# COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

*DEPARTMENT OF*
*BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES*
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov


June 9, 2025

To: The Honorable Ghazala F. Hashmi, Chair, Senate Education and Health
The Honorable Luke E. Torian, Chair, House Appropriations
The Honorable Mark. D. Sickles, Chair, House Health and Human Services
The Honorable R. Creigh Deeds, Chair, Behavioral Health Commission

From: Nelson Smith, Commissioner, Department of Behavioral Health and Developmental Services

RE: SB 34, 2024 Session

Senate Bill 34 from the 2024 Session, is a pilot project which allows non-community services board (CSB) emergency services staff to conduct preadmission screening for the purposes of determining in criteria is met for a temporary detention order (TDO). The language reads:

> *Authorizes hospitals with a psychiatric emergency department located in the City of Hampton to employ certain trained individuals to perform evaluations to determine whether a person meets the criteria for temporary detention for behavioral health treatment. The bill requires participating hospitals with psychiatric emergency departments in the City of Hampton to annually report the length of time between when a person who is the subject of an emergency custody order arrives at the psychiatric emergency department of a participating hospital and when the temporary detention order evaluation is completed and (ii) the number of (a) admissions, (b) psychiatric emergency department visits, (c) temporary detention order evaluations completed, (d) temporary detention orders executed, (e) individuals under temporary detention admitted to the participating hospital, and (f) individuals transferred from the psychiatric emergency department of the participating hospital to a state facility to the Senate Committee on Education and Health, the House Committee on Health and Human Services, and the Behavioral Health Commission. The bill requires participating hospitals with psychiatric emergency departments in the City of Hampton to report monthly to the Commissioner of Behavioral Health and Developmental Services the number of (a) crisis evaluations conducted each month; (b) temporary detention orders executed as a result of such evaluations and the percentage of evaluations such temporary detention orders represent; (c) reportable events associated with such temporary detention orders and the percentage of temporary detention orders that such reportable events represent; (d) certain reportable events; and (e) other events. The bill requires DBHDS to submit by October 1, 2026, to the Senate Committee on Education and Health and the House Committee on Health and Human Services an evaluation of the overall effectiveness of certified evaluators conducting temporary detention order evaluations pursuant to the bill. The bill has an expiration date of July 1, 2026.*

DBHDS and Riverside developed an MOU to determine procedures and data to be collected during the pilot program. Following is a preliminary report derived from several months of data. The final report is due October 1, 2026.

cc: Janet V. Kelly, Secretary, Health and Human Resources

DBHDS

Virginia Department of Behavioral Health and Developmental Services

# Preliminary Report: Riverside Pilot Project

# Senate Bill 34

**October 1, 2026**

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797 PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

# Senate Bill 34

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## Background

In the 1990s, the General Assembly amended the Virginia Code to remove the ability of private hospitals to prescreen individuals having a psychiatric emergency for the purposes of determining if criteria are met for a temporary detention order (TDO). Virginia Code (§§ 37.2-808, 37.2-809, and 37.2-809.1) was amended to require third-party community services boards (CSB) to conduct all psychiatric prescreen evaluations for involuntary behavioral health treatment. The Code was also amended to require that the certified preadmission screening clinician cannot have any conflict of interest in the location where the individual is being evaluated or where the individual would be held under temporary detention.

For many years hospital systems have advocated to have their own staff conduct these legal evaluations. Hospitals with dedicated psychiatric units within their emergency departments, like Riverside Medical Center, have communicated that their staff provide duplicative services as CSB certified pre-admission screening clinicians, and by allowing hospital staff to conduct the evaluation for a TDO, it will speed up access to care and reduce burden on the patient, hospital, law enforcement, and CSB staff. CSBs have communicated concerns that outcomes of the evaluations conducted by facility staff are not clinically objective, the assessment would not be comprehensive, least restrictive options would not be adequately explored, and that the power differential between non-medical and medical staff would influence clinical decision making. There are also concerns about potential conflict of interest as medical staff working for a private facility could hypothetically use the authority to assess for TDO eligibility to inappropriately remove individuals in crisis from their emergency department (ED).

Multiple bills allowing private hospital staff to conduct prescreen assessments for the purposes of temporary detention were introduced and failed to pass in prior sessions. However, in 2024, SB 34 was passed to create a pilot project where a single hospital in the City of Hampton would employ “certified evaluators” who can conduct evaluations for adults in a behavioral health crisis to determine if they meet civil commitment criteria for a TDO.

