

North Carolina Crisis System of Care Advisory Committee

Pre-Read Materials for Advisory Committee on October 28, 2026

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Overview of the Revolving Door Pattern in North Carolina

Instructions for Review & Discussion

Pre-Read Instructions: Revolving Door Pattern

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

- Do you agree with the description of the population(s) that cycle in and out of the "revolving door" in North Carolina? If not, how would you modify the description?
- Do you agree that that many of the causes of the "revolving door" pattern are the same as those contributing to IVC?

10/28 Advisory Committee Meeting Process

- During the 10/28 Advisory Committee meeting, Advisory Committee members will leverage the **Level of Agreement cards** to provide feedback on the revolving door pattern included in the pre-read.

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

The NC Crisis System of Care Advisory Committee will advance a report on the "revolving door" to the NC General Assembly by January 1, 2027, given that individuals with IVC get caught up in the "revolving door".

Revolving Door Charge

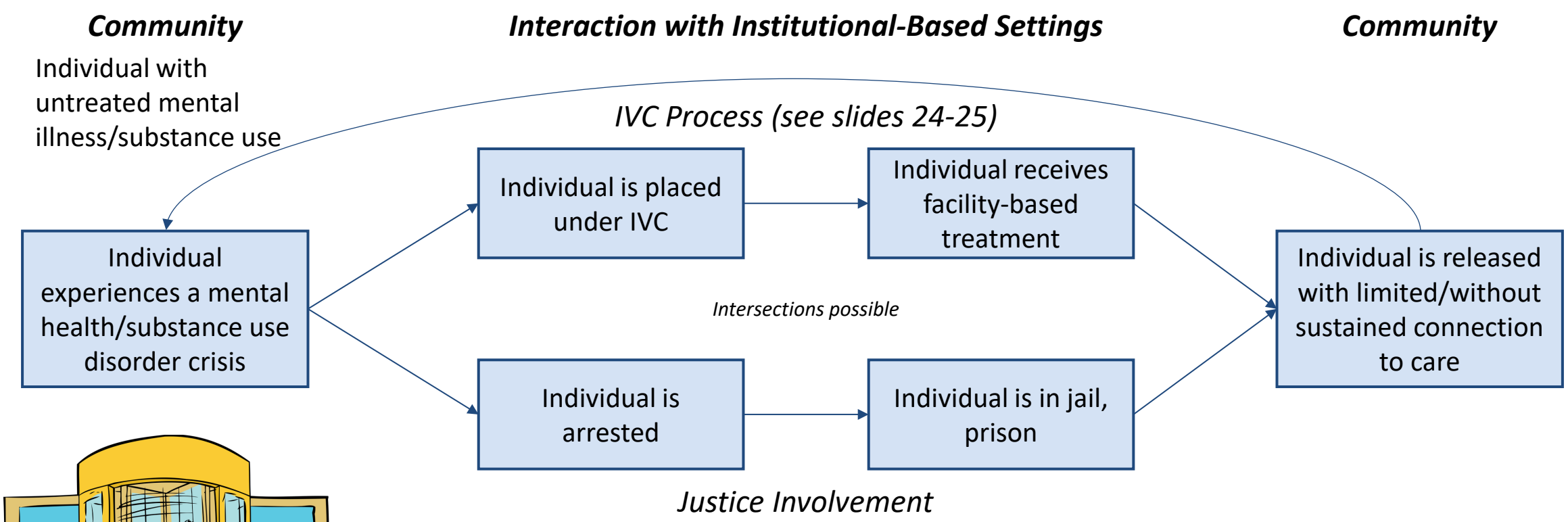
*"To examine the systemic factors contributing to the prevalent '**revolving door' pattern in which individuals cycle repeatedly through arrest, detention, or involuntary commitment, only to be released back into the community without sustained stabilization or support.** The purpose of the working group 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).*

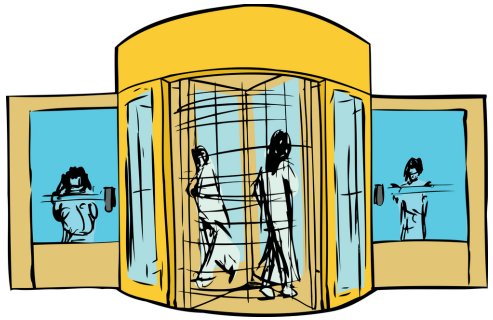
Timeline

- **September - October 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

The Populations that Cycle In and Out of the "Revolving Door"

