North Carolina Crisis System of Care Advisory Committee

Meeting Minutes

In-Person & Virtual Hybrid Meeting | Wednesday, September 30, 2026 | 9:00 AM – 1:00 PM ET |
NC State Laboratory of Public Health, 4312 District Drive, 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 **–**

- *In-Person*: Joe Amos; Mary Carla Babb; Greg Berry; Mark Botts; Robert Broughton; Carrie Brown; Arthur Campbell; Cherene Caraco; Kimberly Clement; Lauren Earnhardt; Kevin FitzGerald; Sonja Frison; Allison Gosda; Mary Grillo; Ariana Huselid; Nicholle Karim; Tamzin Kinnett; Colleen Kochanek; Christy Land; Laura McIlvaine; Spencer Merriweather; Tara Muller; Jeff Prichard; Kelly Redmon; Lillie Rhodes; Johana Troccoli
- *Virtual*: Danny Earl Britt, Jr.; Marisa Cornell; Jonah Garson; Natasha Holley; Candice Moore; Marcia Morey; Timothy Reeder; Sy Saeed; Angela Smith; Marvin Swartz

Advisory Committee Members Absent – Ashley Barber; Christopher Graves; Nidhi Sachdeva; Orlando Rodriguez; Regina Parker

Staff Members Present – Lisa DeCiantis; Kindl Shinn Detar; Katie Gold; Hanaleah Levy Hoberman; Emily McGee; James Werner; Becky Zornick

Members of the Public Present In-Person – Diane Arms; Devon Barnhardt; Jessica Cruz; Avery Davis; Sandhuya Gopal; Taylor Knopf; Stephanie Oliver; Mark Olexnik; Erik Ruiz; Andrea Skidmore; Lexi Solaman

Guest Facilitators Present

- *In-Person*: Zoe Barnard; Giuliana Del Guercio; Tony Fiori; Arielle Traub
- *Virtual*: Amanda Fischman; Niki Reddy; Ashley Traube, Madeleine Toups Tranchina

Agenda

I. Agenda, Goals, & Meeting Objectives
II. Aligning on Current State
III. Key Improvements & Solutions
    a. Overreliance on Involuntary Commitment (IVC) to Enter Care
    b. Dependence on Law Enforcement & Emergency Departments (EDs)
IV. Wrap Up & Next Steps

Agenda Topic: Agenda, Goals, & Meeting Objectives

Meeting Opening and Introduction of New Members

- Co-Chair Sherry Hunter, Deputy Secretary of Professional Standards with NC DPS, opened the North Carolina Crisis System of Care Advisory Committee meeting by thanking members for their time and commitment. Sherry introduced new members of the Advisory Committee who have joined since the last meeting, including:
    - Senator Danny Earl Britt, Jr. of the NC General Assembly
    - Mary Carla Babb, Dr. Arthur Campbell, Mary Grillo, and Orlando Rodriguez of the NC Department of Adult Correction (NC DAC)
    - Christopher Graves of Wake County Magistrates
    - Christy Land of FirstHealth
    - Johana Troccoli of Duke University Health System

Level of Agreement Exercise

- Sherry reviewed the meeting objectives: 1) Align on the current state of the IVC process and 2) Identify improvement opportunities related to overreliance on IVC, dependence on law enforcement, and dependence on EDs.
- Members were asked to use a five-point "level of agreement" scale to indicate agreement with the current state descriptions, problem definitions, and proposed solutions, and to identify modifications, implementation barriers, geographic considerations, and potential unintended consequences.

Approval of 9/2 Meeting Minutes

- The Advisory Committee approved the minutes from the 9/2 North Carolina Crisis System of Care Advisory Committee meeting.

