BHC Behavioral Health Commission

Aligning crisis services and the civil commitment process

October 7, 2025

Study

Study mandate

- SB 574 (2024) directed BHC staff to study how to align the civil commitment process and the crisis services system
  - Identify barriers to maximizing access to crisis services for individuals who are (or at risk of becoming) involved in the civil commitment process
  - Make recommendations for any changes needed to fully leverage crisis services and minimize civil commitments
- Interim briefing on the status of Virginia's crisis system buildout in November 2024

Research activities

- Site visits to 7 CSBs[1] and local law enforcement agencies
- Interviews with state agency staff from DBHDS[1], DMAS[1], OES[1], the Governor's Office; CSBs; local magistrates, independent evaluators, and law enforcement officers; stakeholders from the Virginia CIT[1] Coalition, HopeLink Behavioral Health, Connections Health Solutions, and VACSB[1]
- Meetings with stakeholder workgroup
- Analysis of data on prevalence of ECOs[1] and TDOs[1], 988 calls, 911 calls, and admission to crisis facilities
- Review of the research literature and state reports on crisis services and civil commitment

[1]CSB: Community Services Board; DBHDS: Department of Behavioral Health and Developmental Services; DMAS: Department of Medical Assistance Services; OES: Office of the Executive Secretary of the Supreme Court of Virginia; CIT: Crisis Intervention Team; VACSB: Virginia Association of Community Services Boards; ECO: emergency custody order; TDO: temporary detention order

In brief

- Virginia's current crisis system is not structured to serve most individuals who are (or at imminent risk of being) involved in the civil commitment process
- The civil commitment process does not appear to create barriers to accessing crisis services
- 988 and regional mobile crisis response teams are geared toward voluntary patients and seldom benefit individuals who are at imminent risk of an ECO
- Crisis facilities serve few involuntary patients overall, with variation between facilities