The North Carolina General Assembly defines the populations that get caught in "revolving door" as individuals with mental health and/or substance use needs who "cycle repeatedly through arrest, detention, or involuntary commitment, only to be released back into the community without sustained stabilization or support."[1]





[1] General Assembly of North Carolina Session 2025, Session Law 2026-38

Contributing Factors to the “Revolving Door” Pattern

A substantial portion* of individuals experiencing mental health and substance use crises cycle in and out of arrest, detention, and IVC because of:

- Insufficient capacity and limited utilization of **community-based crisis services and outpatient care.**
- Insufficient **data and tracking of individuals** placed on IVC and/or interacting with the justice system.
- **Overreliance on law enforcement to respond to MH/SU crises.**
- Inadequate **follow-up and connection to community-based treatment** for individuals following IVC, arrest, and/or detention.
- Lack of **housing, employment, and social supports.**

While many of these factors are relevant to people experiencing MH/SU crises with no justice system involvement, for people with justice involvement, **inadequate** MH/SU **treatment in jails and prisons** is also a factor that exacerbates the revolving door pattern.

** Data is not conclusively available on the scale of the revolving door pattern.*

Key Areas of Improvement in North Carolina's IVC Process & Intersections with the Revolving Door Pattern

Key Improvement Areas & Initial Solutions

10/28 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 Provider Capacity & Cross-System Integration

1. Build Crisis Provider Capacity to Support IVC Process
2. Expand Telehealth Capacity for IVC First Exams
3. Improve Collaboration Between Community-Based Crisis Providers & EDs

4. Court Processes are Difficult to Navigate

1. Strengthen & Standardize Training & Guidance
2. Promote Least Restrictive Alternatives to Care
3. Increase Person-Centered Supports During IVC Proceedings

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

Instructions for Review & 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 (slides 11-20).

Please come prepared to the 10/28 Advisory Committee meeting to discuss your level of agreement with the problem definitions, key improvement areas #3 and #4, 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?

10/28 Advisory Committee Meeting Process

- During the 10/28 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 #3: Limited Provider Capacity & Cross-System Integration

Problem Definition for Limited Provider Capacity & Cross-System Integration

Crisis Provider Capacity

- While BHUCs and FBCs are authorized to conduct first IVC exams, they do not consistently do so due to:
  - Safety concerns;
  - 24-hour receiving facility protocols with additional requirements beyond the first IVC examination (e.g., bloodwork); and,
  - Inconsistent onsite capabilities of maintaining appropriate supervision over individuals under IVC orders.
- Some, but not all, of North Carolina's 40+ BHUCs and FBCs leverage telehealth to support trained and timely IVC first exams.
- It is challenging today to conduct an IVC first exam in the community via mobile crisis teams, which do not currently require IVC examiners on staff.

Lack of System Integration

- Information is not routinely shared among community-based crisis providers and EDs, which can result in duplicating information gathering, prolonging potentially stressful experiences for individuals.
- Individuals may remain in the ED for days or weeks after the first IVC exam, waiting for a bed to open in a 24-hour receiving facility.
  - Individuals who are waiting to be transferred to a 24-hour receiving facility for the second IVC examination can be held beyond the 7-day limit if petitions are continually refiled and renewed (122C-263(d)(2)).
  - There is limited data available today on the length of ED boarding for individuals under IVC orders who are waiting a 24-hour receiving facility bed.
  - Lengthy ED boarding stays can contribute to additional trauma and stress for individuals under IVC orders.

During the 9/30 Advisory Committee meeting, members discussed how community-based crisis options are limited in their ability to consistently conduct IVC exams, contributing to overdependence on hospital systems.

Build Crisis Provider Capacity to Support IVC Process. Position mobile crisis teams, BHUCs, and FBCs can conduct IVC first examinations and minimize dependence on hospitals.

