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COMMISSIONER

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June 30, 2026

To: The Honorable Abigail D. Spanberger, Governor of Virginia
The Honorable Louis L. Lucas, Chair, Senate Finance Committee
The Honorable Luke E. Torian, Chair, House Appropriations Committee

From: Daryl Washington, Commissioner, Department of Behavioral Health and Developmental Services

RE: Annual Report on the Implementation of 2014 ECO and TDO Law Changes

This report is submitted in response to Senate Bill 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.*

Please find enclosed the report in accordance with Senate Bill 260. DBHDS staff are available should you wish to discuss this request.

CC: The Honorable Marvin B. Figueroa, Secretary of Health and Human Resources

DBHDS

Virginia Department of Behavioral Health and Developmental Services

Annual Report on the Implementation of 2014 ECO and TDO Law Changes

June 30, 2026

DBHDS Vision: A Life of Possibilities for All Virginians

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Executive Summary

In 2014, the General Assembly enacted SB 260 in response to concerns about access to inpatient psychiatric care during behavioral health crises. Among other changes, the legislation established the "Bed of Last Resort" requirement, directing state hospitals to admit individuals under a temporary detention order (TDO) when no private psychiatric bed could be identified during the emergency custody order period. An overview of the legislation is provided in Appendix A.

While the legislation succeeded in expanding access to inpatient psychiatric treatment, it also produced significant unintended consequences for Virginia's behavioral health system, particularly its state hospitals. Following implementation, civil TDO admissions to state hospitals increased dramatically, rising nearly 400 percent by FY 2019. The resulting demand drove state hospitals to sustained occupancy levels at or above capacity, well beyond the generally accepted maximum safe utilization rate of 85 percent, creating significant challenges for patient care, safety, and staffing.

Although DBHDS has restored nearly all state hospital bed capacity and added new beds to the system, demand continues to exceed available resources. At the same time, state hospitals have experienced substantial growth in forensic admissions, which now account for approximately 63 percent of the inpatient population. As a result, individuals requiring admission under the Bed of Last Resort provision often cannot be admitted immediately, despite statutory requirements.

The Commonwealth now faces a troubling reality: despite substantial investments and reforms, some individuals experiencing psychiatric crises are again unable to access timely inpatient treatment. This challenge reflects multiple factors, including workforce and service gaps in the community behavioral health system, increasing demand for both civil and forensic services, limitations in private hospital capacity for individuals with specialized needs, and broader systemic reliance on state hospitals and the legal system to address behavioral health crises.

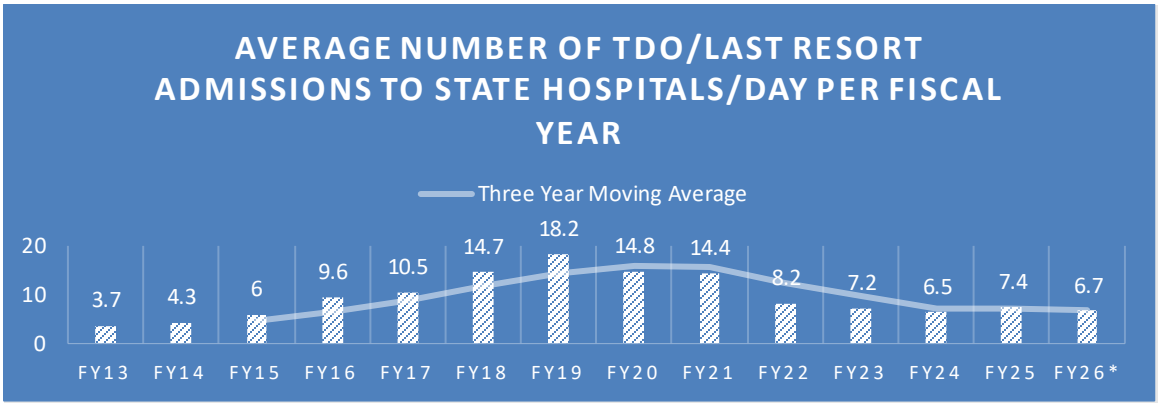
This report examines the most significant impacts of the 2014 legislation, efforts undertaken to address unintended consequences, and data related to implementation of the Bed of Last Resort requirement.