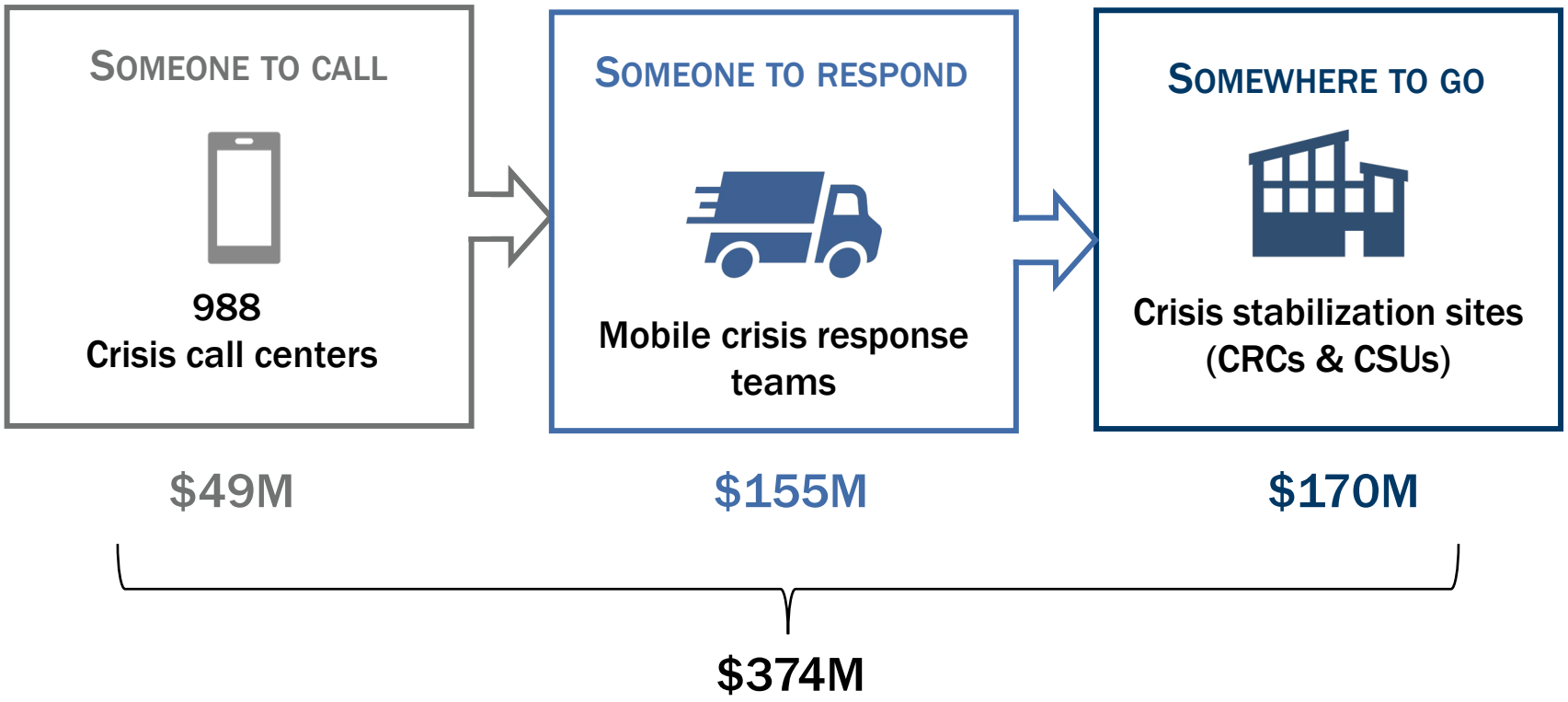
In this presentation

Background

988 and regional mobile crisis teams

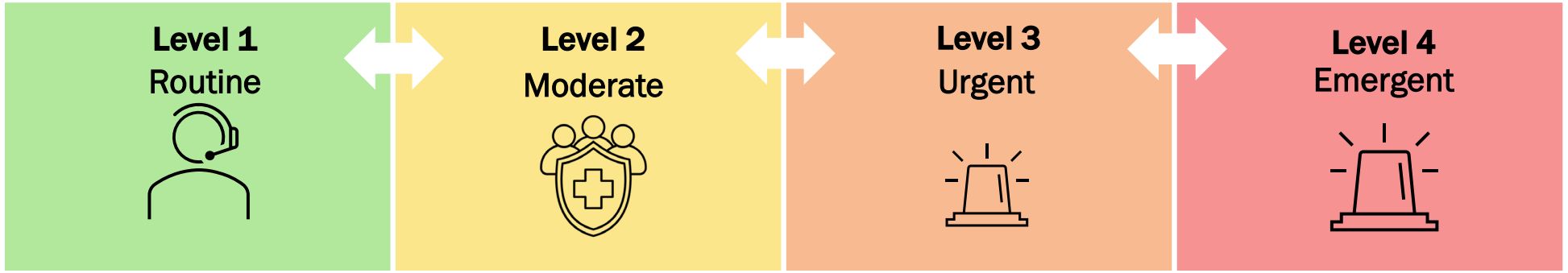
Crisis facilities

Virginia has invested heavily in the three core elements of the “Crisis Now” model between FY22 and FY26



988 and regional crisis call centers offer someone to call for individuals experiencing a mental health crisis

- Callers are routed to the nearest regional crisis call center (5 in Virginia)
- Call center counselors use multilevel triage framework (per Marcus Alert) to determine best course of action based on level of urgency



	Level 1 Routine	Level 2 Moderate	Level 3 Urgent	Level 4 Emergent
Common Practice:	Supportive counseling & community referrals	Dispatch mobile crisis	Transfer to 911	Transfer to 911

Mobile crisis teams provide response for callers who need in-person support or services

- Offered by public and private providers
- Teams of at least two behavioral health providers who can deploy to an individual's location in the community 24/7
  - Law enforcement not involved unless requested for backup
- Provide rapid response, assessment, and early intervention to individuals in crisis
- Rarely dispatched to Level 3 or Level 4 calls

Crisis facilities offer specialized treatment in a therapeutic environment

- Community-based crisis facilities provide assessment and stabilization to individuals experiencing a behavioral health crisis
  - 23-hour Crisis Receiving Centers (CRCs) provide “chairs” used for observation, to conduct assessments, and to provide supportive care in a more therapeutic setting than EDs
  - Crisis Stabilization Units (CSUs) have beds that can be used for several days for crisis intervention and stabilization to avoid hospitalization
- CRCs and CSUs may be co-located to offer a continuum of services

Benefits of crisis systems include early intervention and prevention

- Improved response to lower acuity crises can have downstream, long-term benefits
  - Talking to someone and connecting to community-based services may prevent future, higher-acuity crises and self harm, including suicide
  - Immediate access to crisis services can reduce severity, and improve recovery and long-term well being
  - Positive experiences with crisis system may encourage individuals to reach out for services voluntarily if experience another crisis in future, avoiding an ECO
- Positive downstream impacts to communities are more challenging to capture
  - Cost avoidance in health care
  - Prevention of negative outcomes (e.g., involvement in criminal justice system)

Full benefits of a comprehensive crisis system accrue from improved response to population at risk of or under a civil commitment order

- Reduced ED boarding for individuals under TDO awaiting a hospital bed
- Reduced inpatient psychiatric hospitalizations, especially in state hospitals
- Lower costs compared to inpatient psychiatric
- Reduced law enforcement time spent maintaining custody of individuals under an ECO or TDO

Individuals must meet all 3 statutory criteria to be placed under a civil commitment order

Note: §§37.2-800 through 37.2-847 describe the civil commitment process

Civil commitment process includes 3 phases with differing timeframes for assessment and treatment, as needed

Initiation

Petition by any responsible person, treating physician or provider, magistrate

Emergency Custody Order (ECO)

8 hours

- Issued by magistrate or law enforcement officer (LEO)
- LEO takes custody
- CSB prescreens to assess whether meet TDO criteria
- CSB identifies treatment facility – state hospital as last resort

Temporary Detention Order (TDO)

72 hours

- LEO or alternate provider transports to facility
- Treatment may be initiated
- Independent evaluator assesses if meet commitment criteria

Commitment hearing

Involuntary admission

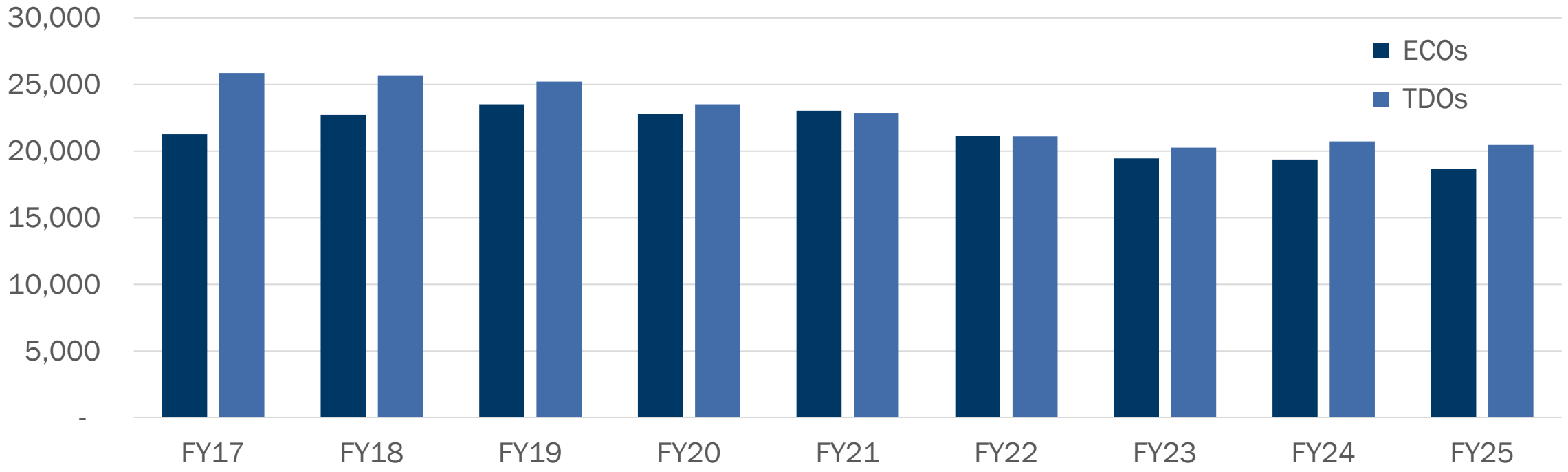
30 days*

Hearing results in either:

