COMMONWEALTH of VIRGINIA

JACK BARBER, M.D.
INTERIM COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
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June 30, 2017

The Honorable Thomas K. Norment, Jr.,
The Honorable Emmett W. Hanger, Jr.
Senate Finance Committee
14th Floor, Pocahontas Building,
900 East Main Street,
Richmond, VA 23219

Dear Senator Norment and Senator Hanger:

Senate Bill 260 of the 2014 Legislative Session required the Department of Behavioral Health and Developmental Services (DBHDS) "*submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*"

Please find enclosed the report in accordance SB260. Staff at the department are available should you wish to discuss this request.

Sincerely,

Jack Barber, M.D.

Cc:
William A. Hazel, Jr., M.D.
Kathy Drumwright
Joe Flores
Susan E. Massart
Mike Tweedy
Daniel Herr

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June 30, 2017

The Honorable S. Chris Jones, Chair
House Appropriations Committee
900 East Main Street
Pocahontas Building, 13th Floor
Richmond, Virginia 23219

Dear Delegate Jones:

Senate Bill 260 of the 2014 Legislative Session required the Department of Behavioral Health and Developmental Services (DBHDS) "*submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*"

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June 30, 2017

The Honorable Terry McAuliffe, Governor
Commonwealth of Virginia
Patrick Henry Building
P.O. Box 1475
Richmond, VA 23218

Dear Governor McAuliffe:

Senate Bill 260 of the 2014 Legislative Session required the Department of Behavioral Health and Developmental Services (DBHDS) "*submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*"

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Virginia Department of Behavioral Health & Developmental Services

Annual Report on the Implementation of Senate Bill 260 (2014)

June 30, 2017

DBHDS Vision: A Life of Possibilities for All Virginians

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Annual Report on the Implementation of Senate Bill 260 (2014)

Preface

This report is submitted in response to Senate Bill (SB) 260 (Chap. 691, 2014), which amended and added several sections of the *Code of Virginia* related to emergency custody and temporary detention of adults and minors. The fourth enactment clause of this legislation reads as follows:

> *4. That the Department of Behavioral Health and Developmental Services shall submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*

Annual Report on the Implementation of Senate Bill 260 (2014)

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Introduction

SB 260 was designed to eliminate specific concerns with Virginia's behavioral health emergency response system and to guarantee that everyone who met clinical criteria for temporary detention was able to access necessary care. In the three years since SB 260 was implemented, DBHDS has been working with state psychiatric hospitals, community services boards and other stakeholders to ensure that the expectations set forth in SB 260 are met and to address challenges that have arisen as a result of the legislation. A brief summary of the most significant effects of SB 260 on Virginia's emergency response system is provided below. An overview of the legislation itself can be found in Appendix A.

Since the new law went into effect on July 1, 2014:

- Importantly, no individual subject to an emergency custody order (ECO) who was clinically evaluated and determined to meet clinical criteria for temporary detention has been turned away for lack of a psychiatric bed.

- There has been a sustained increase in the average daily number of face to face evaluations completed by community services boards (CSBs) emergency services clinicians for involuntary hospitalizations over the last two and a half years.
    - FY 2015: 229 evaluations per day
    - FY 2016: 262 evaluations per day
    - First two quarters of FY 2017: 252 evaluations per day

- There has been a consistent increase in the daily number of temporary detention orders (TDOs) issued by magistrates:
    - FY 2015: 68 TDOs issued daily
    - FY 2016: 71 TDOS issued daily
    - First two quarters of FY 2017: 70 TDOs issued daily

- There has been a consistent increase in the daily number of emergency psychiatric hospital admissions:
    - In FY 2014, state hospitals admitted an average of 12 persons per day
    - In FY 2015, state hospitals admitted an average of 14 persons per day
    - In FY 2016, state hospitals admitted an average of 17 persons per day
    - In the first two quarters of FY 2017, state hospitals admitted an average of 16 persons per day

