

North Carolina Crisis System of Care Advisory Committee

Meeting Minutes

In-Person Meeting | Wednesday, September 2, 2026 | 9:00 AM – 1:00 PM ET | Albemarle Building 325 N Salisbury Street, Raleigh, North Carolina

Co-Chairs:

Kelly Crosbie, Assistant Secretary, of the Division of Mental Health, Substance Use Services, Developmental Disabilities (DMH/DD/SUS), North Carolina Department of Health and Human Services (NC DHHS)

Sherry Hunter, Deputy Secretary of Professional Standards, North Carolina Department of Public Safety (NC DPS)

Attendees

Advisory Committee Members Present – Joe Amos; Ashley Barber; Greg Berry; Robert Broughton; Cherene Caraco; Marisa Cornell; Lauren Earnhardt; Kevin FitzGerald; Sonja Frison; Jonah Garson; Allison Gosda; Natasha Holley; Ariana Huselid; Nicholle Karim; Colleen Kochanek; Laura McIlvaine; Candice Moore; Marcia Morey; Tara Muller; Regina Parker; Jeff Prichard; Kelly Redmon; Lillie Rhodes; Sy Saeed; Marvin Swartz

Advisory Committee Members Absent – Mark Botts; Kimberly Clement; Spencer Merriweather; Timothy Reeder; Nidhi Sachdeva

Staff Members Present – Devon Adams; Mary Carla Babb; Carrie Brown; Arthur Campbell; Lisa DeCiantis; Katie Gold; Hanaleah Levy Hoberman; Orlando Rodriguez; Emily McGee; Angela Smith; Madhu Vulimiri; Karen Wade; Becky Zornick

Guest Facilitators Present – Zoe Barnard; Giuliana Del Guercio; Madeleine Toups Tranchina; Arielle Traub

Members of the Public Present – Amanda Dale; Gabby Chiarenza; Twamasi Duah-Mensah; Michael Duncan; Denise Foreman; Sanduya Gopal; Carla Huff; Taylor Knopf; Katy Kranze; Timothy Lentz; Keischa Lovelace; Martha Turner-Quest; David Walker

Agenda

- I. Welcome & Introductions
- II. Overview of the North Carolina Crisis System
- III. Involuntary Commitment (IVC) in North Carolina & Opportunities for Reform
- IV. Wrap Up & Next Steps

Agenda Topic: Welcome & Introductions

- Co-Chairs Kelly Crosbie, Assistant Secretary for DMH/DD/SUS with NC DHHS, and Sherry Hunter, Deputy Secretary of Professional Standards with NC DPS, opened the inaugural meeting of the North Carolina Crisis System of Care Advisory Committee by thanking members for their time and commitment. They emphasized the value of hearing from community members and other stakeholders.
- The Co-Chairs provided an overview of the Advisory Committee's goals:
 - Improve the lives of those living with mental health and/or substance use (MH/SU) 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; and
 - Foster collaboration and coordination across public and private sector partners engaged in crisis system modernization efforts.
- Advisory Committee members introduced themselves and summarized their experience in the MH/SU field and reasons for participating in the Committee.

Agenda Topic: Overview of the North Carolina Crisis System

History of the Crisis System in the United States

- Presented on the history of the crisis system in the United States, emphasizing that:
 - Historically, law enforcement agencies and inpatient institutions served as the primary responders for individuals with severe MH/SU needs.
 - The community-based MH/SU safety net is a relatively recent development that builds on decades of reform, and the Advisory Committee's work should consider both historical context and current system gaps.

Overview of the Crisis System in North Carolina

- Emphasized North Carolina is in the process of building a crisis system of care based on best practices and national guidelines.
- Lisa DeCiantis described ongoing efforts to improve access to MH/SU services, including raising awareness of 988, expanding peer warmlines, and implementing other initiatives to de-escalate crises. Standardized statewide protocols for 911 handoffs to 988 are under development.

Additional Discussion

- Members highlighted other initiatives in which they are involved to improve crisis services across the state, including the North Carolina Statewide Telepsychiatry Program (NC-STeP), Crisis Intervention Team (CIT) training for law enforcement, and community response teams.
 - Sy Saeed described NC-STeP as an initiative that began in response to people in crisis being held in emergency departments (EDs) without adequate treatment and later expanded to help bring treatment into safe care settings.
 - Jeff Prichard noted that CIT training has changed law enforcement practice in Alamance County, where many officers have completed training and are recognized as trained crisis responders.
 - Cherene Caraco noted that some 988 calls are transferred to the peer warmline, which can help callers receive support when peer support is more appropriate.
- Members noted that limited information sharing across systems, such as clinical care and social services, can contribute to uncoordinated and delayed services.
- Members with law enforcement experience emphasized that staffing and capacity constraints are major barriers to accessing the crisis system, contributing to reliance on law enforcement and EDs to fill service gaps.

Agenda Topic: IVC in North Carolina & Opportunities for Reform

Advisory Committee members discussed three overarching issues with the current IVC process: 1) how individuals enter the crisis system without first accessing lower-acuity, voluntary care, 2) reliance on law enforcement to transport individuals, and 3) the role of the ED in receiving and evaluating individuals under IVC orders. Members discussed:

How Individuals Enter the IVC Process

- Members discussed the multiple pathways into IVC, including petitions initiated in the community and cases that begin in EDs. Robert Broughton noted that a substantial share of cases begin in EDs, while Tara Muller emphasized that petitions can be filed by a broad range of individuals.
- Members raised concerns that IVC may be relied upon when voluntary, lower-acuity, or community-based services are unavailable, difficult to access, or not trusted by law enforcement, families, or community members.
- Members also discussed situations in which individuals with MH/SU needs voluntarily seek hospital care but later experience an IVC after arriving, raising questions about how voluntary care can be preserved when clinically appropriate.
- Members noted that understanding how and why people enter the IVC process is essential for determining where policy, training, service access, or data improvements could reduce unnecessary petitions.