Agenda Topic: Aligning on IVC Current State

IVC Process Flow

- Members reviewed the updated IVC process flow detailing what happens when an individual goes through the IVC process. Members generally agreed that the updated IVC process flow—revised to reflect feedback from the 9/2 Advisory Committee meeting—better reflected the statutory process.
    - Robert Broughton noted that individuals may remain at the site of the first IVC examination under an initial custody order for up to seven days while awaiting inpatient psychiatric admission. If, after seven days, the individual still remains at the site of the first examination awaiting such placement, then the initial custody order is automatically terminated. If – after such a termination - providers determine it remains necessary to continue seeking inpatient psychiatric admission of the individual, the commitment examiner must submit a new petition and the individual must be reassessed via a new first examination. If a new custody order is issued in response to this new examination, the seven-day clock starts anew. This process may be repeated indefinitely, with the individual detained at the site of first evaluation, until either the individual no longer meets commitment criteria or is admitted to an inpatient psychiatric unit. Members noted that repeated renewals can result in individuals waiting beyond seven days prior to admission to a 24-hour receiving facility.
- Tamzin Kinnett and Mark Botts explained that many cases are resolved between the second IVC examination and district court hearing that is required to occur within 10 days of a custody order. This may be through discharge (e.g., a person is not found to meet IVC criteria during the second IVC exam), termination of IVC proceedings, or another disposition. Members discussed variation across counties in when counsel is appointed and when individuals meet with counsel during the IVC process.
- Members emphasized that an individual's clinical condition may change after the first IVC exam due to medication and/or stabilization at the site of the first exam. This can explain why someone may no longer meet IVC criteria within a few days of initially being found to meet IVC criteria, either at the site of the first exam or once transported to the site of the second IVC examination. Other members raised concerns about consistency in applying IVC criteria (e.g., IVC proceedings are initiated for people who do not meet criteria;

individuals are discharged but pose a public safety risk) and the limited data available about cases resolved before a district court hearing following the second exam (e.g., IVC proceedings that are dismissed prior to a court hearing are not reported to a publicly available database. This information could inform public safety-related decisions, like firearm ownership).
- Members discussed the need for timely discharge planning after IVC, follow-up care, and wraparound supports. They noted that the setting and supports available at discharge may affect clinical risk (e.g., someone with housing instability vs. someone with robust caregiver support) and whether an individual returns to crisis care, exacerbating the "revolving door."

Availability of Data on IVC
- The Advisory Committee discussed the availability of IVC data. Members agreed that available data is limited, dated, and imprecise.
- Members emphasized that the IVC petition counts do not reflect the number of unique individuals receiving an IVC petition or number of repeat petitions. The data also does not reflect qualitative indicators, such as reasons for petition, discharge or termination of proceedings, dispositions, treatment availability, or an individual's outcomes after discharge.
    - Kevin FitzGerald noted that current data do not adequately measure the frequency or speed of the "revolving door."
    - Cherene Caraco described prior efforts to compile North Carolina Administrative Office of the Courts (AOC) data. While the AOC data shows substantial growth in IVC petitions between 2009-2021, it does not provide individual-level information on hospitalization or disposition.
    - Nicholle Karim highlighted opportunities to improve information collected through eCourts forms and IVC custody order records.
- Members recommended linking legal, clinical, service-use, and outcome data and examining variation by community, available treatment capacity, and urban or rural context. Sy Saeed noted that the North Carolina-Statewide Telepsychiatry Program (NC-STeP) data may offer additional information on IVC petitions for people who were not found to meet IVC criteria after the first examination.

Agenda Topic: Key Areas of Improvements & Solutions

Advisory Committee members discussed three areas of improvement with North Carolina's current IVC process: 1) overreliance on IVC to enter care, 2) reliance on law enforcement to transport individuals to first exams, second exams, and upon discharge from 24-hour receiving facilities, and 3) the role of the ED in receiving and evaluating individuals under IVC orders. Members rated their level of agreement with the problem statements associated with each issue, as well as level of agreement with each associated solution. They also raised considerations across each area.

<u>Overreliance on IVC to Enter Care</u>

Problem Statement
- Members generally agreed that IVC is often used as an entry point to care because voluntary and lower-acuity services have not been available or accessible prior to a crisis escalating. Members cautioned that available resources differ substantially across urban and rural communities.
- Members emphasized that crises may be driven by housing, family, social, or other non-clinical needs and that clinical access points should be paired with peer supports and community-based responses. Cherene Caraco and Greg Berry cautioned against defining all crises solely through a clinical lens.
- Several members noted that IVC cannot be entirely eliminated; they stressed the need to distinguish unnecessary IVC petitions from situations involving acute illness and significant safety concerns.

Solutions
- **Strengthen clinically led crisis access points.** Members generally agreed on expanding and normalizing access to 988, mobile crisis teams, behavioral health urgent care centers (BHUCs), facility-based crisis (FBC) centers, outpatient providers, and co-response models.