- Voluntary admission to facility
- Involuntary admission to facility
- Mandatory outpatient treatment
- Release

*Court can order extensions up to 180 days

Number of ECOs and TDOs has decreased since peak in FY17-FY19 but remains around 20,000 annually



In this presentation

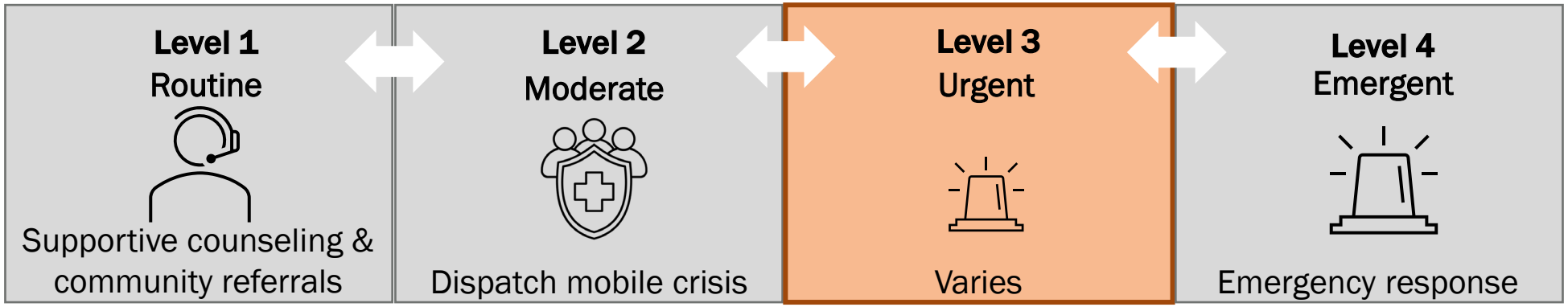
Background

988 and regional mobile crisis teams

Crisis facilities

Level 3 crisis situations are at risk of ECO but could be diverted

- Level 3 and 4 more at risk of ECO than Level 1 and 2
- Level 3 has opportunity for behavioral health-only response; Level 4 requires emergency response
- Behavioral health-only response increases potential for diversion from ECO when no imminent safety risk exists



	Level 1	Level 2	Level 3	Level 4
ECO Risk:	Low	Low	High	High
Response:	BH only	BH only	BH only, co-response, LEO	LEO, fire, EMS