North Carolina's Current, Planned & Proposed Efforts

- **Strengthen requirements and oversight for BHUCs and FBCs to conduct IVC first examinations:**
  - Improve oversight and accountability measures
  - Standardize facility requirements and reimbursement
  - Address staffing constraints
  - Develop statewide guidelines to conduct lab work onsite (which is often required by 24-hour receiving facilities) without additional transfer to an ED
- **Require mobile crisis teams to have IVC-designated evaluators** embedded within the team or available via telehealth to conduct IVC first examinations when responding to a crisis
  - Including, partnering with LME/MCOs to develop a plan to further leverage IVC first examiners on mobile crisis teams (per SL 2026-38)
- **Pilot co-response teams with mental health providers trained in IVC evaluation joining law enforcement** on mental health or substance use-related calls

State Example

Kentucky

- Requires "crisis stabilization units" to provide IVC first examinations before an individual is transported for treatment (either to a hospital or inpatient psychiatric facility)
- Crisis facilities must assist with the transfer of individuals to hospitals



This proposed solution builds on solutions and discussion from the 9/30 Advisory Committee meeting.

Source: NC DHHS' Community Crisis Center Map.

Expand Telehealth Capacity for IVC First Exams. Expand capacity for EDs and community-based providers to leverage telehealth for IVC first examinations.

North Carolina's Current & Planned Efforts

- **Improve telehealth first examination access** for North Carolina's EDs *and* community-based crisis providers (e.g., BHUCs, FBCs, mobile crisis teams), particularly in areas with provider shortages (e.g., rural areas, pediatric specialty)
- **Support NC Sheriffs' Association efforts to advance planning on a pilot program in county jails** to utilize telehealth services to conduct IVC first exams (pilot plan due to the NC General Assembly in March 2027, per SL 2026-38)

Spotlight: NC's Statewide Telepsychiatry Program (NC-STeP)

NC-STeP has connected 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.
- Since NC-STeP was established, it estimates $67.4M in savings from preventing unnecessary hospitalization discharging individuals after first IVC examinations

Improve Collaboration Between Community-Based Crisis Providers & EDs. Coordinate IVC data collection, transportation, and entry processes between community-based crisis providers and EDs.

North Carolina's Proposed Efforts

- **Require EDs to report to NC DHHS on ED boarding** of more than 24 hours for individuals with IVC orders who are awaiting placement for inpatient care
- **Require community-based crisis providers (including BHUCs and FBCs) to develop MOUs with local EDs** to streamline data sharing, transfer and entry protocols, and first IVC examination processes

State Example

Massachusetts

- Massachusetts Medicaid (MassHealth) requires plans to:
  - Minimize wait times in ED for MH/SU services, especially for individuals with dual diagnosis of MH/SU and/or "assaultive or combative presentation resulting in the need for special accommodation in an inpatient psychiatric hospital setting"
  - Report to the state on any member awaiting placement in a 24-hour MH/SU receiving facility who remains in an ED for 24+ hours
  - Participate in data collection and improvement efforts with the state to reduce ED wait times for members in need of MH/SU services

Deep Dive on Key Improvement Area #4: Court Processes are Difficult to Navigate

Problem Definition for Court Processes Are Difficult to Navigate

- *Individual/Family Burden*
  - The IVC process – from petition, evaluation, transport, hearings, to discharge – is difficult to navigate for individuals and families. The process can be opaque and vary by geography.
  - Individuals and their families often do not have professional support (such as court navigators) during the IVC process. Individuals under an IVC order are only appointed a special counsel *after* the second IVC examination *if* inpatient commitment is recommended.
  - Mistrust of the MH/SU system can increase the likelihood of people avoiding needed care, contributing to the revolving door pattern.
- *Court Processes*
  - People under IVC must be "discharged as soon as a less restrictive mode of treatment is appropriate (Chapter 122C-201)," but there is no requirement for petitioners, magistrates, providers, or judges to consider least restrictive alternatives or community-based stabilization as part of IVC petitions/decision-making about IVC orders.

Strengthen & Standardize Training & Guidance. Improve existing guidance and develop, where needed, new standardized statewide guidance and training on IVC processes and procedures for courts, law enforcement, EMS, and crisis providers to ensure all entities in the IVC process are working together to best support individuals under IVC orders.