Significant Impacts of the 2014 Law Changes

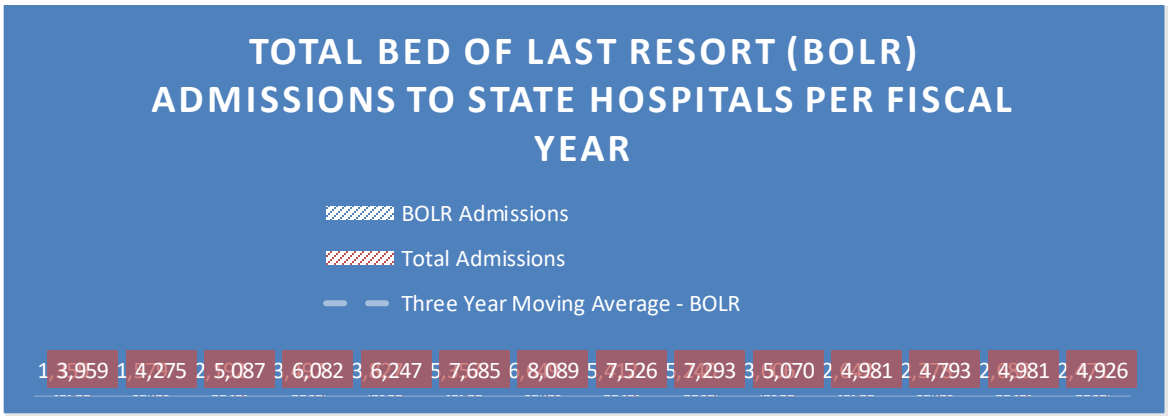
The most significant impacts of the 2014 law changes for Virginia's behavioral health system have occurred within the crisis and state hospital systems - and the patients they serve - as described below.

Admissions to State Hospitals

Since the enactment of the 2014 changes, there was a continual increase in the *daily number* of state hospital admissions of individuals under a TDO (or Bed of Last Resort/safety net admissions) between FY 2013 and FY 2019, growing by 389 percent during that time. There was a slight decrease in state hospital TDO admissions in FY 2020 and FY 2021, with a continual decrease in FY 2022-2024. This was due, in part, to critical state hospital staffing levels in FY 2022 and 2023, and significant increase in demand for state hospital beds for forensic patients. In FY 2026 (first three quarters) there has been a slight decrease in daily Bed of Last Resort admissions to state hospitals; however, due to the demand for beds for forensic individuals, the hospitals continue to operate between 95 to100 percent of their capacity.



*FY 2026 numbers are projected based on the first three quarters of FY 2026



Fiscal Year	Average daily number of individuals under civil TDOs waiting for admission
FY 2022	47.2
FY 2023	37.7
FY 2024	34.3
FY 2025	27.5
FY 2026 Year to Date	41.6

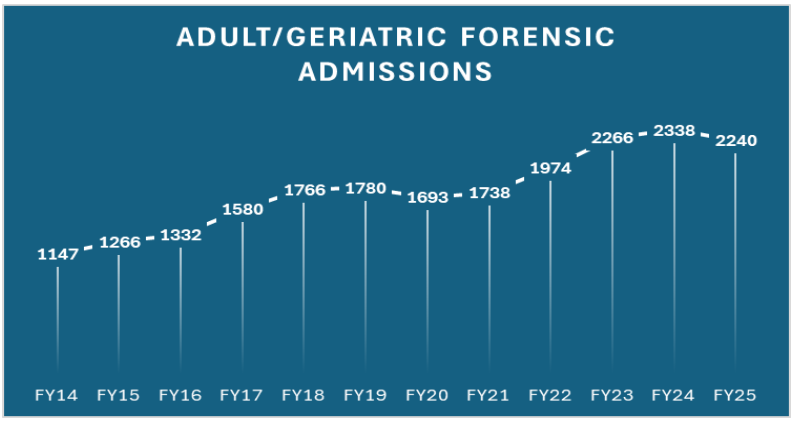
Law Enforcement "Drop Offs" of Patients at State Hospitals

