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

2025-2026 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Judiciary. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 17, 2026
Introduced by:	Reps. Reeder, Blackwell, Miller, Cotham	**Prepared by:**	Stewart Sturkie Staff Attorney
Analysis of:	Second Edition		

OVERVIEW: House Bill 1104 would direct stakeholders to conduct studies relating to involuntary commitment (IVC) and would make various changes to IVC laws.

CURRENT LAW AND BILL ANALYSIS:

Section 1 would require the Department of Health and Human Services (DHHS), the Department of Information Technology (DIT), and the Administrative Office of the Courts (AOC) to study relevant statutes, practices, and available technological resources to identify areas for improvement in the IVC process. On or before February 1, 2027, DHHS, DIT, and AOC would be required to report 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 DHHS and the Sheriffs' Association to develop a plan to use telehealth services to complete the first IVC evaluation in jails. No later than October 1, 2026, DHHS and the Sheriffs' Association would be required to submit a report containing the listed criteria to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

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 report to the Joint Legislative Oversight Committee on Health and Human Services.

Section 7 would direct DHHS and the Sheriffs' Association to provide law enforcement access to BH Scan. DHHS would be required to report to the Joint Legislative Oversight Committee on Health and Human Services when access is complete. This provision would become effective August 1, 2026.

DHHS would be required to develop and implement real-time data availability within BH SCAN and ensure that BH SCAN provides timely information on available beds to authorized users. DHHS would be required to develop and implement functionality within BH SCAN that allows authorized users to reserve an available bed in real time. These provisions would become effective August 1, 2027.

Section 8 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 shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services.

Section 9 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 10 would require the North Carolina Department of Adult Correction (DAC) and the Sheriffs' Association 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, DAC and the Sheriffs' Association would be required to submit a report on the study and recommendations to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

Section 11 would direct the UNC Health Care System (UNC Health) to explore the feasibility of improving the provision of services at Broughton Hospital, Central Regional Hospital, and Cherry Hospital.

DHHS is directed to cooperate with UNC Health to complete the required research.

No later than December 1, 2026, UNC Health 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 12 would direct the Collaboratory to explore the feasibility of improving the provision of services at Broughton Hospital, Central Regional Hospital, and Cherry Hospital.

DHHS is 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 report on the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

Section 13 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:
    - Prior convictions for violent offenses.
    - Violations of civil protective orders.
    - Incarcerations for any offense.
    - 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 there is a nexus between the respondent's past conduct and the reasonable probability of the respondent's future dangerousness to self. A finding of noncompliance with an outpatient commitment order would create a rebuttable presumption that there is a nexus between the respondent's past conduct and future dangerousness.
- 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.

Section 14 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.

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