North Carolina's Current & Planned Efforts

- Standardize mobile crisis management services, through **a Center of Excellence that will oversee quality, training, and technical assistance**
- Develop and provide **cross-training for 911 and 988 staff** (per EO 33)
- Identify **training requirements for crisis providers, including co-response teams,** and **require LME/MCOs, CFSP, and SPs to monitor the training of their in-network crisis providers**
- Strengthen magistrate **training and develop bench cards,** in partnership with the University of North Carolina School of Government and NC DHHS
- **Expand Crisis Intervention Teams (CIT) and training** with cross-team collaboration with law enforcement community mental health providers, and advocates

State Examples

North Carolina

- The University of North Carolina School of Government offers courses and sessions for magistrates where they can receive a civil law certification in either IVC or domestic violence after completing a 5-component course. Courses are typically delivered over 2 days, and magistrates attend an additional 1-day seminar *or* 6 hours of sessions during the Magistrates' Spring/Fall Conferences.
- Magistrates can also attend standalone IVC-focused sessions to improve their understanding of the IVC petition, transport, and evaluation process.

Idaho

- The Center of Excellence Crisis Mobile Response Team (MRT) Competency Center provides statewide, standardized MRT trainings, 1:1 coaching for MRTs, mentoring, fidelity support, technical assistance, CIT training, and monthly collaboratives.

Oregon

- The CIT Center of Excellence (CITCOE) provides structure, support, and technical assistance to law enforcement agencies and their local behavioral health agencies in the development of local CIT programs.

Promote Least Restrictive Alternatives to Care. Increase use of least restrictive alternatives and community-based stabilization whenever clinically appropriate.

North Carolina's Current & Planned Efforts

- Require **IVC petitioners and magistrates and examiners to document consideration of least-restrictive alternatives** (e.g., Assisted Outpatient Treatment) and why those alternatives were not considered suitable options, *before* ordering inpatient care for individuals under IVC orders

State Examples

Arizona

- If an individual under commitment orders is subject to a court hearing, then the court must consider all available and appropriate alternatives for the treatment and care of the patient, and the court must file a report on its findings of alternatives for treatment.
- The court must order the least restrictive treatment alternative available.

Rhode Island

- State law requires that petitioners (a person living with the individual; immediate family member; guardian; attorney general; director of a department of behavioral healthcare, developmental disabilities and hospitals, director of a department of corrections, or the superintendent of the Rhode Island training school for youth) consider alternatives to IVC, prior to submitting an IVC petition to the court.
- The IVC petition must list:
  - Alternatives to IVC;
  - What alternatives have been investigated; and
  - Why alternatives are not deemed suitable.

Sources: Arizona: Arizona Revised Statutes 36-540. Rhode Island: General Laws of Rhode Island, Section 40.1-5-8 (2025).

Increase Person-Centered Supports During IVC Proceedings. Provide peer-support services to individuals under IVC orders as they navigate court processes and hearings.

North Carolina's Proposed Efforts

- **Explore a peer supports pilot program to assign peer-led court navigators** to individuals with pending/required IVC orders to attend and support them in hearings before a district judge and other court-related activities

Example

Peer-Led Court Navigation

- CourtConnect – developed by RTI International and piloted in New England – connects individuals with SU with peer-led court navigators with lived experience in the justice system and SU services, who provide information and referrals on the process and procedures of the court, adjunctive legal services, and navigation.

