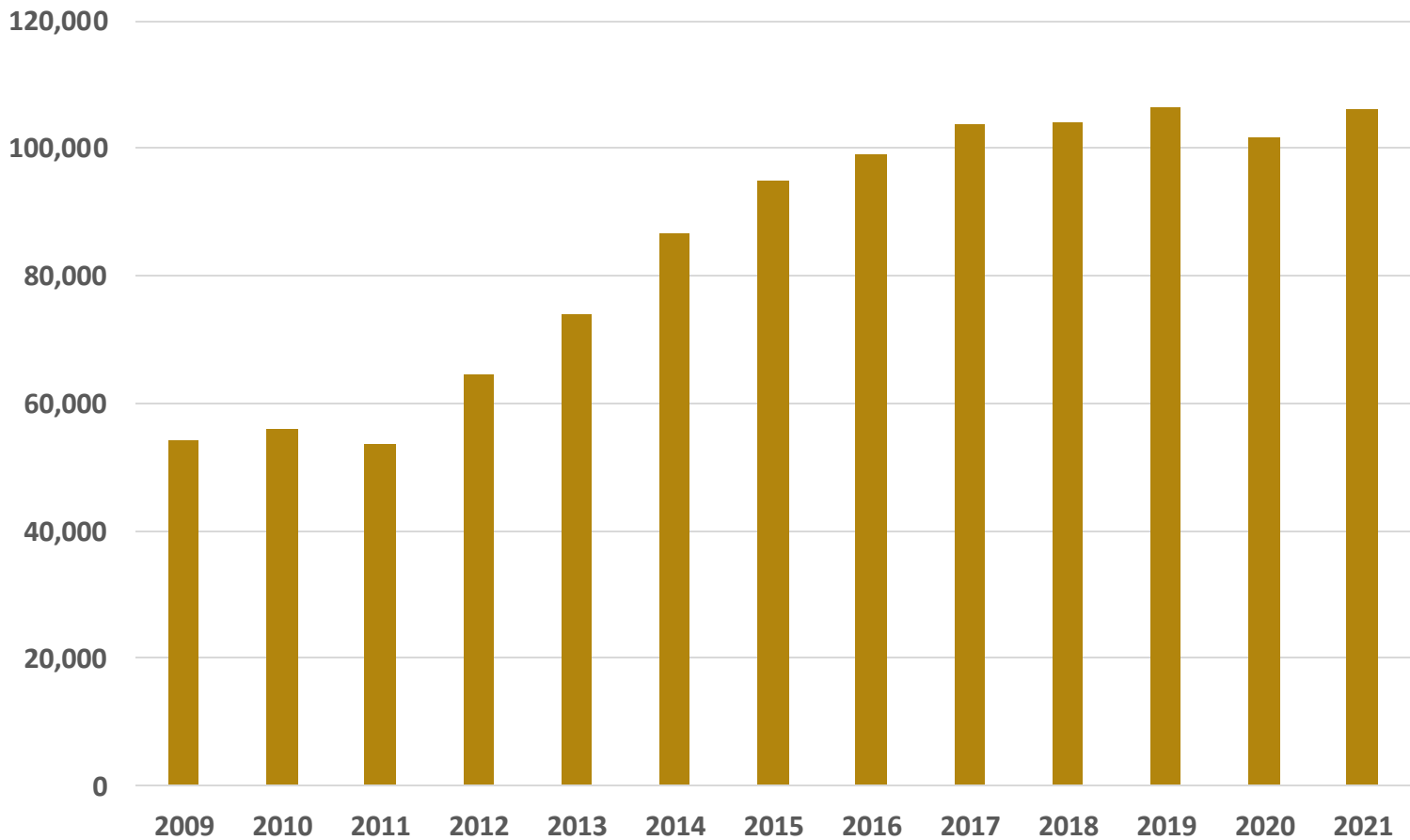
State law encourages voluntary admission and that individuals under an IVC order are discharged to a less restrictive care setting as soon as appropriate. Voluntary admission does not abdicate a person’s civil liberties.¹¹

*Process outlines process flow for community-initiated petitions.