- Kelly Redmon and Joe Amos cautioned that many rural communities have limited or none of these crisis resources and that mobile crisis teams may take two to three hours to respond.
- Christy Land noted that BHUCs and FBCs in south-central North Carolina may not accept individuals under an IVC order or may transfer individuals to an ED if they become aggressive. Other Committee Members noted that this also occurs in other parts of North Carolina.
- Cherene Caraco and Greg Berry emphasized the importance of pairing clinical services with peer-led services and other non-clinical approaches that address social drivers of crisis and engender trust.
- Candice Moore recommended building on crisis approaches already working in local communities, rather than creating entirely new structures.

- **Create clear pathways to voluntary care.** Members generally agreed to a standardized, statewide pathway that can connect individuals to voluntary services before legal escalation, regardless of payer.
  - Co-Chair Kelly Crosbie and Carrie Brown suggested positioning 988 as a recognizable "front door" that can route people to the appropriate level of crisis services and care. They also emphasized that MH/SU providers must be able to respond and should not turn people away.
  - Sy Saeed urged the Advisory Committee to view crisis care as a continuum beginning with screening, primary care, psychiatric access, peer support, and medication management rather than starting only after a person experiences a crisis and presents to an ED or is under an IVC order.
  - Spencer Merriweather cautioned that creating additional access points for community-based MH/SU services may have a limited impact in communities where MH/SU capacity remains insufficient.
  - Marvin Swartz recommended explicitly addressing the need for increased transportation supports to help people reach voluntary care.
- **Ensure timely clinical input into court processes.** Members agreed on the need to provide magistrates and law enforcement with timely clinical information through mobile crisis teams, co-response teams, or telehealth before an IVC custody order is executed. Co-Chair Kelly Crosbie shared that DMH/DD/SUS will pilot a mobile crisis-magistrate partnership in four counties for mobile crisis teams to share clinical information with magistrates to inform IVC orders.
  - Tamzin Kinnett noted that individuals petitioned in the community often dispute the allegations detailed in an IVC petition and have no immediate opportunity for clinical evaluation.
  - Lauren Earnhardt agreed that magistrates need more support but raised implementation concerns in sharing clinical information with magistrates. For example, she explained that once the law enforcement officer serves an IVC order, the individual is not initially brought to the magistrate for assessments or verification of the petition; rather, the individual is brought to a facility (e.g., ED, BHUC) for a first IVC examination. She inquired how the role of law enforcement would change if magistrates and courts received clinical input prior to acting on IVC petitions.
  - Mark Botts added that any changes would need to align with existing law or be accompanied by statutory changes.
  - Members also noted that implementing clinical information-sharing with magistrates would require dependable 24/7 clinical capacity, clear delineation of responsibilities among clinicians, courts and law enforcement, and protocols for urgent safety concerns.
- **Expand public awareness of non-IVC options.** Members agreed to increased education and related materials for families, residential facilities, schools, and communities on available crisis resources, how to access voluntary care, and the process and impact of IVC.
  - Tara Muller recommended that educational materials explain what occurs once an IVC petition is filed and the potential impacts associated with IVC, such as stigma, transportation limitations, and financial losses.
  - Nicholle Karim noted that educational materials should also reach residential settings where IVC petitions may originate.
  - Sonja Frison emphasized that youth with aggression or substance use needs are often removed from community settings or returned to detention facilities even after IVC stays, making it difficult for youth to engage in non-institutional settings.
  - Kevin FitzGerald encouraged the Committee to distinguish individuals using IVC as a first entry point from individuals experiencing repeated IVC episodes.

- Members stressed that awareness efforts about non-IVC options must be complemented by reliable, locally available services and timely response.

Dependence on Law Enforcement

Problem Statement

- Members agreed that law enforcement is available 24/7 and often become the default responders and transporters to crises when other crisis resources are unavailable; members agreed this creates strain on public-safety resources.
- Members clarified that transportation needs occur at multiple points during an IVC petition, such as transport from the community to a first IVC examination, between facilities (e.g., ED or BHUC to an inpatient treatment facility), and after discharge (e.g., inpatient treatment facility to home, ED to home).
- Advisory Committee members raised questions about oversight and accountability for maintaining and implementing counties' IVC transportation plans. Most current county plans identify law enforcement as the transport provider.
- Advisory Committee members associated with EMS and hospital/health systems noted that reimbursement, destination rules, liability, and federal requirements can limit who transports people to EDs.
- Members also emphasized the need for safe, trained transporters and highlighted issues with poorly trained/vetted private transport arrangements.