Appendix

9/30 Advisory Committee Meeting Summary & Recap

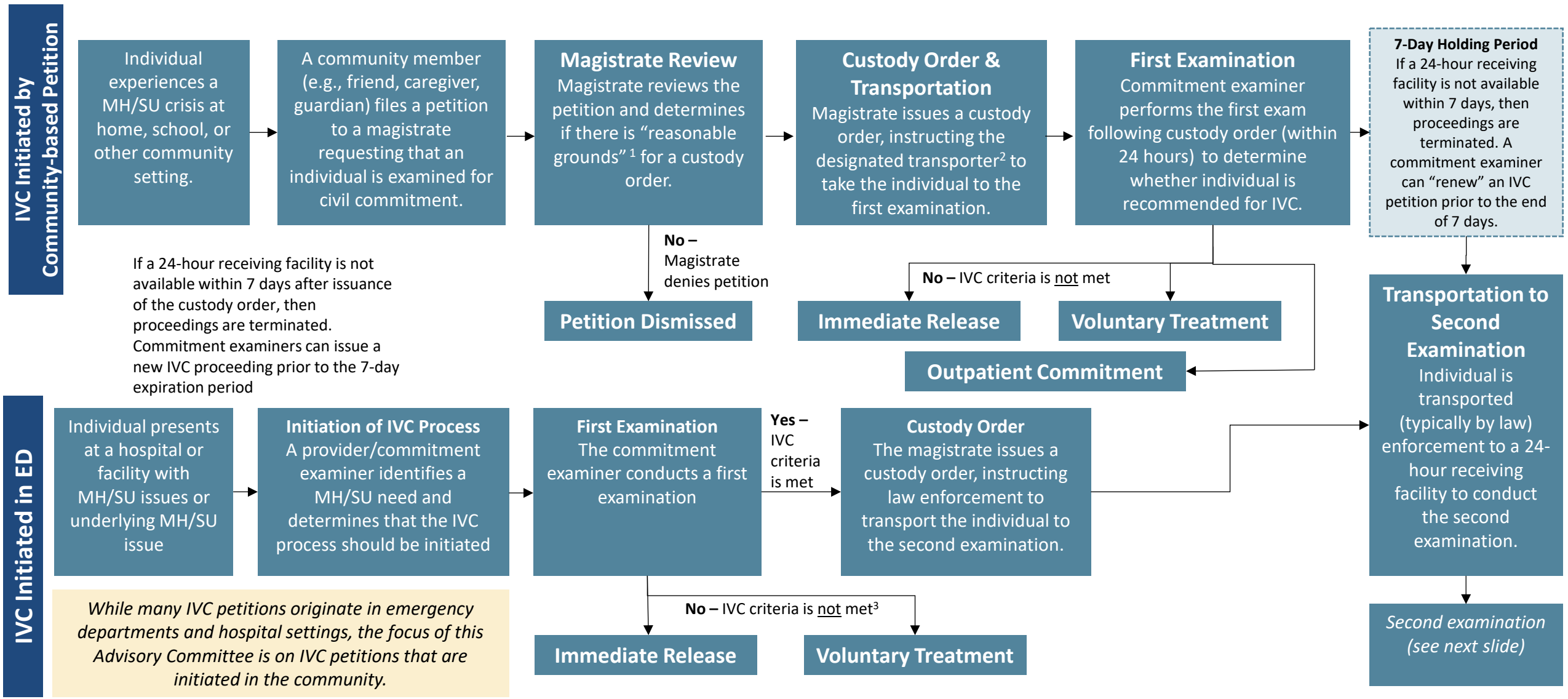
Recap of NC Crisis System of Care Advisory Committee 9/30 Meeting

The Advisory Committee broadly agreed that reducing IVC and interrupting the "revolving door" will require clearer pathways to voluntary care, greater crisis-system capacity that allows for less reliance on law enforcement and emergency departments, more clinically informed decision-making, and substantially stronger data.

- **Advisory Committee members emphasized that North Carolina lacks sufficient data to understand how individuals move through the IVC process and repeatedly cycle through IVC.** Members called for more granular information on repeat IVC petitions, petition sources, first and second examination outcomes, IVC dismissals, disposition, geographic variation, transportation, and post-crisis follow-ups.
- **Advisory Committee members highlighted due-process and continuity-of-care concerns within the current IVC process,** including repeated seven-day holding periods, access to counsel variance, limited clinical information available to magistrates, and the information and support individuals receive while waiting for exams and hearings. Members also noted that an individual's clinical condition may change rapidly following stabilization treatment in EDs, contributing to exits from the IVC process before a hearing.
- **Members supported expanding voluntary, clinically led pathways to care,** including stronger integration with 988, mobile crisis, as well as connections to peer support, primary care, and community-based providers. There is significant variation in crisis resources across communities, particularly in rural areas. Members stressed that solutions should build on effective local models and include non-clinical supports that address social factors.
- **Members supported reducing unnecessary reliance on law enforcement for transportation, while recognizing that alternative transport models will require clear roles, appropriate training, sustainable financing, and safeguards.** The discussion emphasized reserving law enforcement involvement for situations involving safety concerns and developing trauma-informed transportation options that reflect local capacity.
- **Emergency departments continue to function as default crisis settings because community-based facilities often lack the clinical and medical staffing, security, or reimbursement structures (e.g., inconsistent funding across sites) to stabilize individuals.** Members identified opportunities to strengthen requirements and oversight of BHUCs and FBCs, expand telehealth IVC examinations, improve capabilities of BHUCs and FBCs to conduct health screenings, and facilitate timely movement from EDs to treatment/community supports.
- **Members emphasized that crisis-system reforms should address follow-up and connections to care following the crisis episode.** Stronger discharge planning, rapid follow-up, care coordination, peer supports, housing supports, and other community-based services are essential to sustaining stabilization and reducing the revolving door pattern.

