HOUSE BILL 1104: Improve IVC Process and Enhance Public Safety.

2025-2026 General Assembly

Committee:		**Date:**	July 1, 2026
Introduced by:	Reps. Reeder, Blackwell, Miller, Cotham	**Prepared by:**	Hannah Kendrick
Analysis of:	Fifth Edition		Staff Attorney

OVERVIEW: House Bill 1104 would direct stakeholders to conduct studies relating to involuntary commitment (IVC) and would make various changes to IVC laws. House Bill 1104 would also implement a capacity restoration program for defendants found to be incapable of proceeding to trial.

CURRENT LAW AND BILL ANALYSIS:

Section 1 would require the North Carolina Collaboratory (Collaboratory) to study relevant statutes, practices, and available technological resources to identify areas for improvement in the IVC process. No later than December 1, 2026, the Collaboratory would be required to submit a progress report on the study, and no later than March 1, 2027, the Collaboratory would be required to submit a final report on the study, to the Joint Legislative Committee on Health and Human Services on the results of the study.

This section would be effective when it becomes law.

Section 2 would require the Sheriffs' Association to create a proposal for the implementation of a pilot program to utilize telehealth services to conduct first examinations for individuals in custody of county jails. No later than March 1, 2027, the Sheriffs' Association would be required to submit this proposal to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services.

Section 3 would direct the Local Management Entities/Managed Care Organizations (LME/MCOs) and DHHS to develop a plan to use mobile crisis units to enhance the efficiency of the IVC process. In developing this plan, the LME/MCOs and DHHS are required to consult with relevant stakeholders.

No later than October 1, 2026, the LME/MCOs and DHHS would be required to submit a report on the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

Section 4 would direct DHHS to evaluate the standardized training program for IVC examiners for necessary improvements and to incorporate additional training for IVC first examiners.

No later than December 1, 2026, DHHS would be required to submit a report on the standardized training program to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

Section 5 would direct DHHS to develop a plan to address (i) the ongoing shortage of staffed and available behavioral health beds in State-Operated Facilities for individuals in crisis, (ii) the staffing deficiencies that limit the use of existing behavioral health bed capacity, (iii) potential use of non-state-operated entities or facilities to provide staffing for or leasing of state-operated facilities, and (iv) contracting for behavioral health beds or staffing as supplementary or alternative to state-operated or staffed beds.

No later than December 1, 2026, DHHS would be required to submit a report on the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

Section 6 would require the North Carolina Collaboratory (Collaboratory) to conduct a study on how outpatient commitment can be more effectively used and implemented in the State.

No later than December 1, 2026, the Collaboratory would be required to submit a progress report on the study to the Joint Legislative Oversight Committee on Health and Human Services. No later than March 1, 2027, the North Collaboratory would be required to submit a final report on the study to the Joint Legislative Oversight Committee on Health and Human Services.

Section 6.5 would direct DHHS, in consultation with the Sheriffs' Association, to study the practicality of granting law enforcement access to BH SCAN. DHHS would be required to submit a report on this study to the Joint Oversight Committee on Health and Human Services no later than March 1, 2027.

Section 7 would require the Collaboratory to conduct a comprehensive study of the differing legal standards governing IVC and incapacity to proceed and identify statutory revisions that would enhance each system's effectiveness.

No later than December 1, 2026, the Collaboratory would be required to submit a progress report on the study to the Joint Legislative Oversight Committee on Health and Human Services. No later than March 1, 2027, the North Collaboratory would be required to submit a final report on the study to the Joint Legislative Oversight Committee on Health and Human Services.

Section 8 would require DHHS to establish a working group composed of representatives from AOC and other stakeholders to examine the systemic factors contributing to the "revolving door" pattern in which individuals cycle through arrest, detention, and IVC.

Beginning on January 1, 2027, and quarterly thereafter, DHHS would be required to report on the findings and recommendations of the group to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

Section 9 would require the Collaboratory to study the provision of medical and behavioral health care delivered in county jails in the State and make recommendations to improve the healthcare provided to individuals in custody.

No later than December 1, 2026, the Collaboratory would be required to submit a progress report on the study to the Joint Legislative Oversight Committee on Health and Human Services. No later than March 1, 2027, the North Collaboratory would be required to submit a final report on the study to the Joint Legislative Oversight Committee on Health and Human Services.

Section 10 would direct the Collaboratory to explore the feasibility of improving the provision of services at Broughton Hospital, Central Regional Hospital, and Cherry Hospital.

UNC Health and DHHS are directed to cooperate with the Collaboratory to complete the required research.

No later than December 1, 2026, the Collaboratory would be required to submit a progress report on the study to the Joint Legislative Oversight Committee on Health and Human Services. No later than March 1, 2027, the North Collaboratory would be required to submit a final report on the study to the Joint Legislative Oversight Committee on Health and Human Services.

Section 11 would modify laws relating to outpatient commitment as follows:

- Replace the term "outpatient treatment physician or center" with "outpatient treatment provider."