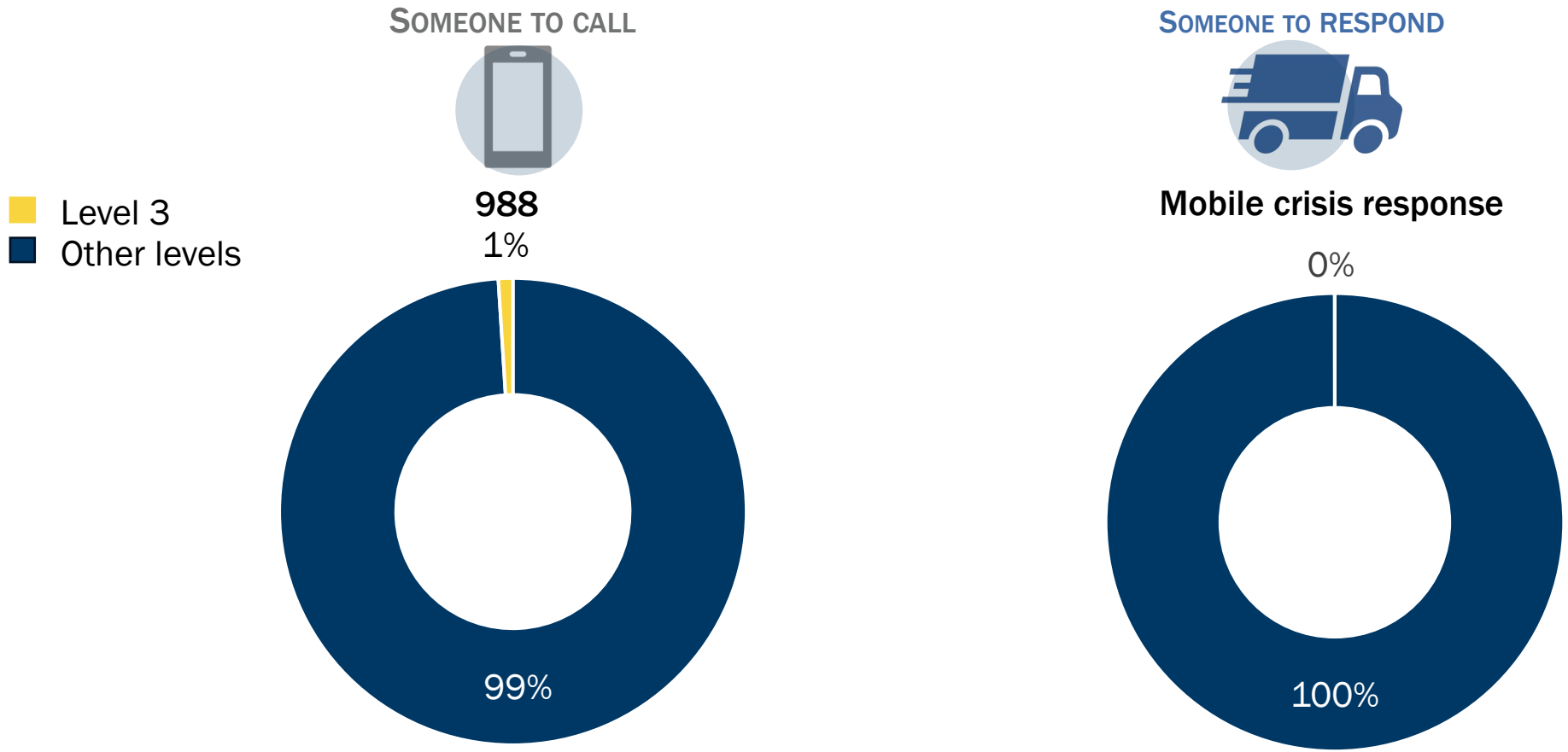
Finding

- Individuals who are at imminent risk of an ECO seldom benefit from 988 or mobile crisis

Mobile crisis is the only 988 service that could benefit Level 3 callers

- 988 offers supportive counseling, community referrals, and mobile crisis dispatch
- Supportive counseling and community referrals are not appropriate services for Level 3 callers
- Mobile crisis is a behavioral health only response and could divert Level 3 from involvement in the civil commitment process

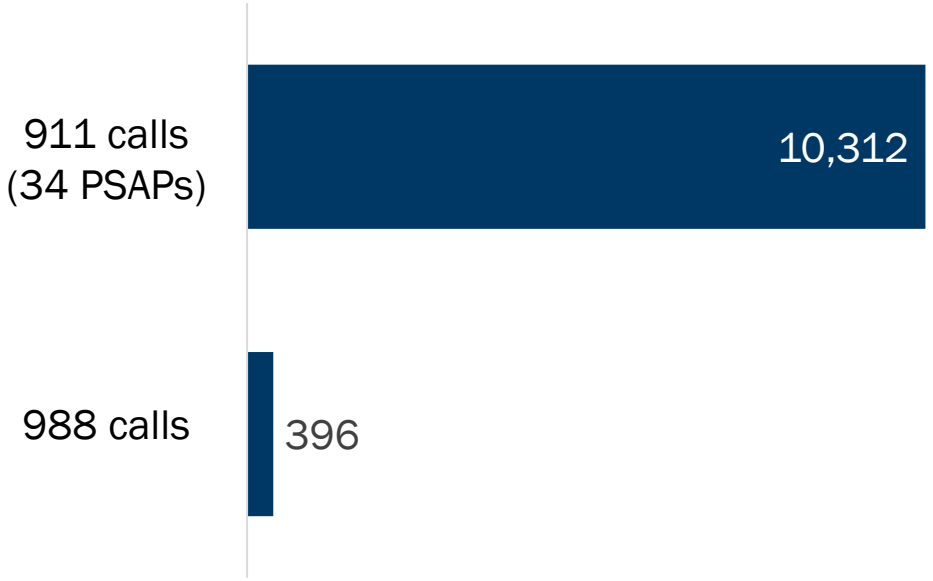
Few Level 3 calls go to 988; those that do are transferred to 911 instead of receiving mobile crisis



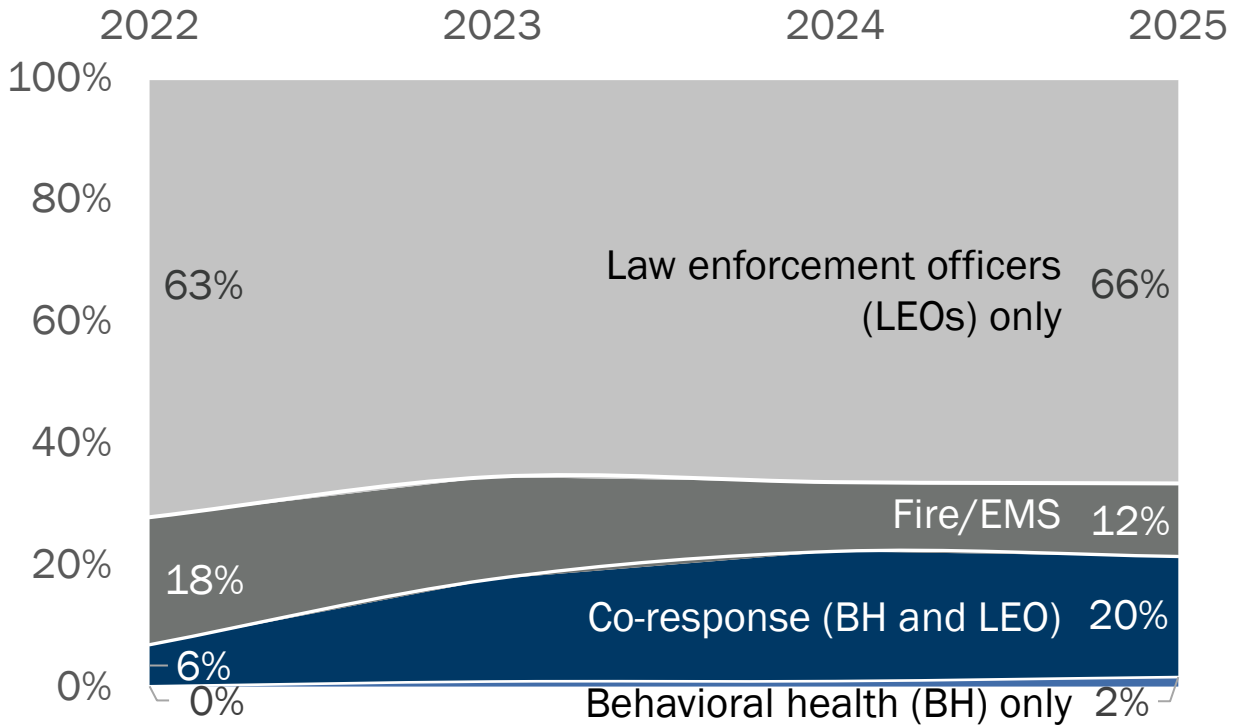
Source: BHC staff analysis of data from Virginia Crisis Connect (VCC) January 2024 – May 2025 provided by DBHDS