Magistrate Review, Training, & Petition Requirements

- Members discussed the role of magistrates as an early check in the IVC process and raised questions about how magistrates can make informed decisions when reviewing petitions, particularly during nights or weekends and in communities with limited crisis resources.
- Laura McIlvaine suggested that magistrates should be consistently included in education and planning efforts. Awareness of available services varies by county, and magistrates are not consistently involved in educational efforts.
- Joe Amos noted that magistrates receive limited IVC-specific training (approximately two hours) and suggested that more robust training through the University of North Carolina at Chapel Hill's School of Government could help reduce unnecessary petitions.
- Tara Muller suggested revising petition forms or processes to require petitioners or magistrates to document whether available crisis options, such as Local Management Entity/Managed Care Organization (LME/MCO) resources or mobile crisis, had been considered before an IVC petition proceeds.
- Regina Parker noted that magistrates often make difficult decisions under time pressure, take their responsibilities seriously, and may not always be able to reach crisis system partners. Members emphasized that solutions should recognize both the importance of magistrate review and the practical limitations that magistrates face.

Data Availability, Data Coordination, & System Performance

- Members identified a need for more complete data on the IVC process, including where petitions originate, who files them (e.g., clinicians, families, hospitals, schools, neighbors, others), why they are filed, whether the individual was already receiving services, dismissed petitions, first and second examination outcomes, transportation practices, racial and socioeconomic trends, post-release outcomes, how individuals use services before and after a crisis, and whether voluntary or lower-acuity alternatives were attempted before IVC.
 - Marvin Swartz noted that work is underway to obtain data related to transportation for IVC from the North Carolina Administrative Office of the Courts.
- Members discussed the importance of identifying what data the state has, what data is missing, how individuals engage with services before and after crisis events, and what post-crisis follow-up care is available.

Transportation & Reliance on Law Enforcement

- Members raised concerns that IVC may sometimes be used by hospitals and EDs primarily to secure transportation to treatment, rather than because involuntary treatment is needed.
- Marvin Swartz noted that risk-averse providers may call law enforcement or seek IVC petitions to move

individuals from one setting to another, which can have a corrosive effect on the purpose of the IVC process.

- Lauren Earnhardt and Kelly Redmon shared that law enforcement may not always have clear guidance on when transport-related situations require the involvement of law enforcement. Additionally, sheriffs' offices may prefer to transport an individual as opposed to waiting with the individual for long periods of time in an ED.
- Members identified a need to better understand transportation alternatives, including what the state and counties could support to reduce the burden on law enforcement while maintaining safety for individuals and communities.

Youth & Families Impacted by IVC

- Members discussed youth-specific concerns, including the use of IVC for children and adolescents and the interaction between the crisis system, hospitals, families, and juvenile justice settings.
- Sonja Frison raised concerns about youth with MH/SU needs being held in detention settings or returned to detention when appropriate treatment options are unavailable.
- Tara Muller and Cherene Caraco emphasized that families may misunderstand how voluntary and involuntary processes impact parental rights, youth placement, and where a child may be transported for treatment.
- Robert Broughton provided an example that children are put under IVC orders if parents or guardians disagree with the providers' treatment plan and/or facility placement.
- Members discussed the need for crisis pathways that better support families before, during, and after a crisis in order for families not to be left to navigate a complex system alone.

EDs, Hospitals, & Clinical Assessment

- Members discussed how EDs often become default crisis settings when community-based alternatives are unavailable. Patients, providers, and lawmakers view EDs as a setting that is more immediately accessible.
- Colleen Kochanek noted that hospitals can be appropriate when there are acute medical and behavioral health needs, but that individuals may become stuck in the ED after medical clearance without receiving appropriate follow-up and continued MH/SU treatment.
- Sy Saeed emphasized the importance of high-quality clinical assessment and diagnosis and noted that these types of preventive services should begin prior to the individual presenting in the ED.
- Members discussed the need to understand first and second examination outcomes and whether individuals could have been diverted to voluntary or community-based care earlier in the process.

Community-Based Alternatives and Low-Barrier Services

- Members discussed the difficulty and potential trauma some individuals experience when accessing MH/SU services, underscoring the need for care that is low-barrier, destigmatized, and accessible.
- Marisa Cornell emphasized that the mental health system can be inaccessible and have high barriers to entry, while law enforcement and hospitals often function as low-barrier entry points. She noted that successful programs are often those that are easy to access, low stigma, and responsive.

Local Implementation, Communication, & Cross-System Collaboration

- Members emphasized the importance of community outreach and education, as well as embedding the use of crisis services into existing policies and processes when awareness alone is insufficient.
- Cherene Caraco shared the ongoing work in Wake County that brought together multiple stakeholders examining community response teams and developed recommendations for improved services and crisis system coordination.
- Natasha Holley described the importance of community outreach and noted that each community has a different culture, which affects whether services such as mobile crisis are recognized and used.
- Greg Berry emphasized that community coalitions and cross-sector partnerships can help law enforcement and MH/SU providers build relationships and connect individuals to specialists.

Agenda Topic: Wrap Up & Next Steps

- The meeting concluded at 1:00 PM ET.
- The next meeting will be held on September 30, 2026, from 9:00 AM to 1:00 PM ET in Raleigh, North Carolina (location to be announced).
- Advisory Committee members were invited to complete a [post-meeting survey](#).