IVC in North Carolina: Increase in IVC Petitions Over 15 Years

- IVC petitions in North Carolina have increased in recent years, **doubling from 50,000 in 2009 to 100,000+ in 2021.**
- From 2019 – 2024, **63% of IVC petitions were dismissed after the first examination.**
- **Increase in petitions, especially those that do not result in meeting IVC criteria, puts a strain on the health system and law enforcement and signifies a need for change.**

Number of IVC Petitions in North Carolina from 2009 – 2021



Data limitations described in slide notes

Simultaneous with the growth in IVC petitions, EDs are increasingly functioning as holding environments for people experiencing mental health and substance use needs.

- [Every 2.5 minutes](#), a person in a mental health/substance use crisis visits an ED in North Carolina.
- In SFY 2022, patients waiting for a referral to a State hospital for mental health/substance use needs [spent](#) an **average of 12 days in the ED**.
 - By contrast, the [average ED visit](#) in North Carolina is just over 3 hours.
- About 27% of all North Carolina ED visits for a primary mental health issue were [repeat](#), rather than first visits.

Telepsychiatry & IVC

The [North Carolina Statewide Telepsychiatry Program \(NC-STeP\)](#) connects with over 70 hospital EDs across the state to provide psychiatric assessments and consultations via telemedicine, including IVC first exams.

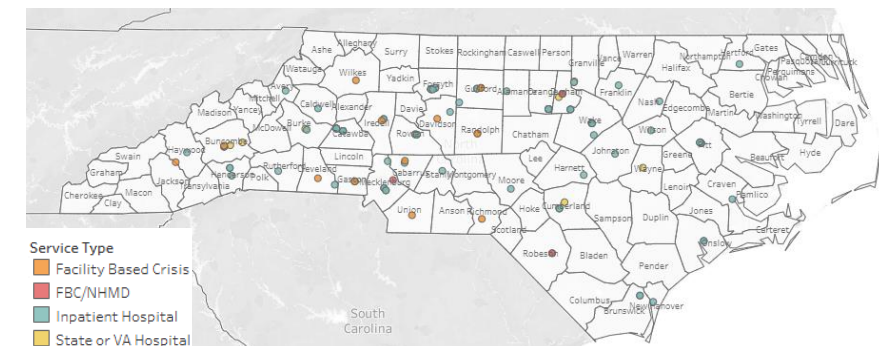
- Through NC-STeP, about half of patients seen have an average length of stay of 30 hours or less.
- NC-STeP conducts ~2,000-3,000 IVC first exams per year.
- NC-STeP does not [recommend](#) IVC for ~30% of individuals after conducting the first exam, on average.

Data reflects NC-STeP utilization from 2023-2026

IVC in North Carolina: Law Enforcement-Related Transportation

- Heavy **reliance of law enforcement for transportation** of individuals with IVC petitions diverts law enforcement away from their primary responsibilities to their communities.
 - Nationally, it is estimated that 21% of total law enforcement staff time is spent responding to and transporting individuals with mental health concerns/crises.
 - In North Carolina, transportation for IVC relies heavily on law enforcement with **68% of individuals transported by law enforcement for second evaluations**.
 - Only about 18% arrived as ED walk-ins or as transfers to psychiatric unit from ED; 7% were transported by private agencies; 6% were transported by EMS, mobile crisis teams, or other means.
 - In contrast, people with physical health needs rarely rely on law enforcement for transportation; about 12% of people arrive by ambulance to an ED and 65% are walking-in or self-transporting.
- 76/100 NC counties have submitted transport plans to NC DHHS on how the county transports individuals under IVC-order, with the **majority of counties relying on law enforcement for transportation**, as opposed to contracting with transport vendors.
 - The magistrates use a standard Transport Request Order Form to request transport between different facilities, which as written today, is directed at law enforcement.
- Some facilities will ask law enforcement to transport an individual when safety is not a concern, often due to fears of liability and lack of alternative options.
- Anecdotally, there are instances of IVC petitions filed to transport an individual; limited data exists on the extent to which this occurs.