Vast majority of Level 3 calls are going directly to 911, where only 2% of them receive a behavioral health-only response

Level 3 calls in 2024



Response to Level 3 911 calls



Note: Figure does not include "other" types of responses (2022: 12%, 2023: 3%, 2024: 1%).

Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert (2022-2025)

There is insufficient flexibility in how and to whom regional mobile crisis response teams are dispatched

- 911 has access to limited number of behavioral-health only response teams
- Since December 2023, dispatch through Virginia Crisis Connect functionally makes 988 the single point of access to mobile crisis
  - Currently no mechanism for mobile crisis dispatch via 911
- Law enforcement agencies have a direct line to regional hubs, but it is rarely used

Option

- The General Assembly may wish to consider funding a pilot program that would enable regional mobile crisis teams to be dispatched to Level 3 calls
  - Could be accomplished as part of pilot programs proposed in Marcus Alert study, which would leverage 911 dispatchers or embed 988 dispatchers
  - Part of the pilot program would entail defining what constitutes an imminent public safety risk, the circumstances under which mobile crisis response is appropriate, when to engage LEOs for backup, and what process is most efficient for dispatch
  - Results of pilot program could be used to refine Marcus Alert triage protocols that apply to Level 3

Recommendation

- DBHDS should collaborate with DCJS to identify strategies for law enforcement to better utilize the direct line to regional hubs for dispatching regional mobile crisis teams

Finding

- Regional mobile crisis teams are rarely dispatched in response to calls from third-parties, which are disproportionately made on behalf of individuals in crises that meet Level 3 criteria, unless individual in crisis consents

Large share of Level 3 calls to 988 are made by third-parties

Source: BHC staff analysis of data from Virginia Crisis Connect (VCC) January 2024 – May 2025 provided by DBHDS

Unclear if third-party dispatch is allowed based on large volume of regulatory and administrative requirements

- Some states appear to dispatch mobile crisis based on third party referrals

Federal

- Vibrant and SAMHSA standards of accountability for 988 vendors
- Medicaid requirements

State

- DMAS reimbursement criteria for mobile crisis
- DBHDS mobile crisis licensure

Other

- Regional hub MOAs with mobile crisis providers
- 988 vendors standard operating procedures

Option

- The General Assembly may wish to consider directing the Secretary of Health and Human Resources to investigate what regulatory, billing, or training changes would be required to enable regional mobile crisis dispatch based on third-party referrals and provide a report of its findings and recommendations to the Behavioral Health Commission by December 1, 2026

CSB preadmission screening clinicians are responsible for providing a clinical TDO recommendation to magistrates

- Code of Virginia requires CSB preadmission screeners to conduct a clinical assessment of individuals under an ECO and determine if they meet TDO criteria
- Magistrates are responsible for determining whether to issue the TDO
  - CSB staff report that magistrates generally follow screeners' recommendation

Preadmission screening clinicians perceive recommending a TDO as less professionally risky

- Some preadmission screening clinicians may feel recommending a TDO carries a lower professional risk than not recommending one
  - Some indicated that professional liability is a concern
  - Some indicated being more likely to recommend a TDO
- Concerns about liability inflate TDO numbers above what clinical judgment alone would have dictated
- Lack of access to crisis services once under a TDO may further exacerbate civil commitment involvement

Recommendations

- DBHDS should modify its training for CSB preadmission screening clinicians to include a module on professional liability that emphasizes true liability exposure and work with the Office of the Attorney General of Virginia to develop legal guidance
- DBHDS should ensure that the training is conducted as soon as practicable after a CSB preadmission screening clinician is hired

In this presentation

Background

988 and regional mobile crisis teams

Crisis facilities

Virginia has spent approximately $111M on crisis facilities and CITACs since FY24

CRC

23-hour assessment
Voluntary

Provides “chairs” / recliners for less than 24 hours for observation, assessment, and supportive care in therapeutic environment

$79M

CITAC

LEO drop-off center
Involuntary

Drop-off alternative to EDs for LEOs with custody of an ECO for assessment

$18M

CSU

Stabilization
All

Provides “beds” for several days for crisis intervention and stabilization to avoid hospitalization