As demonstrated above, concurrent with the requirements and implementation of SB 260, the Commonwealth of Virginia continues to experience a significant increase in the demand for emergency services, including all areas related to the involuntary admission process. In the public system, this trend is reflected in both community services and state hospital care. CSBs have conducted more emergency evaluations; while for state hospitals, there has been an overall increase in the number of TDO referrals and hospital admissions. Further, the above data reflect that these statewide trends tilt the system towards more restrictive and resource intensive interventions. These approaches are inconsistent with national best practices and with *Olmstead*

v. L.C.'s (Olmstead)[1] interpretation of the *American's With Disabilities Act (ADA).*[2] The *ADA* requires states to provide services to individuals with disabilities in the most integrated community settings.

Virginia's nine state mental health hospitals are under tremendous strain as they are weathering a 157 percent increase in temporary detention order (TDO) admissions and a 54 percent increase in total admissions since FY 2013. Such increases in admissions have created an unsustainable utilization rate for the state hospitals, placing both staff and patients alike in potentially unsafe conditions, and leading to increases in turnover rates among critical staff.

Compounding the issue is the extraordinary barriers to discharge list, or EBL. Virginia maintains a list of individuals residing in state hospitals for more than 14 days who are clinically ready to be discharged but are unable to leave because the necessary community services are not available to ensure a safe discharge. In March 2017, there were 205 individuals on the statewide EBL. As part of efforts to reduce the EBL, DBHDS initiated a collaboration project with the CSBs with the goal of safely discharging 100 people from the EBL list by July 1, 2017. This project increases community placement capacity by using one-time special revenue funds, repurposed general funds from Central Office and CSBs, and new funds provided for FY 2018. This project is not a long-term solution for the challenging census issues as beds vacated by patients on the EBL are expected to be filled by new admissions. However, the EBL project will allow time to build a definitive and sustainable process to manage the hospitals' census and build community capacity.

As state hospital census increases continue to cause alarm, it is critical that care is managed from both a clinical and a financial standpoint. Importantly, the vast majority of system experts do not believe adding state beds is the wisest or even the correct solution to this challenge. Adding state beds would be extremely expensive and the hospitals are struggling to staff existing beds. Furthermore, there is no cost for a state hospital bed to CSBs, jails, and Medicaid (for adults), resulting in a financial dynamic that is not aligned to best facilitate community-based care.

To help address this issue, the 2017 General Assembly required that the Office of the Secretary of Health and Human Resources develop an implementation plan for the financial realignment of Virginia's public mental health system. The plan must contain a variety of requirements, including the following (from General Assembly budget language): "A timeline and funding mechanism to eliminate the extraordinary barriers list in state hospitals and to maximize the use of community resources for individuals discharged or diverted from state facility care; Sources for bridge funding, to ensure continuity of care in transitioning patients to the community, and to address one-time, non-recurring expenses associated with the implementation of these reinvestment projects; State hospital appropriations that can be made available to CSBs to expand community mental health and substance abuse program capacity to serve individuals who are discharged or diverted from admission; And, financial incentive for CSBs to serve individuals in the community rather than state hospitals." DBHDS will continue working with state agency partners and system stakeholders to collect information and feedback as potential models for such a financial structure are created. The plan is due December 1, 2017.

[1] Olmstead v. L. C., 527 U.S. 581 (1999).
[2] Americans With Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 328 (1990).

Impact of SB 260

Of central importance to the implementation of SB 260 was the development of new standards and protocols to ensure that no individual in acute psychiatric crisis, meeting clinical criteria for temporary detention, would fail to receive that care due to lack of a clinically appropriate and available bed that meets the needs of the patient. This section describes the impact of these new standards and protocols in the following key areas.

