Testimony of the North Carolina College of Emergency Physicians

Before the North Carolina House Select Committee on Involuntary Commitment and Public Safety

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Representing: North Carolina College of Emergency Physicians (NCCEP)

Opening Statement

Chairman Blackwell, Chairman Reeder, and members of the committee — thank you for inviting me to speak today.

My name is Dr. Jeremiah Gaddy, and I am an emergency medicine physician in North Carolina representing the North Carolina College of Emergency Physicians, which includes more than 1,100 emergency physicians staffing hospitals and emergency departments across our great state.

I want to begin by acknowledging the heartbreaking loss of Iryna Zarutska and the General Assembly's commitment to preventing similar tragedies. We aim to work together to ensure the law achieves its intended purpose—protecting the public while supporting the emergency department's essential role in stabilizing patients with acute illness or injury.

The American Board of Emergency Medicine (ABEM) defines an emergency medicine physician as "a physician who focuses on the immediate decision making and action necessary to prevent death or any further disability" (1).

Emergency physicians are acute care specialists trained to deliver life-saving interventions for both medical and behavioral emergencies.

We respond without hesitation to suicidal crises, violent agitation, and acute psychosis, alongside medical instability associated with behavioral health conditions.

It is equally important to recognize what emergency medicine is not designed to manage. The emergency department (ED) is not an appropriate or sustainable setting for non-emergent psychiatric evaluations such as court-ordered mental health assessments, pretrial screenings, or forensic competency evaluations. These processes require specialized expertise and time beyond the scope and mission of emergency care.

Although emergency departments offer 24/7 access, that access should be reserved for patients requiring emergent stabilization — not as a default location for judicial evaluations.

The Impact of the Current IVC Process on Emergency Departments

Even under current law, North Carolina's emergency departments are straining under the weight of behavioral-health boarding and involuntary commitments.

The majority of patients who present to an ED — whether voluntary or involuntary — will not see a psychiatrist in person. They are typically evaluated through telepsychiatry consultation. Because of limited placement options, behavioral health patients, including children, often remain for multiple days or even weeks in small, windowless rooms awaiting inpatient psychiatric placement.

The magnitude of this problem is clear statewide. According to the North Carolina Healthcare Association, in State Fiscal Year 2022, the average wait time to transfer a patient from an ED to a state psychiatric hospital was 285 hours — nearly 12 days (2). Each week, more than 50 children sleep in EDs or DSS offices because there is nowhere else for them to go (3).

The N.C. Department of Health and Human Services notes that the front door of our behavioral health system has become the crisis system itself — meaning people often only receive care when they reach a crisis point (4). This overreliance on emergency departments has led to a crisis-based model of behavioral health care that is neither efficient nor humane.

Meanwhile, the risk of workplace violence continues to rise. Nearly one in three North Carolina health-care workers has experienced or witnessed workplace violence in the past year (5). The U.S. Bureau of Labor Statistics reports that health-care workers experience violent incidents at five times the rate of all other industries (6). To have those who have recently committed a violent act without a medical need to be in the emergency department puts our healthcare workers at even more risk.

Without reforms, these pressures will worsen as Iryna's Law takes effect.

Justice-Involved Individuals and Judicial Evaluations

Looking ahead to December 2026, one key implementation issue involves justice-involved individuals — people in law-enforcement custody who are not under involuntary commitment but who a judge or magistrate has ordered to receive a mental-health evaluation to determine whether commitment might be appropriate.

Under the current language of Iryna's Law, these evaluations could occur in hospital emergency departments even when individuals are medically stable and not in crisis.

However, these judicial evaluations differ from emergency IVCs in both purpose and urgency:

• Involuntary Commitment (IVC): When a person poses an immediate danger to self or others, statute requires an evaluation within 24 hours (N.C. Gen. Stat. § 122C-263(c)) (7).
• Iryna's Law (Judicial Evaluations): Ordered by courts to assess whether commitment is appropriate; no statutory timeframe (e.g., 24 or 48 hours) currently exists (8).

Because these judicial evaluations do not address immediate harm, there is no clinical or legal reason to bring such individuals to an emergency department. Doing so diverts critical resources from true emergencies and increases risks for patients, providers, and law enforcement alike.

NCDHHS's 2023 Investing in Behavioral Health and Resilience plan highlights that capacity-restoration pilots for justice-involved patients can occur in jails and the community, freeing hospital beds and supporting treatment in the least restrictive environment (9). This aligns directly with NCCEP's recommendation that judicial evaluations occur via telepsychiatry or in behavioral-health settings, not emergency departments.

Perhaps one of the largest impacts this bill will have is the time law enforcement officers are transporting and staying with individuals while at the hospital in custody, away from the communities they love to serve.

Operationally, using EDs for judicial evaluations results in:
• Law enforcement officers remaining at the bedside for extended periods.
• Hospital beds and staff diverted from urgent care needs.
• Shared spaces between acutely ill patients and those in custody, increasing safety risks.

While the goal is safety and timely evaluation, the result is delay and resource strain.

Telepsychiatry: A Proven North Carolina Strength

North Carolina is already a national leader in telepsychiatry through the Statewide Telepsychiatry Program (NC-STeP) under DHHS. This network connects hospitals to psychiatrists via secure video and has already reduced ED boarding and expanded rural access (10).

Both the NCDHHS white paper and NCHA's 2024 brief identify telehealth expansion as a critical component of the state's $835 million behavioral health investment — particularly for crisis and justice system integration (11).

The next logical step is to extend this telepsychiatry model beyond hospitals to jails, magistrate offices, and crisis facilities, allowing judicial evaluations to occur remotely within hours rather than days.

Telepsychiatry allows evaluations in secure environments under law-enforcement supervision, eliminates unnecessary patient transport, and keeps ED beds open for true emergencies. It achieves the safety and evaluation goals of Iryna's Law without the collateral strain on emergency departments, officers, and patients.

Recommendations to Prepare Before December 2026

Clarify the Role of Emergency Departments
• Define "ED evaluation" as emergent medical or psychiatric stabilization only.
• Judicial evaluations should occur via telepsychiatry or in behavioral-health settings.

Expand Telepsychiatry Access Statewide
• Fund NC-STeP expansion to law-enforcement and judicial sites.
• Establish a 24/7 telepsychiatry pathway for court-ordered evaluations.

Increase Behavioral-Health Alternatives
• Ensure each region has Behavioral-Health Urgent Care and Crisis Stabilization Units.

Enhance Workplace Safety
• Support violence-prevention training and enforce zero-tolerance policies for assaults on health-care workers.

Improve Data Sharing and Coordination
• Create a real-time information system linking courts, law enforcement, and hospitals to track evaluation status and reduce duplication.

Conclusion

Emergency physicians share the legislature's goal of protecting North Carolinians and caring for those in crisis. By using the time before December 2026 wisely, North Carolina can implement Iryna's Law in a way that strengthens both public safety and patient safety.

Emergency departments must remain focused on true emergencies — those requiring immediate intervention. For individuals who are stable and awaiting judicial assessment, telepsychiatry offers the same standard of care but in a safer and more sustainable way.

Telepsychiatry is the bridge between the vision of Iryna's Law and the reality of emergency care. It delivers timely evaluations, enhances coordination, and protects patients, providers, officers and communities alike.

Chairman Blackwell, Chairman Reeder and members of the committee — thank you for your leadership and consideration. I welcome your questions.

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