The pilot project began July 1, 2024, at which time, Riverside Hospital became responsible for conducting and managing all code mandated emergency services (ES) functions, to include the pre-admission screening evaluation, bed search using the bed registry, ensuring all least restrictive alternatives have been exhausted, and contacting the Regional, Education, Assessment, Crisis Services, and Habilitation program (REACH) if a patient has a developmental disability. SB 34 also created new reporting responsibilities. Additional reporting requirements were included in the memorandum of understanding (MOU) between Riverside and DBHDS.

## Implementation and Ongoing Activities

DBHDS first met with Riverside leadership in April 2024 to ensure the program would be ready to begin on July 1, 2024. Implementing the pilot involved a great deal of staff time from both Riverside and DBHDS. The following were major areas of activity around standing up the pilot and ensuring its successful operation:

**Memorandum of Understanding (MOU)** –The MOU was developed collaboratively to document the process and procedures needed to launch the pilot, including certification and training, and to detail the reporting necessary to monitor the program, ensure ongoing training, and align with emergency services data submitted by CSBs. Leadership meetings occurred at least monthly to discuss the MOU. The final MOU can be found in Appendix B.

**Certification** – The Code of Virginia (§§ 37.2-809, 16.1-338-340.1, and 19.2-169.6) requires any person who conducts preadmission screening evaluations, for the purposes of temporary detention, to complete a certification program approved by DBHDS. The certification is valid throughout the Commonwealth. DBHDS regulates the certification, and recertification, of certified preadmission screening clinicians (CPSC)/certified evaluators, through regular compliance inspections. DBHDS provides the certification based on the attestation of the individual's supervisor and executive director that the individual meets the certification requirements and has completed the orientation requirements. All CPSC/certified evaluators must successfully complete orientation that meets the following content, observational and experiential requirements. Please reference Appendix A for requirements. Riverside now has 22 certified evaluators, including the program and clinical director.

**Training** – DBHDS provided the required online modules training for a clinician to become a certified evaluator in May 2024. In addition, it has also been strongly encouraged for Riverside to hold staff trainings on commitment hearings, policy and procedure guidelines related to medical complications, and the ECO/TDO process for support staff who do not conduct prescreen evaluations. It has also been strongly encouraged for Riverside to develop policies related to internal disagreements with staff regarding patient disposition.

**DBHDS Guidance and Technical Assistance** – A DBHDS emergency services subject matter expert (ES SME) met with Riverside on a recurring cadence to provide technical assistance (TA), face to face on site observation, review of the prescreen modules, in service trainings to staff, and to conduct quality improvement/quality assurance reviews of completed preadmission screenings. The ES SME continues to meet with Riverside at least twice monthly and provides TA during off hours when needed. To date, the ES SME has spent approximately 80 direct hours with Riverside (not including supervision and internal collaborative meetings). DBHDS staff has provided in service training on topics to include regional protocols for state hospitals, alternative transportation, prescreen documentation, assessing for capacity/consent and clinical relevance of the mental status exam.

**Collaboration** – Conducting prescreening admission for the purposes of determining if criteria is met for a TDO requires evaluators to balance clinical and legal considerations which can be complicated. Riverside has collaborated with DBHDS while at the same time, striving for autonomy. This legal and clinical responsibility also requires collaboration with many additional stakeholders, such as law enforcement, Fire/EMS, other private hospitals, magistrates, commitment hearings teams, CSBs, and various advocacy groups. DBHDS has strongly encouraged Riverside to inform these stakeholders of this pilot project and to create and/or maintain relationships with those stakeholders. DBHDS has also accompanied Riverside to some stakeholder meetings, as staff capacity permits, to support engagement and answer questions. Riverside also attends regional ES meetings monthly.