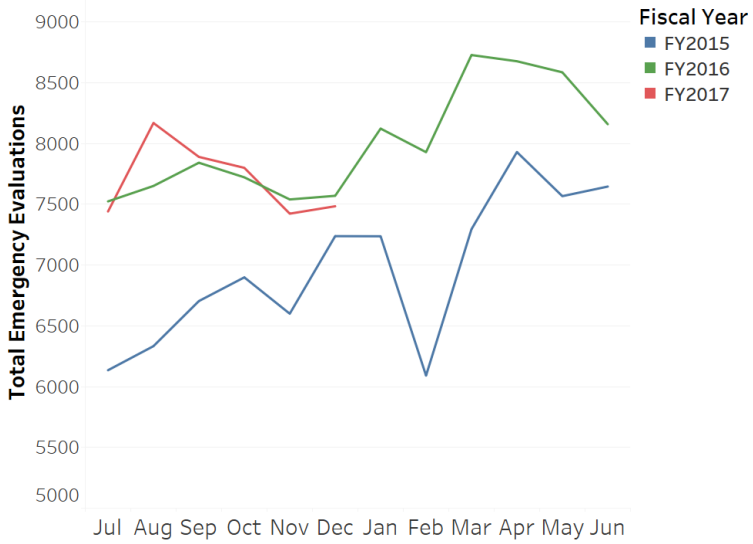
Emergency Custody Orders, CSB Emergency Evaluations, and Executed TDOs – Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis. These evaluations may be conducted in person or electronically by two-way video and audio communication. An emergency custody order (ECO) is issued by a magistrate authorizing a person to be taken into custody for up to eight hours and transported for an evaluation to determine if the individual meets the criteria for temporary detention and to assess the need for hospitalization and treatment.

Figure 1, below, shows the frequency of ECOs during FY 2016 and the first two quarters of FY 2017. ECO data has been collected since November 2015.

Figure 1: Number of Emergency Custody Orders, FY 2016 - Mid-Year FY 2017

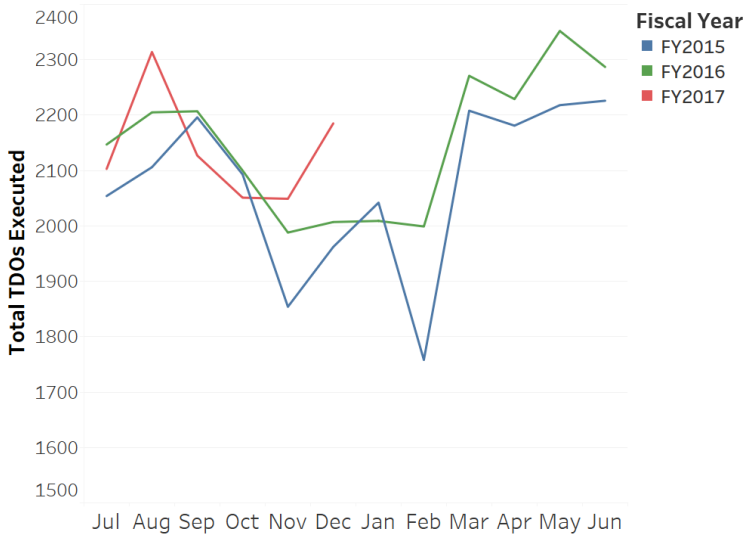
Figure 2, below, shows the number of emergency evaluations completed by CSBs during FY 2015, FY 2016 and the first two quarters of FY 2017.

Figure 2: Number of CSB Emergency Evaluations, FY 2015 - Mid-Year FY 2017



During the ECO period, if an individual is determined to meet temporary detention criteria, a TDO is issued by a magistrate authorizing a person to be taken into custody for up to 72 hours and transported to a psychiatric facility. A TDO is considered executed at the time when the individual is served with the TDO and taken into custody for the purpose of being transported to the hospital for admission. Figure 3, below, shows the number of executed TDOs for FY 2015, FY 2016, and the first two quarters of FY 2017.