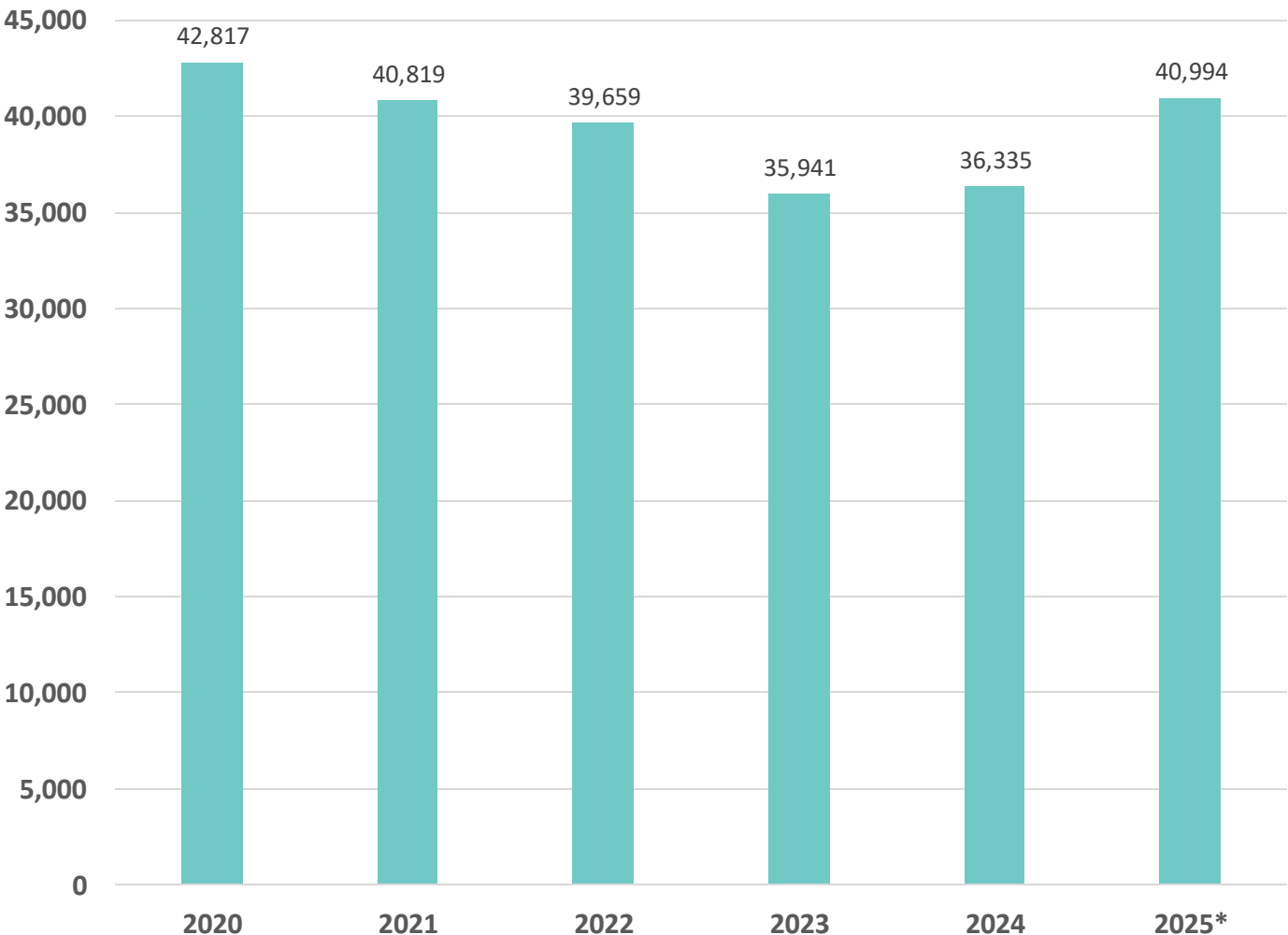
Fewer than 50 North Carolina counties have a facility that can perform the second IVC exam. Transportation to reach such facilities can take several hours, with some data indicating 3 hours of travel.



IVC in North Carolina: Second Examinations at 24-Hour Receiving Facilities

- NC DHHS is required to annually collect and submit data to the NC General Assembly on **IVC care provided at 24-hour receiving facilities** (e.g., those conducting second exams).
- **These facilities include non-hospital medical detoxification facilities, facility-based crisis (FBC) centers, and inpatient psychiatric hospitals** (See [Chapter 122C-255](#)).
 - State-run psychiatric facilities are not required to submit data.
 - As of July 2025 – June 2026, there were 70 facilities reporting on IVC second exams.*
- Each IVC admission noted here is a unique *encounter*, not a unique *individual* – **there are individuals who receive an IVC second examination more than once in a year.**

of IVC Admissions at 24-Hour Receiving Facilities in NC
(SFY 2020 –2025: June 2020 – June 2026)



*Report from SFY2025 still in draft form and contains incomplete data

IVC can become a financial burden for committed individuals, with indirect costs to taxpayers.