## Data Reporting Requirements

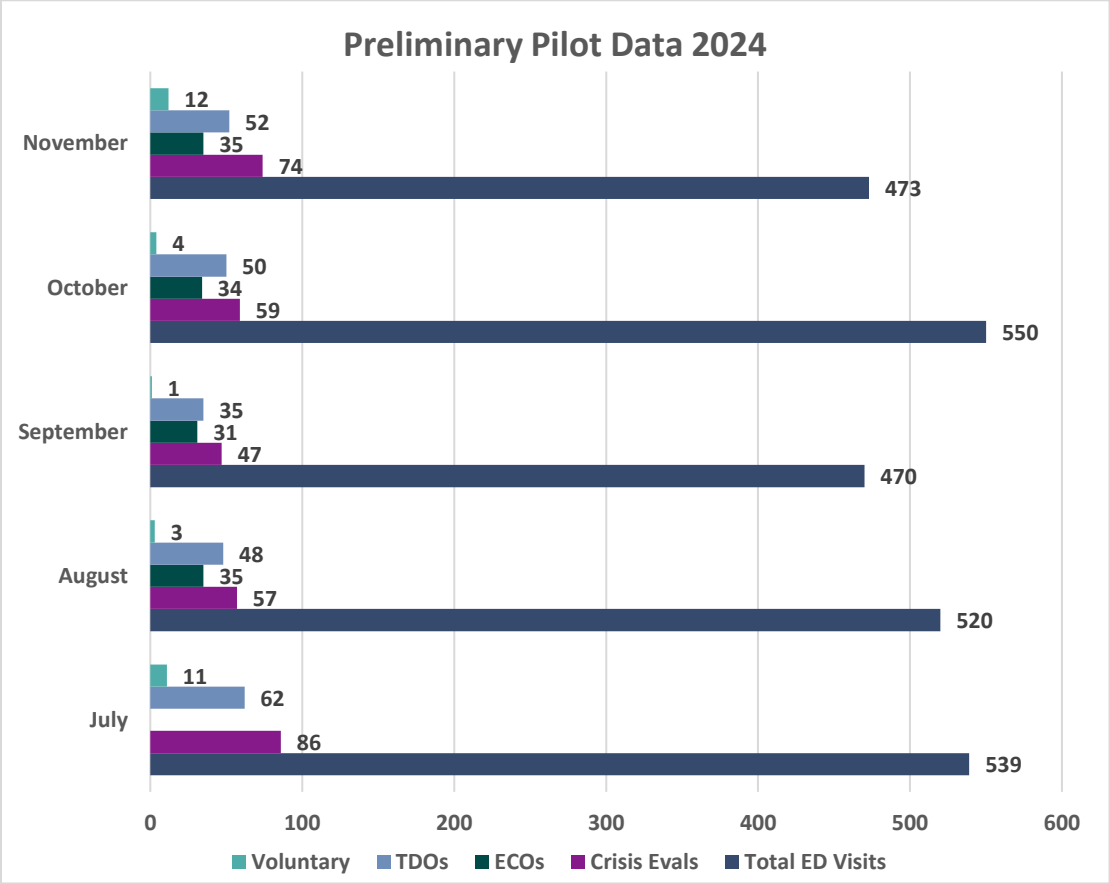
The chart below shows the monthly data reporting requirements in SB 34 and the DBHDS-Riverside MOU. After initial delays, Riverside has fulfilled the data reporting required by SB 34. However, additional monthly data submissions were agreed to in the MOU that have not yet been provided, including data point defined in II, III, IV in the below MOU column. Monthly access to this data is essential for DBHDS to identify and address problems in a timely fashion and fulfill SB 34's requirements for DBHDS to assess performance of the pilot. DBHDS will continue to work with Riverside on data reporting.