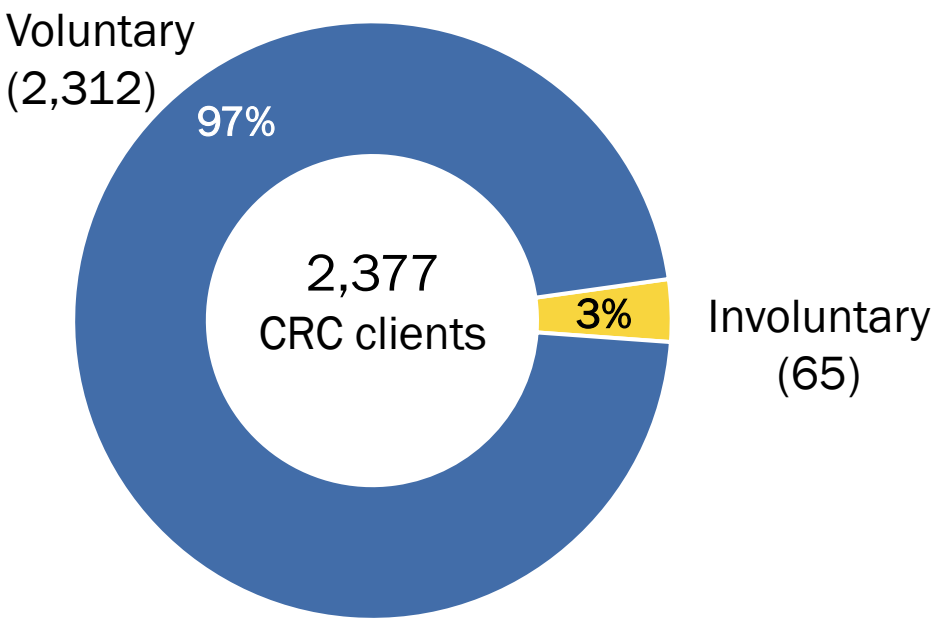
$14M

Finding

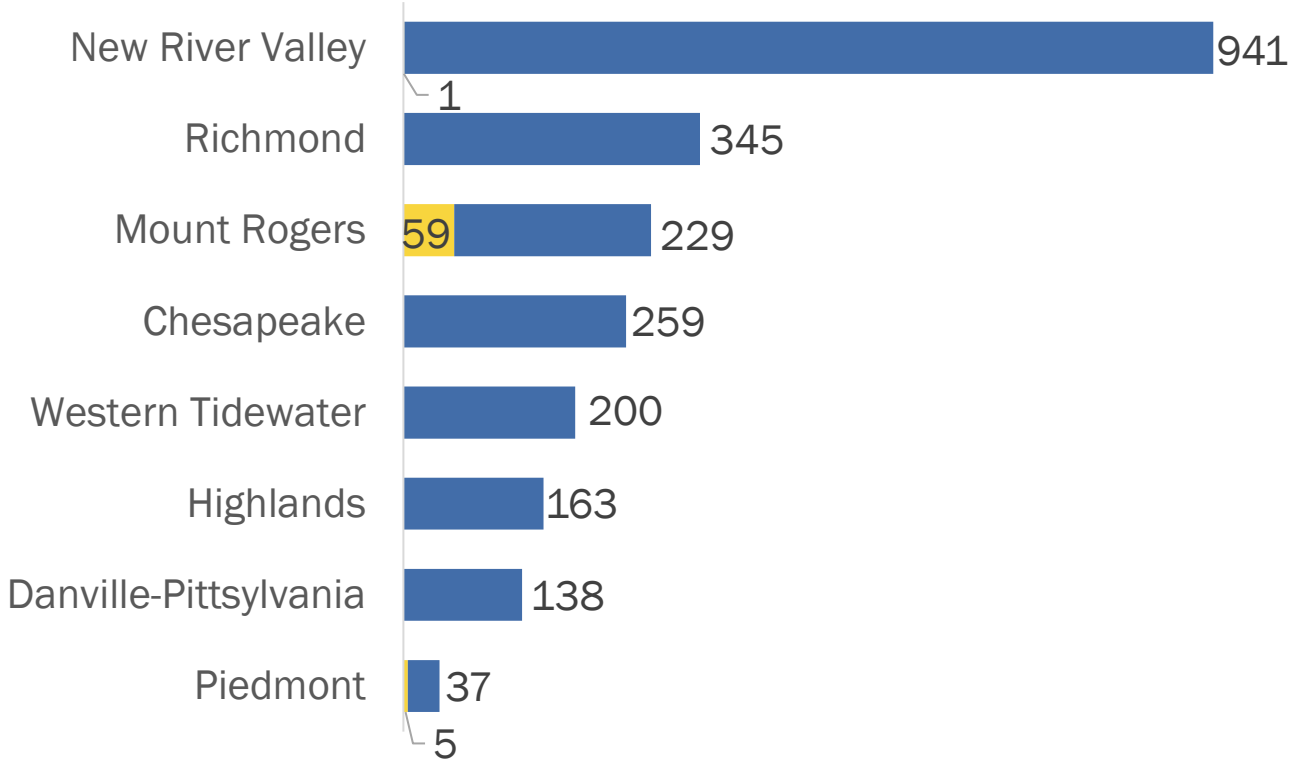
- Individuals who are under an ECO or TDO seldom benefit from crisis facilities
  - Few individuals under an ECO are served in 23-hour CRCs
  - CITACs have limited capacity and capabilities and their role is undefined
  - CSUs serve a small proportion of the overall TDO population

3% of 23-hour CRC clients were under an ECO in FY25, mostly concentrated in 1 CRC