Solutions

- **Expand alternative transport options.** Members agreed on reducing reliance on law enforcement through clinically appropriate transport before and after IVC decisions.
    - Lauren Earnhardt emphasized that shorter travel distances would reduce trauma for individuals under IVC orders and minimize the time law enforcement spends outside its home jurisdiction. She encouraged the state and counties to consider alternatives that allow officers to focus on acute public-safety needs. Additionally, she noted that all available county transportation plans require law enforcement transport upon discharge after an IVC stay. She noted this is when there is the least amount of public safety concerns and officer involvement is not necessary.
    - Marvin Swartz cautioned that mobile crisis teams and other alternative responders already face capacity constraints and that expanding their transportation role would require substantial investment.
    - Laura McIlvaine added that many current service definitions for outpatient MH/SU services (as outlined in North Carolina's Clinical Coverage Policies) do not permit transportation and that implementation would require additional provider capacity.
    - Kimberly Clement noted that EMS can be an option as a primary transporter for individuals under IVC order but faces financial, facility, and liability constraints. Christy Land explained that hospital-owned EMS companies may be required to transport individuals to an ED, as opposed to a BHUC or FBC for a first IVC examination due to hospital protocols and procedures.
    - Members agreed that transportation responsibilities, payment, safety standards, and decision-making authority must be clearly defined.
- **Invest in supportive transport.** Members agreed on reserving law enforcement for acute safety concerns and designing transport around trauma-informed practices, peer supports, and family involvement when appropriate, and ensuring that individuals travel shorter distances to examination sites.
    - Greg Berry recommended embedding peer supports within the IVC process (e.g., upon discharge, after interacting with law enforcement) to increase engagement and ensure that transport is supportive in practice.
    - Kelly Redmon noted that 24-hour facilities often request secure transport when a person is taken to a 24-hour facility. When a safety risk is a concern, mobile crisis teams may not be able to meet that need.
    - Jeff Prichard suggested including family members as an option for transport, when clinically appropriate, rather than defaulting to a formal responder.

- Members recommended increasing accountability measures for county transportation plans so they are up-to-date and encouraging counties to explore alternatives to law enforcement transportation.
- Members recommended clarifying roles and responsibilities during implementation of alternative transport programs and identifying sustainable funding options across public and private sectors.

Dependence on EDs

Problem Statement

- Members agreed that EDs frequently serve as the default site for medical screening, behavioral health stabilization, and first IVC examinations because they are accessible and known to the public, and other settings (e.g., BHUCs, FBCs) may lack medical, staffing, or security capacity.
- Colleen Kochanek emphasized that there are multiple reasons people may end up boarding in EDs. One is because individuals are found to meet IVC criteria and are waiting for an inpatient bed (24-hour receiving facility to accept them). Another reason is that individuals may be stabilized, no longer meeting IVC criteria and are ready to leave the ED but community supports (e.g., case management, outpatient treatment) are unavailable. Christy Land cited lengthy ED boarding periods for children and adolescents.
- Members discussed that 24-hour receiving facilities have inconsistent requirements about physical health screenings for individuals under IVC order. In some instances, inpatient treatment facilities may require additional labs and bloodwork, requiring an individual to be transported to the ED from a BHUC or FBC to get those tests done before moving to a 24-hour receiving facility.

Solutions

- **Increase crisis facility capacity.** Members supported strengthening BHUCs and FBCs as sites for first IVC examinations, while noting that these facilities must receive adequate reimbursement, secure appropriate health care provider and safety personnel staffing, conduct health assessments, and consistently accept individuals under IVC orders.
    - Members recommended co-located physical and behavioral health services, telepsychiatry, and warm handoffs upon discharge, rather than separating physical and behavioral health care.
    - Members also recommended developing a clearer triage framework that can be used by 988, EMS, law enforcement, providers, hospitals, and families to identify the appropriate level and location of care, including peer respite, crisis residential care, outpatient services, and substance use treatment.

Agenda Topic: Wrap Up & Next Steps

- The meeting concluded at 1:00 PM ET.
- The next meeting will be held on October 28, 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.