**Monthly Data Reporting Requirements for SB34 and MOU**

| SB 34 | MOU |
|---|---|
| **I.** Crisis evaluations conducted<br>**II.** TDOs executed as a result of such evaluations and the percentage of evaluations such TDOs represent by payor type<br>**III.** Reportable events associated with such TDO and the percentage of TDOs that such reportable events represent<br>**IV.** Reportable events<br>a. Involving loss of custody<br>b. With and without an ECO<br>c. With a TDO executed subsequently<br>d. In which the individual subsequently engaged in outpatient treatment<br>e. In which the individual did not engage in treatment services<br>f. Involving medical treatment; and<br>g. Other events<br>h. The facility where each patient, classified by payor type, is placed for any TDO that is executed based on their evaluation.<br><br>**SB 34 Annual Reporting Requirements for Pilot Psychiatric Emergency Department:**<br><br>"(i) the length of time between when a person who is the subject of an ECO pursuant to § 37.2-808 arrives at the psychiatric ED of a participating hospital and when the TDO evaluation is completed and (ii) the number of (a) admissions, (b) psychiatric ED visits, (c) TDO evaluations completed, (d) TDOs executed, (e) individuals under temporary detention admitted to the participating hospital, and (f) individuals transferred from the psychiatric ED of the participating hospital to a state facility." | Provide to the DBHDS Commissioner by the 30th of each month the reporting requirements identified in amendments to § 37.2-1104 by Virginia Senate Bill 34 (2024), for the month prior. In addition to reporting requirements required by legislation, Riverside Mental Health and Recovery Center shall report to DBHDS monthly on (also by the 30th for prior month):<br>**I.** Total number of patients served in the psychiatric emergency department (ED).<br>**II.** Length of time between when a person who is subject of an ECO pursuant to Virginia Code § 37.2-808 733 arrives at the psychiatric ED and (1) when the TDO evaluation is completed and (2) when final disposition is completed, i.e. admitted voluntarily or involuntarily to a treatment facility or discharged from the psychiatric ED.<br>**III.** Length of time between when a request for a TDO evaluation is made for a person who is not subject of an ECO and (1) when the TDO evaluation is completed and (2) when the final disposition is completed, i.e., admitted voluntarily or involuntarily to a treatment facility or discharged from the psychiatric ED.<br>**IV.** Length of time between when a request for a TDO evaluation is made for a person who is not subject of an ECO and (1) when the TDO evaluation is completed and (2) when final disposition is completed, i.e. admitted voluntarily or involuntarily to a treatment facility or discharged from the psychiatric ED.<br>**V.** Number of TDO evaluations completed for individuals under an ECO and<br>**a.** Number of TDOs and what facility the individual went to<br>**b.** Number of voluntary admissions, broken down by accepting facility<br>**c.** Number of released when the individual is found to not meet civil commitment criteria<br>**VI.** Collaborate with DBHDS on any other data elements and information required to evaluate outcomes of the pilot project and complete required reports.<br>**VII.** Collaborate with CSB and prepare documentation prior to the hearing should the certified evaluator recommend mandatory outpatient treatment (MOT) as outlined in § 37.2-817 (D); ( C ) and (C1). |

## Preliminary Outcomes

The table below displays Riverside monthly reported totals for psychiatric ED visits, crisis evaluations, ECOs, TDOs, and Voluntary Admissions.




*The program did not submit ECO data for July.

For each month of the pilot data reported, the total number of TDOs has exceeded the number of ECOs indicating that a number of voluntary walk-ins also resulted in TDO. Riverside did not provide data on total number of prescreening evaluations. More information is needed from Riverside to explain the discrepancy between the number of ED visits to those who were provided "crisis evaluations" and clarification of how many crisis evaluations conducted on voluntary walk-ins resulted in an TDO.

For example, data submitted for September indicates there were 470 visits to the psychiatric ED. Of those, 47 are considered crisis evaluations (assuming completed by a certified evaluator) and of the 47, 31 were ECOs. The difference between the number of crisis evaluations (47) and ECOs (31) is 16, which would indicate the number of individuals receiving an evaluation who arrived voluntarily. Also, it is not made clear why there were 423 individuals (470-47) who visited the psychiatric ED but did not receive crisis evaluations. Those individuals could have been voluntary to the unit, safety planned or referred out.

The program provided data related to the facility where each patient was accepted, classified by

payor type. The data shows that all TDOs were admitted to Riverside except for a total of six individuals. In July there were two individuals sent to Poplar Springs, one to Virginia Beach, and one to Northern Virginia Mental Health Institute (NVMHI). In October, one individual was sent to Maryview Hospital and one to NVMHI. In November, one individual was admitted to NVMHI. There were also two losses of custody for which the program submitted a report describing the incidents.

## Challenges

As discussed previously, the MOU requires Riverside to submit data monthly to DBHDS on the time between when an individual arrived at the ED and when they were initially seen and time of disposition to when the individual leaves the psychiatric ED. Riverside provided part of the missing data elements required for the month of November: ECO to assessment time average (41 minutes), and assessment requested to assessment time average (0 minutes). Without this data, it is difficult to evaluate whether there was a decreased burden on individuals in crisis or the emergency services and crisis system.

Riverside has four medical hospitals (not including Riverside with a psychiatric ED and location of this pilot) throughout the region. CSB emergency services directors in the region noted that historically, if an individual was prescreened at a Riverside ED they would most often be accepted to the Riverside psychiatric unit. Since the implementation of this pilot, it has become increasingly difficult for an individual who was assessed by a CSB certified pre-admission screening clinician to be accepted to the Riverside psychiatric unit.