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

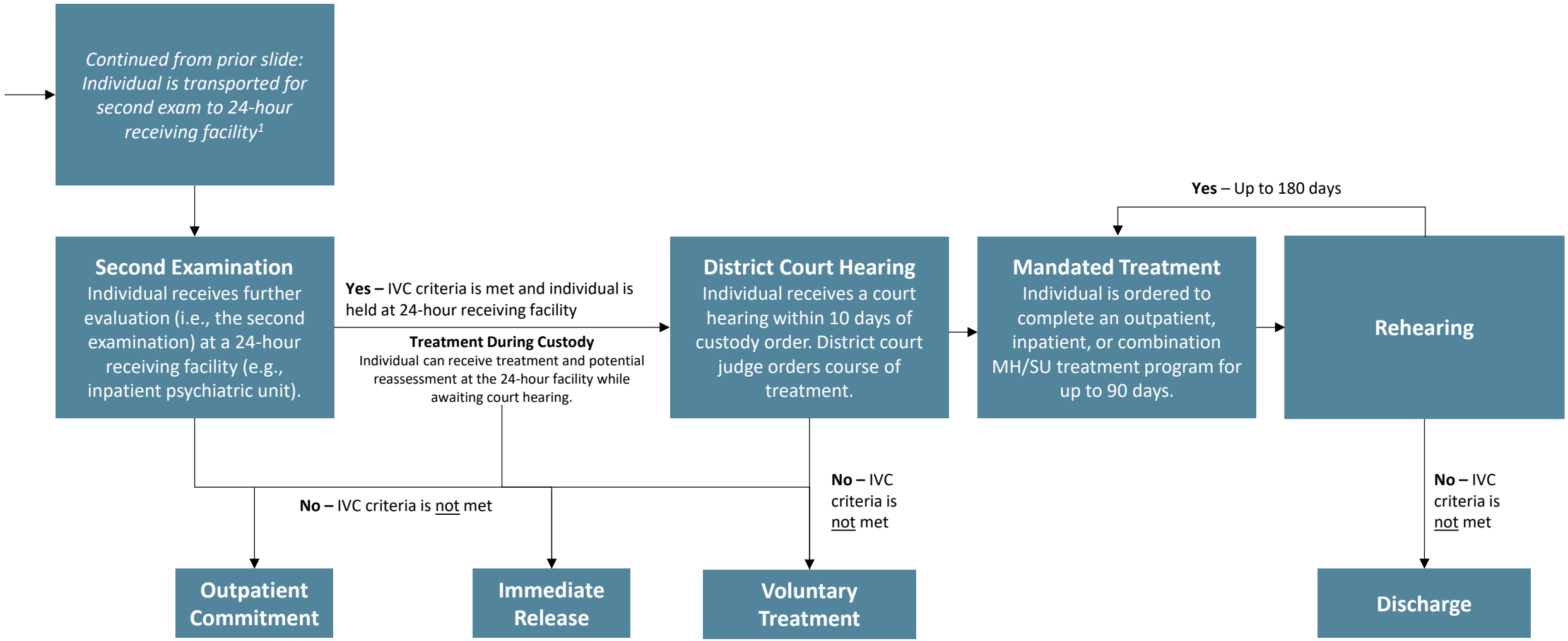
Updated to reflect 9/30 Advisory Committee Meeting Feedback



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. 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.

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

Updated to reflect 9/30 Advisory Committee Meeting Feedback



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).

Need for Improved IVC Data Collection

Updated to reflect 9/30 Advisory Committee Meeting Feedback

Advisory Committee members agreed that more granular, robust data is needed throughout the IVC process, which will aid in decision-making, increase transparency, improve follow-up care and help to mitigate the "revolving door" pattern.

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, court determinations (e.g., release, outpatient commitment), and reasons for exiting the IVC process prior to court hearing
- 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

Investments in improved data collection and ongoing work from the NC Collaboratory will better inform understanding of the IVC landscape as well as the revolving door pattern.