% CRC clients by legal status



Number of clients accepted by CRC, by legal status



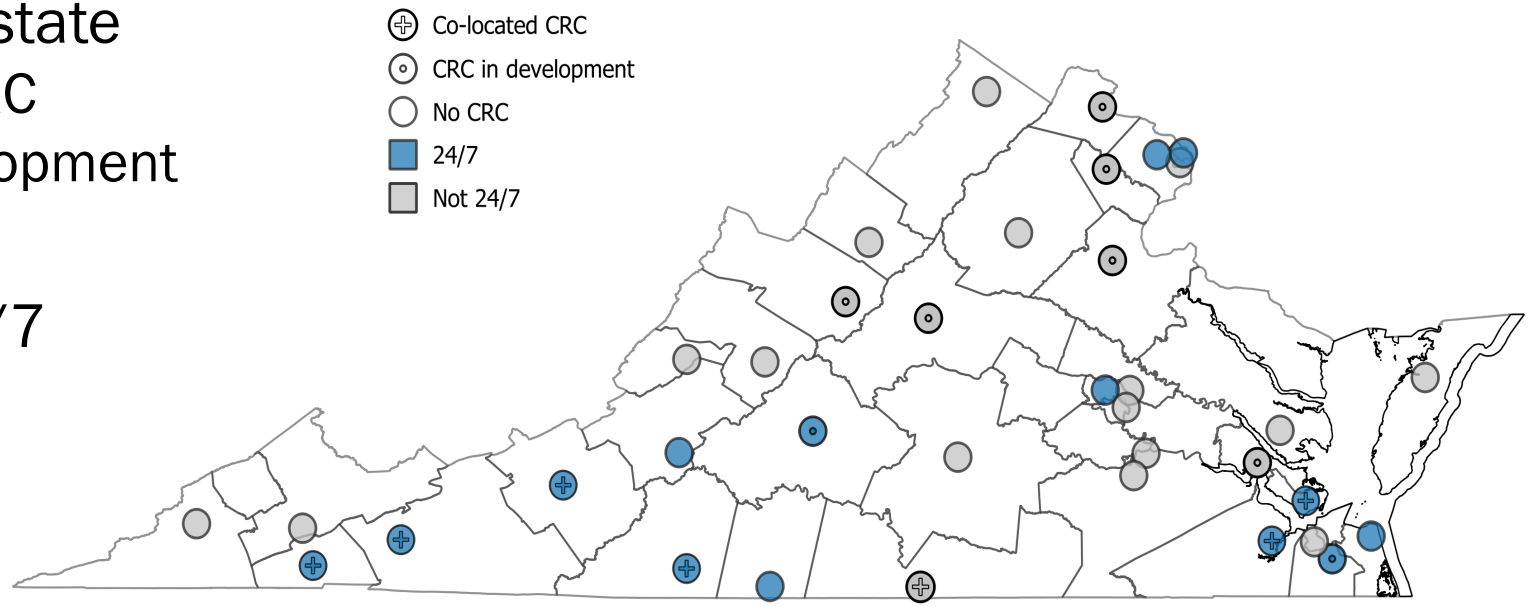
Source: BHC staff analysis of DBHDS CRC & CSU utilization data

CRCs are targeted primarily at voluntary patients and do not appear to have plans to extend services to individuals under an ECO

- Individuals under an ECO still lack therapeutic alternatives to EDs
  - Serving ECOs in CRCs reduces the likelihood of TDOs, increases voluntary uptake of services, and returns law enforcement to public safety duties
- Most CRCs have not taken steps to accept involuntary patients
  - Few crisis facilities have requested authorization from DBHDS to incorporate seclusion and restrain into their programs
- CSBs have differing philosophies on the clinical appropriateness of serving involuntary patients in CRCs
- CRCs may lack capabilities needed for handling involuntary cases
  - Physical infrastructure, staffing, training, rapid law enforcement drop-off

Role of CITACs in the crisis system is undefined

- 37 CITACs across the state
  - 7 co-located with a CRC
  - 8 have a CRC in development
  - 22 have no CRC
- 23 do not operate 24/7



Most CITACs are standalone, and those co-located with CRCs do not leverage their clinical capabilities

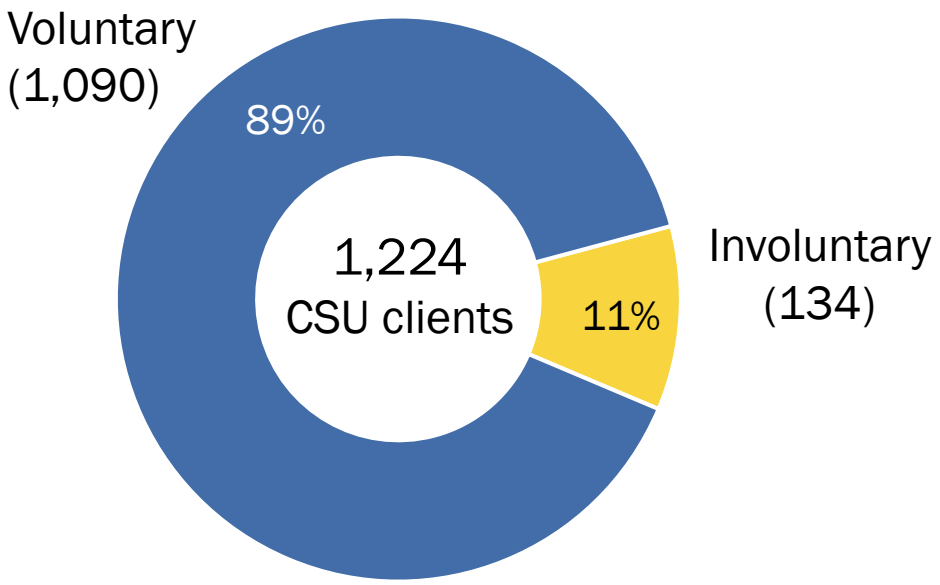
- Freestanding CITACs typically lack CRC capabilities for stabilization and treatment
- Co-location between CITACs and CRCs does not necessarily result in the integration of their capabilities, including rapid law enforcement dropoff
- Best-practice models recommend an integrated model where law enforcement can drop off involuntary patients, and both voluntary and involuntary patients can be assessed, stabilized, and treated
- $9M in FY25 and FY26 appropriated to CITACs for expanding to 23-hour CRCs
  - 2020 DBHDS workgroup recommended CITAC expansion to CRCs