Figure 3: Number of TDOs Executed, FY 2015 - Mid-Year FY 2017

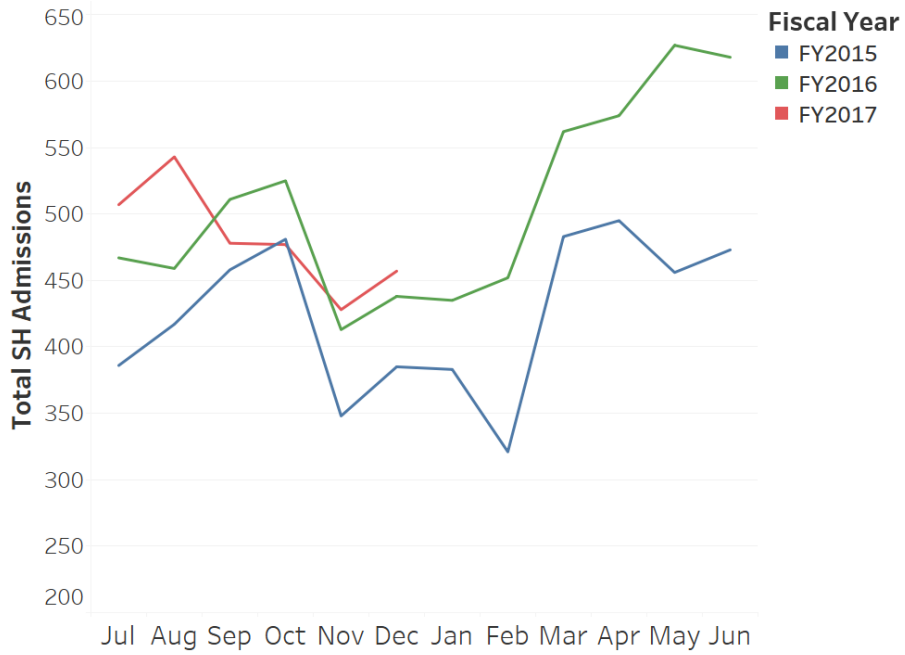


These data show a sustained increase over the course of FY 2016 that continues through the first two quarters of FY 2017.

In addition to the data shown in Figures 1-3 above, the CSBs also collect and report data to DBHDS on critical events associated with CSB emergency services utilization, TDOs, and the factors contributing to these events. DBHDS requires this data be submitted monthly by each CSB and geographic region. DBHDS also requires case-specific reports from individual CSBs within 24-hours of any event involving an individual who has been determined to require temporary detention for which the TDO is not executed for any reason. These reports are aggregated and analyzed monthly with the results and analyses posted on the DBHDS website.[3]

State Hospital Admissions – Overall, admissions to state hospitals have increased significantly since the passage of SB 260. Figure 4, below, shows the trend in state hospital admissions for FY 2015, FY 2016 through the first two quarters of FY 2017.

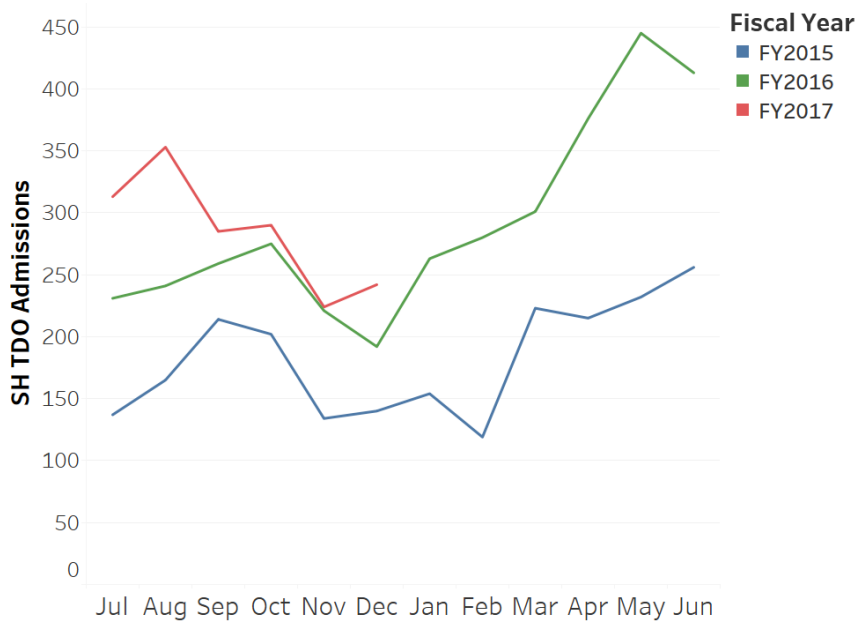
Figure 4: Number of State Hospital (SH) Admissions, FY 2015 - Mid-Year FY 2017