- After the conclusion of the first examination, the commitment examiner would recommend outpatient commitment if, in addition to criteria existing under current law, the examiner also found the following:
    - The respondent is reasonably determined to be capable of surviving safely in the community, without posing a danger to others, when engaged in treatment for the respondent's mental health.
    - The respondent has a history of declining or nonadherence to prescribed treatment, which may be evidenced by the occurrence of one or more of the following in the relevant past:
        - A demonstrated history of prior violent convictions.
        - Repeated violations of civil protective orders.
        - Repeated incarcerations.
        - Repeated involuntary inpatient psychiatric hospitalizations.
    - The respondent is scheduled to be discharged from an inpatient hospital setting or released from a county jail or state prison. An individual residing in a non-institutional setting that meets all other criteria set forth previously would be subject to outpatient commitment within the court's discretion.
- Require the outpatient treatment provider to examine the respondent and develop an initial outpatient treatment plan. The plan would include specific services to be provided, the recommended frequency of participation in services, the name of the provider, the arrangements made for the initial contact with each provider, and any other relevant information. The plan would be admitted into evidence and incorporated into the outpatient commitment order.
- Require that the outpatient commitment order show the provider responsible for care and the LME/MCO or an alternative as determined by the Department responsible for supervision of the respondent's outpatient commitment, and provide instructions regarding monitoring and supervision duties.
- Increase the initial outpatient commitment timeframe from a maximum of 90 days to a maximum of 180 days.
- Require that before ordering outpatient commitment, the court must obtain the availability and consent of the provider to accept the respondent as a client.
- If the respondent fails to comply with any part of the treatment plan, the provider would document efforts to solicit compliance and report these efforts to the LME/MCO, or an alternative, who would then report to the court with a request for supplemental hearing.
- Require the LME/MCO to maintain a list of all individuals on outpatient commitment and ensure the individual's care manager is aware of the treatment plan. DHHS would have access to the lists of individuals subject to outpatient orders, and would keep this information confidential.
- Grant the LME/MCO, or an alternative, the authority to request the respondent be taken into custody for the purpose of an examination if the respondent fails to comply but does not clearly refuse to comply.
- Require the LME/MCO, or an alternative, to notify the clerk of superior court if the respondent moves to another state or unknown location.

- Create an additional option for the court when it determines during a supplemental hearing that the respondent has failed to comply with the outpatient commitment order. The court would be able to issue an order for inpatient commitment upon a finding by clear, cogent, and convincing evidence that the respondent is dangerous to himself or to others. A finding of noncompliance with an outpatient commitment order would create a rebuttable presumption that the respondent is dangerous to himself or to others.
- If a patient under outpatient commitment in one county moves to another county, the court would be required to designate the LME/MCO, or an alternative, that will be responsible for the monitoring and supervision of the respondent in the respondent's new county of residence. The clerk would provide a copy of the court's order to the LME/MCO or alternative in the new county of residence.
- Increase the outpatient commitment period from 90 days to 180 days when a respondent is transferred from inpatient to outpatient commitment at a supplemental hearing.
- Grant DHHS access to all relevant data, court orders, records or other relevant information related to its duties. DHHS would be required to keep all information confidential.

This section would become effective December 1, 2026, and apply to proceedings that occur on or after that date.

Section 12 would allow, in accordance with recent changes to federal law, substance use data to be disclosed through the North Carolina Health Information Exchange (HIE) Network when the North Carolina HIE Authority has provided written notice to participating entities that the data can be disclosed.

It would also add the Deputy Secretary for the State's Medicaid program as an ex officio, voting member of the North Carolina Health Information Exchange Advisory Board.

Section 13 would create and implement an inpatient capacity restoration program. These modifications would reflect the State policy that persons found incapable to proceed should be provided with capacity restoration services whenever feasible and appropriate and that such services should be carried out in as efficient and timely a manner as possible in order to meet the needs of justice for victims, for the public, and for those persons who stand accused of crimes.

Generally, capacity restoration services that are directed toward a defendant gaining capacity to stand trial may include any or all of the following:

- Educational instruction regarding the criminal justice system, to include assisting the defendant in understanding his or her role in the proceedings.
- Psychoeducational instruction regarding the nature of a defendant's diagnosed condition and the resources and coping skills necessary to mitigate capacity deficits caused by the condition.
- Other mental health treatment or counselling which is medically reasonable and appropriate.

This section would become effective December 1, 2026, and apply to any initial or supplemental capacity hearing conducted on or after that date.

Section 14 would move the effective dates for certain sections of S.L. 2025-93 (Iryna's Law) that are not yet effective from future effective dates of December 1, 2026 and December 1, 2027 to the new effective date of July 1, 2028.

EFFECTIVE DATE: Except as otherwise provided, this act would be effective when it becomes law.

**Robert Ryan, Staff Attorney with the Legislative Analysis Division, substantially contributed to this summary.*