- An individual committed for a 30-day period and held at a 24-hour facility for 10 days prior to their court hearing could **be responsible for \$60,000+ in medical bills**. Inpatient stays at a State psychiatric hospital range from **\$900 - \$2,000 per day**.
- Each first evaluation that does **not** recommend IVC may save about \$4,500 in inpatient and hospital costs.
- Forced stays in an inpatient facility can impact an individuals' employment status and ability to obtain employment, as well as strain relationships and create additional stress for families and caregivers.

Need for Improved IVC Data Collection

Improved data collection that tracks movement through the system, and not just within siloes, will help improve understanding of this issue and is a cross-cutting theme across this work.

Gaps in Existing IVC Data

- Category of petitioner (e.g., family member, law enforcement, clinician) and origin of petition location (e.g., ED, community-based setting)
- Details of IVC requests (e.g., primary reasons that constitute “reasonable grounds” for granting an IVC petition, repeat number of IVC orders for the same individuals)
- Information on magistrate decision-making (e.g., consult with mobile crisis, recommendation to least restrictive alternatives)
- Disaggregated rates of dismissal at petition and hearing stages
- Results of second evaluations and court determinations (e.g., release, outpatient commitment)
- Demographic data of individuals under IVC orders (e.g., age, race/ethnicity, sexual orientation/gender identity, geography)
- Near- and long-term treatment outcomes on health and wellness
- Wait times between first and second examinations (e.g., ED boarding)
- Law enforcement transport times between examinations and transportation methods
- Costs to the system (e.g., Medicaid, uncompensated care, transportation)
- Discharge and follow-up care compliance

Current State of the Revolving Door Problem in North Carolina

Advisory Committee's Role with the "Revolving Door" Pattern

NC DHHS will leverage the NC Crisis System of Care Advisory Committee to advance a report on "revolving door" to the NC General Assembly by January 1, 2027, given the intersection between IVC and the revolving door.



Revolving Door Charge

*"To examine the systemic factors contributing to the prevalent **"revolving door"** pattern in which individuals cycle repeatedly through arrest, detention, or involuntary commitment, only to be released back into the community without sustained stabilization or support. The purpose of the working group is to identify gaps, evaluate current practices, and recommend strategies to interrupt repeated crises and reduce avoidable recidivism," in addition to what has previously been examined and reported as part of community restoration, per [House Bill 1104 \(State Law 2026-38\)](#).*



Timeline

- **September 2026:** Catalogue North Carolina's justice and crisis related investments
- **Now – November 2026:** Engage with the Advisory Committee
- **December 2026:** Share draft "revolving door" report with Advisory Committee
- **January 1, 2027:** Finalize "revolving door" report and submit to the NC General Assembly

Key Gaps Related to the Revolving Door

- Crisis system capacity across crisis response and stabilization
- Justice-related diversion programs
- Community-based treatment programs and care coordination
- Reliance on justice system and law enforcement to respond to and treat behavioral health crises

Intersection of IVC & Revolving Door

Often, people living with MH/SU needs have experiences with law enforcement that lead to cycles of short-term treatment, justice-involvement, and repeated crises that prohibit individuals from successfully accessing community-based, long-term supports.