[3] See http://www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/data

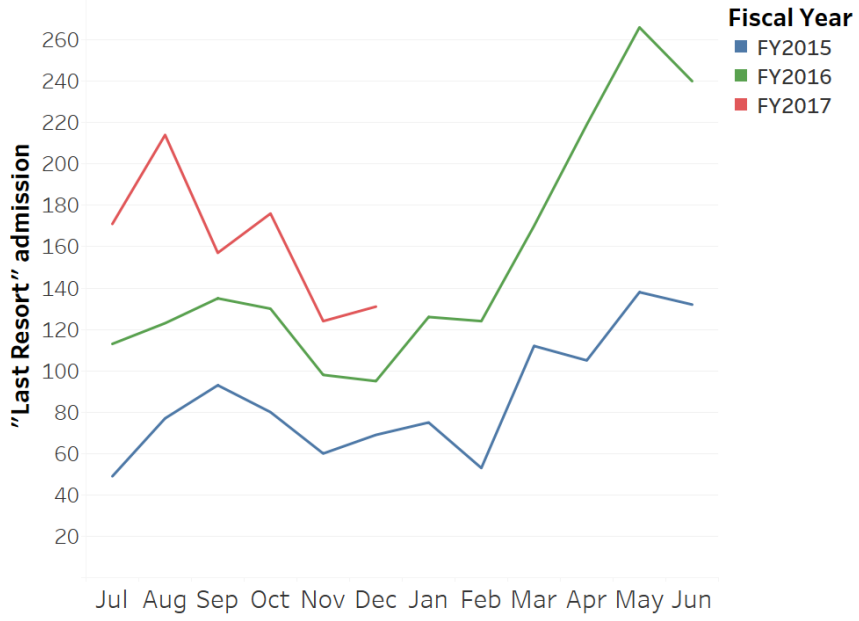
Figure 5, below, shows only the civil TDO admissions to state hospitals. TDO admissions to state hospitals have increased dramatically since 2014 and the passage of SB 260.

Figure 5: Number of State Hospital (SH) TDO Admissions, FY 2015 - Mid-Year FY 2017



Number of "Last Resort" Admissions – Figure 6, below, shows the number of cases when an individual was admitted to a state hospital under the last resort provisions of §§37.2-809.1 and 16.1-340.1:1 because no other alternative facility could be found at the conclusion of the eight hour period of emergency custody.

Figure 6: Last Resort Admissions to State Hospitals, FY 2015 – Mid-Year 2017 (CSB Reports)



Length of Stay for Temporary Detention – SB 260 extended the maximum period of temporary detention for adults from 48 hours to 72 hours. In FY 2014, the average length of stay for adults admitted to state hospitals under a temporary detention order was 4.42 days, in FY 2015 it was 2.25 days, in FY 2016 it was 2.31 days and from July 1, 2016 to December 31, 2016, it was 2.51 days. Corresponding data are not available from private psychiatric hospitals. From July 1, 2016 through December 31, 2016, private psychiatric hospitals admitted 86.6 percent of all individuals under at TDO.

Number of Alternative Hospitals Contacted – Prior to the passage of SB 260, each region developed regional admission protocols, which established the processes for contacting the alternative hospitals prior to requesting admission to the regional state hospital. These regional protocols are posted on DBHDS' website.[4] Each region identified alternative hospitals to be contacted based on variations in resources within the region including:

- Number of residential crisis stabilization beds,
- Number of private hospitals, and
- Capacity of those hospitals to serve individuals with specialized and intensive needs.