Sources: NC Collaboratory Report (April 2026); DRNC Report (May 2025)

Summary of 9/30 Meeting Feedback	
Problem Definition	**Overall agreement.**
Solutions	
Strengthen Clinically Led Crisis Access Points. Expand and normalize access to 988, mobile crisis teams, BHUCs, FBC centers, and outpatient providers.	**Overall agreement.** Advisory Committee members recommended that the solution includes: • Building more crisis services capacity in communities with no/limited access to services, especially in rural communities. • Supporting community crisis providers to build relationships within their communities and promote trust. • Promoting MH/SU care in non-clinical settings and social services.
Create Clear Pathways to Voluntary Care. Establish statewide referral pathways to connect individuals to voluntary crisis services before legal escalation, whenever clinically appropriate	**Overall agreement.** Advisory Committee members recommended that the solution includes: • Improving accessibility of data (e.g., health history, treatment plans) for providers to inform referrals to crisis services. • Connecting individuals to voluntary care throughout the service continuum (e.g., primary care, social services).
Ensure Timely Clinical Input into Court Processes. Ensure courts and law enforcement receive timely clinical information to assist IVC decision making.	**Overall agreement.** • Members raised implementation concerns, including the logistics of how magistrates would receive timely clinical information.
Expand Public Awareness of Non-IVC Options. Educate families and communities on how to access voluntary crisis services before a crisis escalates.	**Overall agreement.** Advisory Committee members recommended that the solution includes: • Providing IVC-related education and training for non-hospital providers, given that IVC petitions can originate in non-hospital settings. • Communicating the short- and long-term impacts of IVC to families, caregivers, providers, and individuals.

Summary of 9/30 Meeting Feedback	
Problem Definition	**Mixed agreement.** Members suggested the following revisions: • Reference all first responders (i.e., law enforcement and EMS), as EMS is often called to stabilize and examine someone under an IVC petition. • Opportunities for alternative transportation beyond law enforcement are not regularly considered throughout the IVC process (i.e., custody to discharge) • Rules and guidelines around IVC-related transportation are unclear and not well communicated to parents/caregivers, hospitals, and providers who request IVC-related transport. • Mental health/substance use (MH/SU) providers' capacity to transport people is limited due to a lack of resources and restrictions in service definitions and reimbursement.
Solutions	
Expand Alternative Transport Options. Reduce reliance on law enforcement transport by expanding clinically appropriate transport options before and after IVC decisions are made.	**Overall agreement.** • Members raised implementation concerns regarding funding alternative transportation options. • Committee members also noted that law enforcement often transports individuals upon discharge from an inpatient facility treatment center back to the community after being discharged from IVC. Members agreed this is not effective use of law enforcement's time.
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.	**Overall agreement.** Advisory Committee members recommended that the solution include: • Requiring that counties maintain up-to-date transport plans and submit them on a regular basis to NC DHHS to support the adoption of alternative transport options and trauma-informed practices, including training first responders or other entities responsible for transport of individuals under IVC orders.

Summary of 9/30 Meeting Feedback	
Problem Definition	**Mixed agreement.** Members suggested the following revisions: • Individuals that have been stabilized in EDs may be waiting for days or weeks for unavailable inpatient or lower acuity crisis supports (e.g., residential, intensive outpatient). • Other community-based crisis settings (i.e., BHUCs, FBCs) may not have the capabilities to conduct necessary physical health screenings, necessitating transport of individuals.
Solutions	
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.	**Overall agreement.** Advisory Committee members recommended that the solution includes: • Standardizing staffing, payment, oversight, and safety protocols statewide for BHUCs and holding FBCs accountable to receive individuals under IVC orders so these facilitates can operate at the top of their capacity and conduct IVC first exams (BHUCs and FBCs) and second exams (FBCs). • Integrating physical health care into FBCs and BHUCs to ensure these facilities can conduct required necessary medical screenings.

Overview of Advisory Committee

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 reduce 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.

Reminder: Focus of the Advisory Committee in 2026 is IVC & Revolving Door

- **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 reduce the "revolving door" for adults and youth with mental health and substance use needs

- **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

Reminder: Public Meeting Guidelines

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 Department of Health and Human Services' (NC DHHS) Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) will publish meeting materials on its website.

NC Chapter 143, Article 33C

Relevant North Carolina Statute

Relevant NC General Statute on IVC (1 of 2)

Article 5. Procedure for Admission and Discharge of Clients.

Part l. 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 Statute 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.