Recommendation

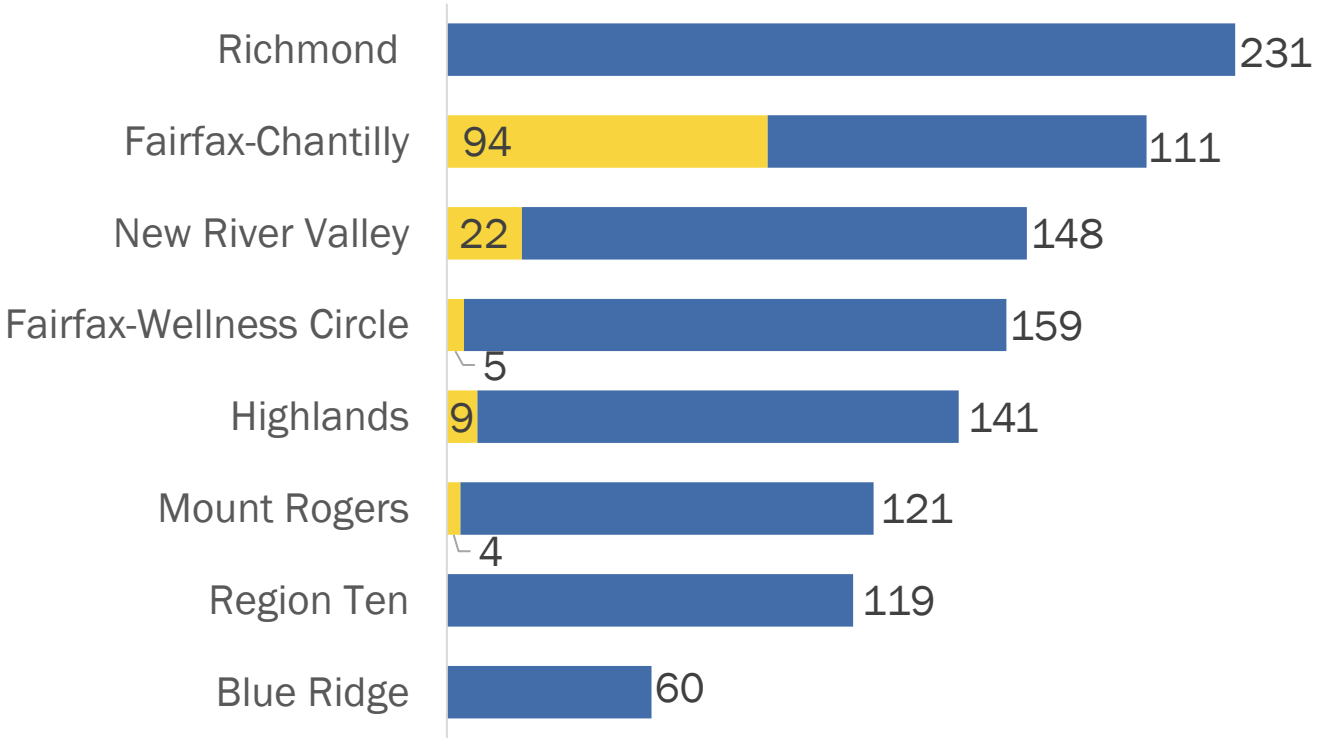
- DBHDS should develop a comprehensive plan to define the role of CITACs in the developing crisis system. Specifically, the plan should address the number of CITACs and CRCs that should be integrated to meet demand and how many standalone CITACs should remain to serve less populated areas; the changes needed to achieve planned integrations and how much they would cost; and the timeframe for integrating CITACs and CRCs where appropriate

11% of CSU clients were under a TDO during first half of 2025, concentrated in 2 CSUs

% CSU clients by legal status



Number of clients accepted by CSU by legal status



Source: BHC staff analysis of DBHDS CRC & CSU utilization data

CSUs are serving a small number of all TDOs in Virginia

- CSUs are not maximizing their role as an alternative to psychiatric hospitals
  - Serving TDOs in CSUs reduces hospitalizations and keeps individuals closer to home
- Some CSUs do appear to accept TDOs, most others accept only “soft” TDOs
  - All CSUs are expected to accept TDOs, when appropriate
- CSBs have differing philosophies on the clinical appropriateness of serving high-acuity, involuntary patients in CSUs
- CSUs may lack capabilities needed for handling high-acuity involuntary cases
  - Physical infrastructure, staffing, training, rapid law enforcement drop-off

Crisis facilities in Virginia do not adhere to national best practices regarding high-acuity and involuntary individuals

- Arizona model stresses “no wrong door” facilities that do not turn anyone away
- SAMSHA’s 2025 national best practices guide for crisis systems recommends a three-tiered crisis facility system that includes “no barrier” facilities
  - High-intensity behavioral health emergency centers for services up to 23 hours
  - High-intensity behavioral health extended stabilization centers for short-term services over 24 hours
- Virginia currently has no facility that adheres to “no wrong door” or “no barrier” model that could meaningfully reduce ECOs and TDOs*

*Prince William County CSB in partnership with Connections Health Solutions will open the first no-barrier crisis facility in Fall 2025

Options

- The General Assembly may wish to consider directing DBHDS to identify strategies to incentivize existing facilities in Virginia to serve individuals subject to an ECO or TDO by modeling a “no-barrier” or “no wrong door” approach
- DBHDS should assess:
  - to what extent existing facilities can be retrofitted to safely adopt a “no-barrier” or “no wrong door” approach;
  - the estimated cost of retrofitting existing facilities compared to building new facilities;
  - the estimated number of ECOs and TDOs that could be appropriately served in CRCs and CSUs if they followed a “no-barrier” or “no wrong door” approach;
  - how much additional capacity would be required to serve appropriate ECO and TDO patients, while balancing the needs of voluntary patients
- Findings and recommendations should be reported to the BHC by December 1, 2026

Takeaways

- Virginia's current crisis system is not designed to serve (1) most high-acuity crises that could result in an ECO, and (2) involuntary patients
- Most involuntary patients are generally unable to benefit from crisis services because of barriers in the state's current crisis system, rather than in the civil commitment process
- Leveraging regional mobile crisis teams in 911 call centers for higher-acuity crises could help divert individuals from the civil commitment process
- "No wrong door" or "no-barrier" crisis facilities could help avoid or shorten civil commitment, offer an alternative to psychiatric hospitalization, and reduce the burden of civil commitment on law enforcement

Staff for this report

- John Barfield, Associate Policy Analyst