Common Pathways into the Revolving Door

- Individual accesses crisis services, but does not receive needed supports and/or treatment
- Individual is under IVC orders
- Individual is arrested for a crime or misdemeanor



A key task of the Advisory Committee will be to review and recommend actions that break the revolving door cycle

Key Areas of Improvement in NC's IVC Process

Key Improvement Areas & Initial Solutions

9/30 ADVISORY COMMITTEE MEETING FOCUS

1. Overreliance on IVC to Enter Care

1. Strengthen clinically led crisis access points
2. Create clear pathways to voluntary care
3. Ensure timely clinical input into court processes
4. Expand public awareness of non-IVC options

2.A. Dependence on Law Enforcement

1. Expand alternative transport options
2. Invest in supportive transport

2.B. Dependence on Emergency Departments

1. Increase crisis facility capacity

3. Limited Integration of Crisis System into IVC Evaluation

1. Increase IVC evaluation capacity
2. Expand telehealth evaluations
3. Enable community-based evaluation
4. Streamline care coordination

4. Court & Operational Processes are Difficult to Navigate

1. Standardize training and guidance
2. Improve education
3. Promote least-restrictive alternatives
4. Strengthen cross-system coordination

5. Weak Follow-Up & Community Linkages Contribute to Repeat Crises

1. Ensure rapid post-crisis follow-up
2. Leverage peer support services
3. Strengthen care coordination
4. Expand community-based alternatives

Framework for Advisory Committee Meeting #2 Materials & Discussion

Pre-Read Instructions: Key Areas of Improvement & Solutions

As you review the pre-read materials, consider your **level of agreement** with the problem statements, issues, and solutions presented in this deck. They will be familiar from the Advisory Committee's meeting #1 materials but revised to reflect feedback from the kick-off pre-meeting survey and 9/2 meeting discussion.

Please come prepared to the 9/30 Advisory Committee meeting to discuss your level of agreement with the problem definitions, key improvement areas #1 and #2, and proposed solutions and consider the following questions:

- Does the problem definition resonate with your experience?
- What would you add or modify?
- What other considerations should be raised?
- Will this work in both urban and rural areas? Across regions?
- What concerns do you have about barriers to implement in your community today?
- Is there something similar working in your community today to lift up to the group?
- Are there any potential unintended consequences to this solution to elevate?

9/30 Advisory Committee Meeting Process

- During the 9/30 Advisory Committee meeting, Advisory Committee members will again leverage the **Level of Agreement cards** to provide feedback on the key areas of improvement and proposed solutions included in the pre-read.

Deep Dive on Key Improvement Area: Overreliance on IVC to Enter Care

Problem Definition for Overreliance on IVC to Enter Care

- IVC is overrelied on to enter care due to:
 - Missing opportunities for early intervention and escalation of crises to the point where lower-acuity care is no longer an option
 - Inaccessibility of community-based MH/SU services, whether through a lack of local availability, negative experiences, or other systemic barriers
 - Lack of awareness of other services and programs
- Individuals experiencing a crisis in the community are often routed into a legal process before clinical assessment occurs.
- Current processes reinforce the perception that accessing mental health and substance use treatment requires IVC.

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.

North Carolina's Current & Planned Efforts

- **988**
 - Launched the [988](#) suicide and crisis call and text 24/7 line in July 2022
 - Advanced efforts to integrate 911/988
- **BHUCs & FBCs**
 - Increase capacity and access to BHUCs and FBCs (e.g., both to conduct first exams, FBCs also to conduct second exams)
- **Mobile Crisis**
 - Deployed [mobile crisis teams](#) in all 100 counties and expanded access to [child mobile crisis teams](#) – Mobile Outreach, Response, Engagement, & Stabilization (MORES) – for youth ages 3 – 21
 - Advance sustainable financing approaches (e.g., firehouse funding) for mobile crisis
 - Require all mobile crisis teams to have capability to conduct first exams
 - Improve the quality and responsiveness of mobile crisis teams

Create Clear Pathways to Voluntary Care. Establish statewide referral pathways that connect individuals to voluntary crisis services before legal escalation, whenever clinically appropriate.

North Carolina's Current & Planned Efforts

- **Develop protocols and standardized referral approaches for mobile crisis providers** connected with community partners to help an individual/family go from a 988/Peer Warmline call to EMS/voluntary community-based care, with linkages to schools and hospitals
- Expand programs that deflect and divert individuals from courts and law enforcement settings, including **mobile crisis** and **community-based centers** (e.g., BHUCs, FBCs)

Spotlight: North Carolina's Mobile Crisis 988 Dispatch Pilot

- In March 2026, NC DHHS launched the [Mobile Crisis Dispatch \(MC Dispatch\)](#) pilot program to establish a real-time dispatch process that streamlines response to individuals in crisis wherever they are
- When someone within the pilot region calls 988 and requires mobile crisis response, **MC Dispatch will send a mobile crisis team** or connect the caller with a provider/other local resources
- MC Dispatch is now operating in **27 North Carolina counties**
- NC DHHS will track MC Dispatch outcomes (e.g., response times) to assess response efficiency and service accessibility)

Ensure Timely Clinical Input into Court Processes. Ensure courts and law enforcement receive timely clinical information to assist IVC decision making.