Treatment Costs for Individuals under Temporary Detention – DBHDS is unable to provide a complete and comprehensive estimate of the full cost of temporary detention in the Commonwealth because these costs are paid from various sources, including private insurance, Medicare, Medicaid, and other funds. There is no available data source for all of this information. Figure 7 below shows the costs for temporary detention in state hospitals for FY 2014 through FY 2016 and through the first two quarters of FY 2017.

Figure 7: Costs for Individuals Under TDO Admitted to State Hospitals for FY 2014 - Mid-Year FY 2017

Total cost for TDO Bed Days by FY at State Hospitals			
	Total Civil TDO Bed Days	Average cost for a Bed Day	**Total Cost for Civil TDO Bed Days**
FY 2014	82,151	$723.83	$59,463,358.33
FY 2015	95,477	$747.14	$71,334,685.78
FY 2016	125,208	$757.86	$94,890,134.88
FY 2017 (July – Dec. 2016)	75,073	$755.50	$56.717,651.50

A more comprehensive measure of the cost of temporary detention is the total charges to the Involuntary Mental Commitment Fund (IMCF) administered by Department of Medical Assistance Services (DMAS). Individuals' TDO stays may be covered by private insurance, by other public insurance, by Medicaid, or it may not be covered. When there is no payer available, the psychiatric facility submits its claims to DMAS for payment through the IMCF, which is funded entirely by general fund dollars. The IMCF pays the hospital and physician costs for uncovered costs associated with individuals hospitalized under a TDO. The TDO Fund in Figure 8 below represents statewide expenditures paid by DMAS through the IMCF to private and state psychiatric hospitals in Virginia for temporary detention services. The Medicaid Fund column represents TDO costs covered by Medicaid. The total IMCF and Medicaid expenditures for FY 2015, FY 2016, and the first two quarters of FY 2017 are displayed below:

[4] See www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/protocols-and-procedures

Figure 8: Reimbursements for Temporary Detention from the IMCF and Medicaid

Temporary Detention Order Expenditures	TDO Fund	Medicaid Fund
FY 2015	$14,608,199.46	$1,460,856.37
FY 2016	$16,146,916.20	$1,089,591.37
FY 2017 (July – December, 2016)	$9,418,874.98	$671,592.66

Source: DMAS

Notifications to State Hospitals – SB 260 added requirements for notifications throughout the emergency custody process. First, a law enforcement officer must notify the appropriate CSB of an ECO "as soon as practicable" after the officer takes the individual into emergency custody. Then, after receiving this notification, the CSB is, in turn, required to notify the appropriate state hospital of the pending ECO evaluation, and to communicate that the individual will be referred to the state hospital for temporary detention if needed and no other alternative hospital is found. The CSB is required to make another notification to the state hospital to convey the results of the evaluation, and may continue to communicate with the state hospital until the case is resolved. DBHDS state hospitals are required to document the initial notifications.

The total number of initial notifications received by state hospitals from CSBs in FY 2015 regarding individuals under ECOs was 19,780. In FY 2016 there were 18,569 notification calls and there were 10,217 during the first two quarters of FY 2017. The reduction in reported initial notifications in the first two quarters of FY 2016 can be attributed to changes in the method of data collection at each of the nine hospitals. During FY 2015, some of the hospital numbers included the initial notification call as well as any additional calls to the hospital for each individual subject to an ECO. Following the review of this data, DBHDS and the state hospitals have developed protocols to ensure improved consistency in data collection.

Enhancements to the Psychiatric Crisis Response System

To further strengthen the emergency services aspects of the public behavioral health system, DBHDS implemented educational, training, certification, and quality oversight requirements for emergency services clinicians. The following new requirements were effective July 1, 2016 and have been included in the FY 2017 performance contract with CSBs:

- All new hires for preadmission clinicians must have an educational attainment of a Master's or Doctoral Degree with an associated professional license or educational attainment that would be required for a license in Virginia.
- Supervisors of Certified Preadmission Screening Clinicians must be licensed and have a minimum of two years of experience working in emergency services or with persons with serious mental illness and be a Certified Preadmission Screening Clinician.
- All Certified Preadmission Screening Clinicians must have 24/7 access to clinical consultation by a qualified supervisor.
- Every Certified Preadmission Screening Clinician must have documentation of a minimum of 12 hours of individual or group supervision annually.
- All Certified Preadmission Screening Clinician must have completed a minimum of 16 documented hours of continuing education annually.