It has also been reported that if an individual arrives voluntarily to one of the Riverside medical EDs experiencing crisis, the individual is typically transported to the psychiatric ED where the pilot is located for assessment. This is known as an emergency department to emergency department (ED-ED) transfer. When this occurs, individuals may be transported significant distances, sometimes up to 90 minutes, to receive initial assessment. Before the pilot when such individuals presented at Riverside EDs they would receive initial evaluation and, if needed, the local CSB ES team would be contacted to complete the prescreening evaluation at the ED where the individual originally arrived.

## Conclusion

In addition to numbers served and data needs, other areas of interest include the relationship between TDO acceptance to Riverside and evaluations conducted by Riverside staff and regional ES teams. Further review of the process of ED-to-ED transfers is needed to determine if this practice supports a more streamlined, less burdensome, time-saving measure for the individual in crisis. Data showing the number of pre-admission screenings that occur on the Riverside psychiatric acute unit for individuals with an initial voluntary admission disposition, but requested to leave Against Medical Advice, would aid in determining the effectiveness of the pilot project as well.

DBHDS staff collaborating with the pilot have reported that Riverside staff are engaging, friendly, and professional and that everyone's desire is evident to help those in crisis. The layout of the facility is well-designed and provides as much of a non-clinical feel as possible despite being located in an ED with inpatient psychiatric services. Historically, this program has conducted a multitude of crisis assessments for individuals who are seeking voluntary inpatient treatment. Many of the suggestions noted in the report are programmatic in nature, with the intent to assist Riverside to deliver this new service. The program should continue to develop clear workflows, process documents and ongoing supervision to assist with clinical decision making after each evaluation, to include how to manage disagreements between clinical and medical staff. Riverside will also need to maintain collaborative relationships with area stakeholders to identify roles and responsibilities and develop processes for situations in which a prescreening assessment is needed and where medical complications may be present or suspected. DBHDS looks forward to the continued collaboration with Riverside, regional ES programs to ensure those in crisis are receiving the best possible care.

# Appendices

## Appendix A

Completion of the requisite online training modules on topics that include legislative and regulatory requirements, disclosure of information, and clinical aspects of risk assessment including the modules on the preadmission screening report and REACH.

1. Completion of an Emergency Services (ES) orientation that meets the content requirements:

    - Orientation to civil commitment process, legal requirements and performance contract related requirements.
    - Orientation to documentation expectations and requirements.
    - Orientation to expectations for use of clinical consultation with peers and supervisors.
    - Orientation to local policies and procedures.
    - Orientation to role and interface with local law enforcement.
    - Orientation to role and interface with magistrates and special justices.
    - Orientation to resources for alternatives to hospitalization.
    - Orientation to bed registry.
    - Orientation to process for securing local private beds.
    - Orientation to process for securing state facility beds.
    - Orientation to process to access LIPOS or SARPOS funding.
    - Orientation to alternatives for special populations (e.g., children, ID/DD or geriatric).
    - Orientation to Federal and State laws about allowed disclosure of information and communication in routine and emergency situations.
    - Tour of local facilities (E.g., local hospitals, CSUs, jail, REACH, etc.) as relevant

2. Completion of 40 hours direct observation and direct provision of emergency services, to include conducting preadmission screening evaluations and other forms of crisis services including, but not limited to: knowledge of relevant laws, interviewing skills, mental status exam, substance use assessment, risk assessment, safety planning and accessing community referrals. The 40 hours may be done concurrently.
3. Completion of preadmission screening evaluations under direct observation of an LMHP or LMHP-R (Licensed Mental Health Professional-Resident) CPSC. The number required will be agreed upon by the Program/Clinical Director
4. Attestation by a supervisor that the applicant has reached an acceptable level of clinical competence and procedural knowledge to be certified.
5. For a minimum of the first three months of the certification period, newly certified CPSCs/certified evaluators are required to consult with a supervisory-level CPSC when the outcome of any preadmission screening evaluation to not recommend hospitalization for an individual under an Emergency Custody Order (ECO).
6. Applicants may begin working independently as a CPSC when an application for certification as well as an attestation of completed orientation and of the ability of the individual to perform the CPSC responsibilities has been submitted to DBHDS.
7. The documentation associated with orientation and training must be maintained by Riverside and be provided to DBHDS for auditing purposes when requested.

## Appendix B

Will be incorporated when made into a PDF.