North Carolina's Current & Planned Efforts

- Pilot [Behavioral Health Mobile Crisis Team Partnerships](#) with NC DHHS' 4-year, \$750,000 annual [SAMHSA grant](#) to **integrate mobile crisis teams and 988 within the IVC process** used by magistrates in Bertie, Halifax, Hertford, Northampton counties, to ensure clinical assessments are completed and shared to inform magistrate decision making
 - Magistrates in this pilot will have a **direct line to 988** for mobile crisis coordination to occur at the start of the IVC process
 - The mobile crisis teams should have a certified IVC examiner on staff

Spotlight: Oregon, Rhode Island, & Washington's Clinical Evaluations Process for IVC Petitions

Oregon requires clinical evaluations for IVC petitions to be completed in a timely manner:

- Once a petition is filed, a **Community Mental Health Program officer** immediately conducts an investigation to determine if IVC is needed
- The clinical investigation must be completed **at least 24 hours before the court hearing, which is scheduled within five days of an individual being taken into custody**

Rhode Island requires clinical input *prior to* submission of an IVC petition to a district or family court:

- The petition must include a **certificate signed by two physicians stating that the individual needs inpatient care and treatment**

Washington's Health Care Authority requires **mobile crisis teams** to meet individuals in the field and be able to transport individuals safely to voluntary crisis services; if the mobile crisis determines IVC is the best option, then a **Designated Crisis Responder** is called in to provide an IVC first examination

Expand Public Awareness of Non-IVC Options. Educate families and communities on how to access voluntary crisis services before a crisis escalates.

North Carolina's Current & Planned Efforts

- Encourage individuals to develop **psychiatric advance directives** prior to experiencing crises
- Provide free awareness materials in NC DHHS' [Crisis Services Communications Toolkit](#)
- Train UNC system universities and community college campus staff and students on **suicide prevention training** statewide
- In commemoration of 988 Day, NC DHHS [installed 988 Suicide and Crisis Lifeline signage in state government parking lots](#) throughout Raleigh

Spotlight: Colorado & Washington's Crisis Communication Efforts

Colorado partnered with stakeholders and state agencies to **develop and disseminate clear messaging about 988** and related crisis services

- Includes a [988 Toolkit](#) with customizable materials depending on the audience, platform, and topic

Washington clinicians are required to inform parents of least-restrictive options when children are seeking intensive mental health/substance use services

- WA's Health Care Authority developed [guidance](#), [trainings](#), and [toolkits](#) for its [Family Initiated Treatment \(FIT\) program](#), which allows **parents to request a mental health/substance use assessment for their child** to see if they need involuntary inpatient or outpatient services

Deep Dive on Key Improvement Area: Dependence on Law Enforcement & Emergency Departments

Problem Definition for Dependence on Law Enforcement

- Law enforcement is available 24/7 to respond to emergencies and often becomes the default first responders to mental health and substance use crises as a result.
- Counties are responsible for transportation of an individual for the entirety of the IVC process. Every municipality must develop a county- or city-level transportation plan and submit it to NC DHHS.
 - While they may include non-law enforcement transport options, the majority of the 76 submitted transport plans designate law enforcement as the primary transporters of individuals under an IVC order (i.e., to first exam following custody order, to second exam following first exam that meets IVC criteria, upon discharge).
- Law enforcement's primary job is to protect public safety and enforce laws; serving as primary respondents to mental health and substance use crises puts a strain on law enforcement's ability to execute its primary role.
- Engagement with and reliance on law enforcement – including for transport – during a mental health or substance use crisis also may unintentionally exacerbate the crisis and trauma associated with the experience.

Expand Alternative Transport Options. Reduce reliance on law enforcement transport by expanding clinically appropriate transport options before and after IVC decisions are made.