- Prior to certification, the individual must have completed all the required training modules and an emergency services orientation that meets the requirements of DBHDS.
- Certified Preadmission Screening Clinician must re-certify every two years.

Since July 1, 2016, 1,036 emergency services clinicians completed the training models necessary to achieve certification and will continue to be re-certified on these modules every two years. Additionally, as part of DBHDS' investment in the professional development of the emergency services workforce, in April 2017, DBHDS sponsored two workshops titled *Conceptualizing and Communicating Risk for Suicide and Violence in Pre-Screening Evaluations*. In these two full-day workshops, over 230 participants updated their skills and knowledge for assessing suicide and violence risk with adolescents and adults. Starting with case examples, the participants learned and applied new models for efficiently bringing together risk information gathered from diverse sources, such as family members, law enforcement, and patient report. Work shop discussions also centered on overcoming practical barriers to apply these models, such as time constraints and incomplete information, in the emergency services prescreening environment.

Acute Psychiatric Bed Registry

On March 3, 2014, DBHDS, in collaboration with the Virginia Hospital and Healthcare Association (VHHA) and Virginia Health Information (VHI), launched the psychiatric bed registry to assist CSB emergency evaluators in locating available beds for individuals who are under an emergency custody order and need to receive mental health treatment under a temporary detention order.

In the fall of 2016, prior to the expiration of the current contract with VHI, DBHDS issued a request for proposals to host the bed registry service. From this competitive process, Etelic, Inc. was selected to provide the bed registry service for Virginia and the transition from the service hosted by VHI to the service hosted by Etelic occurred on March 13, 2017. Etelic's service contains the same functionality as the VHI's service; however, some of the visuals, screens, and processes differ from those hosted by VHI. Training sessions were offered to all of the users to assist them with the transition to the new processes, visuals, and screens. DBHDS is providing ongoing support to the end users of this service and actively working with stakeholders to further refine and develop the platform as issues are identified.

System Changes

To reform the system, DBHDS designed System Transformation Excellence and Performance (STEP-VA), an innovative initiative for individuals with behavioral health disorders featuring a uniform set of required services, consistent quality measures, and improved oversight in all Virginia communities. STEP-VA is based on a national best practice model that contains deliberately chosen services for a comprehensive, accessible behavioral health care system. An extensive stakeholder initiative then helped define the services that are needed in Virginia. The

resulting STEP-VA services improve access, increase quality, build consistency and strengthen accountability across Virginia's public behavioral health system:

- Same Day Access
- Outpatient Services
- Primary Care Integration
- Detoxification
- Care Coordination
- Peer and Family Support
- Psychosocial Rehabilitation/ Skill Building
- Targeted Case Management
- Veterans Services
- Person-Centered Treatment
- Mobile Crisis Services

STEP-VA is designed to incorporate services over multiple years, each providing the infrastructure and expertise needed to build on the next. To implement these changes, STEP-VA will expand certain existing services and implement new services to maximize impact. Notably, STEP-VA services are intended to foster wellness among individuals with behavioral health disorders in everyday life to prevent crises before they arise. Outcomes would include fewer admissions to state and private hospitals, decreased emergency room visits, and reduced involvement of individuals with behavioral health disorders in the criminal justice system.

In 2017, Governor McAuliffe and the General Assembly provided funds for an initial group of CSBs to implement Same Day Access, a program that allows a person who calls or appears at a CSB to be assessed that same day instead of potentially waiting weeks for an appointment. In addition, the General Assembly required that STEP-VA services be implemented over the next two biennia, including Same Day Access and primary care screening by FY 2019 and the remainder of services by FY 2021. Funding would need to be allocated in future years. The next STEP-VA phase includes implementing Same Day Access in the rest of the CSBs, installing primary care screening and tight linkages to medical providers in all CSBs, addressing existing gaps in outpatient services (multiyear process), including medication assisted treatment for substance use disorders, and improving targeted case management services for children.

