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**Revision to IVC Statutes Becomes Law**

The legislature passed S.630 to revise the involuntary commitment processes statewide. The bill was originally put forward last year during the 2017 long session and, after significant changes to the proposal this year, was signed into law on June 22, 2018. The general intent is to move communities further toward ensuring that IVC is the appropriate process for each individual, expanding flexibility for involved parties in IVCs and using community-based crisis services to the extent possible instead of emergency rooms. The legislature has directed State funding toward behavioral health (BH) crisis services to divert all individuals from ERs, regardless of insurance coverage, for many years. This new law could be seen as one mechanism of many needed to make the culture shift from using emergency room services to using BH community crisis services. LME/MCOs have spearheaded local initiatives to build crisis and urgent care centers to divert individuals from emergency rooms. To find BH crisis services near you, use this NC DHHS link that will direct you to your LME/MCO and the crisis services available in your county: http://crisissolutionsnc.org/.

The legislation reconfirms and expands NC General Statute 122C-Section 263.1 that allows not only physicians and eligible psychologists but also other health and mental health professionals [rule specifically names licensed clinical social workers, master's or higher level psychiatric nurses and clinical addiction specialists and the law adds licensed professional counselors and physician assistants] who are certified to conduct first examinations. There will no longer be a requirement for a waiver by the Secretary for professionals other than physicians and eligible psychologists to perform commitment examinations. The Secretary will be responsible for certifying other professionals to be used more readily than on a case-by-case basis. The hope is that these "boots on the ground" professionals will be able to reduce the number of unnecessary involuntary commitments.

To increase the coordination by state and local stakeholders, the new law:

- Allows a facility to share confidential information regarding the MH/SUD needs of an individual in that facility with a sheriff when the individual is confined in a county jail or jail annex.
- Gives the responsibility to the LME/MCOs for leading the development of a community crisis services plan by:
    - Incorporating the involuntary commitment transportation agreements that have been struck in local areas within the LME/MCO catchment area;
    - Holding contracts with one or more organizations capable of conducting health screenings and first examinations;
    - Identifying available training for law enforcement personnel and others who transport individuals in a BH crisis.
- Includes representation in the community crisis planning committee from the LME/MCO, local law enforcement agencies, acute care hospitals, magistrates, area facilities

with identified commitment examiners, other agencies and identified stakeholders as determined appropriate by the LME/MCO.

- Any party involved in the community crisis planning committee has the right to disagree with the plan and the plan will not be adopted without unanimous agreement. The NC DHHS Secretary will have a procedure in place to work through the conflict.
- All local plans will be submitted to NC DHHS by October 1, 2019 and in the future when changes are needed, they must be submitted 10 days prior to the changes taking effect.
- NC DHHS will also be collecting annual data on the use of IVCs and providing that data to the legislature for potential future changes.

Procedural changes include:

- Incorporates language in the circumstance when an individual is transferred from a 24-hour facility to include a transfer to an acute care hospital.
- Sets a timeframe of 12 hours that the 24-hour facility must hold the bed for that individual.
- Expands who is immune from liability to include individuals, facilities, acute care and general hospitals, LME/MCOs and law enforcement officials.
- Considers any advance instruction in MH treatment as a part of the evaluation process.
- Provides parameters that allow an individual who stabilizes to be discharged from services.
- Allows use of restraint in transportation at the discretion of the law enforcement officer and strongly encourages that children under the age of 10 be transported without any restraints.
- Ensures that there is a process to determine availability of treatment when an outpatient commitment order is developed and that an outpatient treatment provider is named.

The new law has been met with mixed reviews related to whether the bill language encourages giving consumers options in how they proceed with their care and how the changes to the proposal were vetted before legislative action was taken. (See NC Health News article, *Legislature Moves to Reduce Psychiatric Boarding in Hospital Emergency Rooms*).