North Carolina's Current & Planned Efforts

- Expand co-response teams with mental health providers joining law enforcement on mental health/substance use-related calls
- Invest in non-law enforcement transportation (NLET), including mobile crisis teams with transport capabilities, for individuals in mental health crisis to be transported from (1) a crisis to a FBC, BHUC, or ED and (2) from a first examination facility to a second examination facility

Spotlight: Oklahoma & Virginia's Transport Options for IVC

Oklahoma's RideCare program partners with local transportation vendors for individuals who meet emergency detention criteria, using **unmarked vehicles with specially trained drivers to securely assist individuals** with getting to the nearest treatment facility

- RideCare services are engaged if the local mobile crisis team determines they cannot transport the individual and the nearest treatment option is over 30 miles away

Virginia contracts with **alternative transportation vendors** for individuals under IVC orders in which **Special Conservators of the Peace (SCOPs) trained in trauma-informed care** provide transport when a bed becomes available

Invest in Supportive Transport. Reserve law enforcement for acute safety concerns and when engaged for IVC transports, ensure statewide transport protocols on trauma-informed practices are implemented.

North Carolina's Current & Planned Efforts

- Expand [Crisis Intervention Teams \(CIT\)](#) and training with cross-team collaboration with law enforcement community mental health providers, and advocates
- Reserve **law enforcement for involvement in situations involving acute safety concerns**, including individuals identified under Iryna's Law or who have been arrested/pose a community safety risk
- Develop **standardized, trauma-informed guidelines** to inform law enforcement IVC transport, including:
 - Training for transporters (including law enforcement transport)
 - Required transportation capabilities
 - Potential to include peer support

Spotlight: SAMHSA's Principles of Trauma-Informed Care & Application to IVC Transport

SAMHSA's five principles of [trauma-informed care](#) can apply to multiple aspects of the IVC process, including transportation practices:

- *Safety* – Physical and psychological safety is prioritized for all involved (e.g., restraints used only when clinically necessary)
- *Trustworthiness & Transparency* – Individual is informed of what is happening throughout the transport (e.g., pre-transport explanation of destination, process, rights)
- *Peer Support* – Peer support and mutual self-help are key as vehicles for establishing hope and recovery (e.g., peer ride-along programs)
- *Collaboration & Mutuality* – Power differentials between staff and the individual are minimized (e.g., offering music choices during the ride)
- *Empowerment, Voice, & Choice* – Individual's preferences and autonomy are respected (e.g., same-gender staff/officer accompaniment upon request)

Problem Definition for Dependence on EDs

- Mental health/substance use emergencies puts a huge strain on hospitals; the majority of IVC first examinations occur in EDs, as opposed to other community-based crisis settings (e.g., BHUCs, FBCs).
 - There is anecdotal evidence that FBCs often deny accepting someone under an IVC petition.
 - In certain areas of the state, EDs will not release individuals to FBCs due to EMTALA.
- EDs continue to serve as the primary setting for both physical *and* mental health/substance use crisis stabilization.
- However, most EDs are better suited to managing physical health than mental health/substance use emergencies.
- Individuals awaiting mental health treatment may end up boarding in EDs until a bed or other placement becomes available. This can result in days or weeks in an ED, often in noisy, harshly lit, chaotic settings – sometimes physically restrained.

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.

North Carolina's Current & Planned Efforts

- **Strengthen BHUC ability to conduct IVC first examinations** by standardizing facility requirements and reimbursement and addressing staffing constraints
- Increase accountability measures for **FBCs to accept patients under IVC orders and conduct second examinations**, as appropriate

Map of BHUCs in North Carolina



BHUCs provide immediate help, but not hospital-level care, 24/7 for up to 23 hours of support. BHUCs are required to conduct *first examinations* for individuals under IVC orders.

Map of FBCs in North Carolina



FBC centers for more intensive care and a safe place to stay for more than one day, including short-term inpatient mental health stabilization and substance use detox. FBCs can conduct *second examinations, hold, and treat* individuals under IVC orders.

Appendix

Article 5. Procedure for Admission and Discharge of Clients.

Part 1. 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.
 - Note: "Reasonable grounds" and "probable cause" are both used in statute as the basis by which magistrates must make their decision to issue a custody order and advance the IVC process.

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, 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, 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, the individual can be taken to a 24-hour receiving facility by law enforcement so a qualified professional can perform the second examination.