Through STEP-VA's focus on behavioral health wellness, early identification of treatment needs, and prompt intervention in behavioral health conditions, individuals are able to receive the necessary treatment before it reaches crisis level.

Conclusion

Since the implementation of SB 260, Virginia has made significant improvements in the quality and accountability of community services through legislative and administrative efforts. These accomplishments have ensured that no person has been turned away from a psychiatric hospital bed when needed, increased qualifications of emergency custody and preadmission screening evaluators, updated communications infrastructure between the courts and behavioral health care providers, improved key outcome and performance measures, and strengthened CSB performance contracts. However, there have also been significant challenges related to the legislation and system changes, including the dramatic increase in state hospital censuses since FY 2013. Through the improvements in SB 260, STEP-VA and the state hospital and community services financial realignment, DBHDS is working closely with the Administration, the General Assembly and stakeholders to move Virginia's system forward in a cohesive, strategic manner.

Appendices

Appendix A: Overview of SB 260

SB 260 bill was signed into law as Chapter 691 by Governor McAuliffe effective April 6, 2014. The salient features of this bill are described below:

- *Eight hour maximum period of emergency custody:* The legislature doubled the maximum period of emergency custody to eight hours, in §§ 16.1-340 (minors), 19.2-182.9 (NGRI acquittees on conditional release), and 37.2-808 (adults).
- *Law officer notification:* SB 260 specified that a law officer who executes an ECO under §§ 16.1-340 (minors) and 37.2-808 (adults) must notify the appropriate community services board (CSB) of the execution of the emergency custody order "as soon as practicable" after execution.
- *Written explanation of ECO and TDO process:* An adult taken into emergency custody or temporary detention must be given a written explanation of the process and the statutory protections associated with these procedures (§§ 37.2-808. and 37.2-809).
- *Eight hour mandatory outpatient treatment (MOT) examination period:* The period of custody to perform an examination required for court review of a MOT plan was changed from four hours to eight hours in §§ 16.1-345.4 (minors) and 37.2-817.2 (adults).
- *State hospitals are "last resort" for temporary detention:* Under §§ 16.1-340.1 and 16.1-340.1:1 (minors), and §§ 37.2-809 and 37.2-809.1 (adults), state hospitals are required to admit any individual for temporary detention who is not admitted to an alternative treatment facility, such as a community private psychiatric hospital, prior to the expiration of the emergency custody period. This provision ensures that no individual meeting clinical criteria for temporary detention is denied access to care, because the state hospital will serve as the "last resort" in the event that treatment cannot be accessed in a private psychiatric community hospital or other facility. Finally, to ensure that no individual slips through system cracks, an individual who is deemed to need temporary detention may not be released from custody except for the purposes of transportation to the temporary detention facility.
- *State hospitals may seek alternative facilities:* Under §§ 16.1-340 (minors) and 37.2-808 (adults), state hospitals and CSBs may continue to search for an alternative temporary detention facility for an additional four hours following admission of anyone who is admitted because a suitable alternative facility could not be found by the time the eight hour emergency custody period expired. Any such alternative facility must be willing and able to provide appropriate care. A second enactment clause in SB 260 specifies that these provisions expire on June 30, 2018.
- *72-hour maximum period of temporary detention:* The maximum period of temporary detention prior to a hearing was extended from 48 hours to 72 hours in §§ 19.2-169.6.A.2 (jail inmates), 19.2-182.9 (NGRI acquittees on conditional release), and 37.2-809 and 37.2-814 (adults).
- *Acute Psychiatric Bed Registry:* § 37.2-308.1, was added to SB 260 requiring DBHDS to operate an acute psychiatric bed registry to provide real-time information on bed availability to designated searchers so that CSBs, inpatient psychiatric facilities, public and private residential crisis stabilization units, and health care providers working in an emergency room of a hospital or clinic or other facility rendering emergency medical care could access information about psychiatric bed availability through the bed registry and this information.