Due to frustration with wait times and the need to provide other law enforcement services to their communities, many law enforcement agencies in parts of Virginia have engaged in the practice of "dropping off" patients at state hospitals without the hospital's acceptance or an available bed. The primary state hospitals impacted by this practice are Southwestern Virginia Mental Health Institute, Catawba Hospital, and Western State Hospital. This practice is unsafe for patients and staff alike as in many cases it violates requirements for medical clearance and often there are no appropriately staffed beds. Also, it further delays treatment for individuals in other parts of Virginia who are waiting in emergency departments for an inpatient psychiatric bed. In FY 2023, the state hospitals averaged 77 law enforcement drop offs each month. While the average number of monthly drop-offs decreased in FY 2025 to 51 per month, that number increased again in FY 2026 to an average of 66 per month. This may be attributable to an increased number of individuals on the state hospital civil waitlist, therefore resulting in longer wait times.

Forensic Admissions

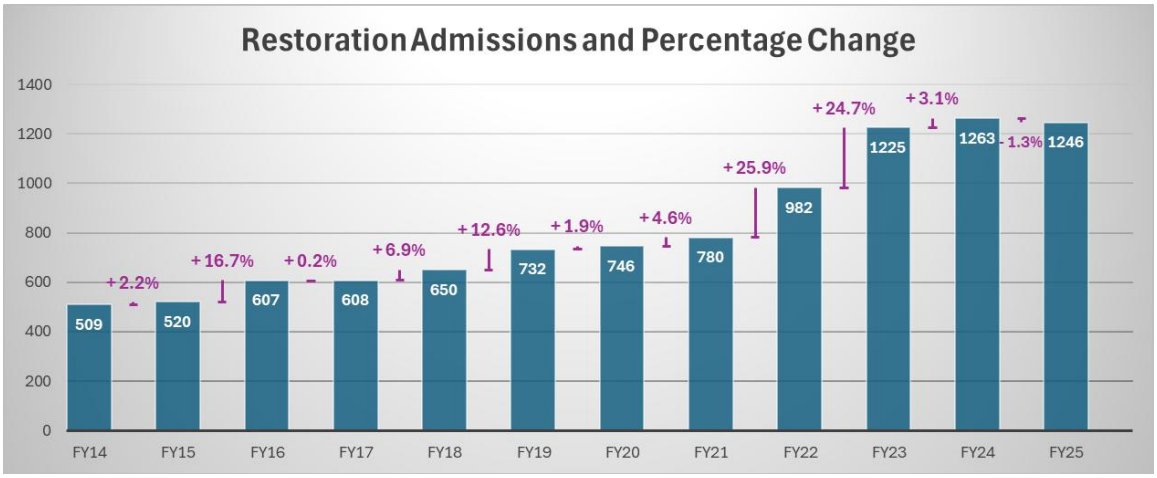
Forensic admissions include those committed from jail for emergency treatment pending trial, for evaluations of competency to stand trial and mental state at the time of the offense (aka sanity), restoration of competency to stand trial, those found unrestorable to competency to stand trial, those found not guilty by reason of insanity, and those civilly committed after completion of their sentence with the Department of Corrections. Not captured here are individuals under a Sexually Violent Predator (SVP) civil commitment as those residents are housed at the Virginia Center for Behavioral Rehabilitation (VCBR), not at state psychiatric hospitals.

In FY 2025, individuals discharged from state hospitals who were admitted under Not Guilty by Reason of Insanity commitment orders had an average total length of stay of 2,196.5 days, individuals in the hospitals for forensic evaluation had an average total length of stay of 110.2 days, and individuals who were admitted under a restoration of competency order had an average length of stay of 127.5 days. By comparison, over 50 percent of individuals admitted under civil TDOs have a length of stay of 30 days or less. More individuals being admitted to state hospitals under forensic orders results in longer lengths of stay for patients in state hospitals and less availability for new admissions - while maintaining operating census of between 95 to 100 percent capacity.

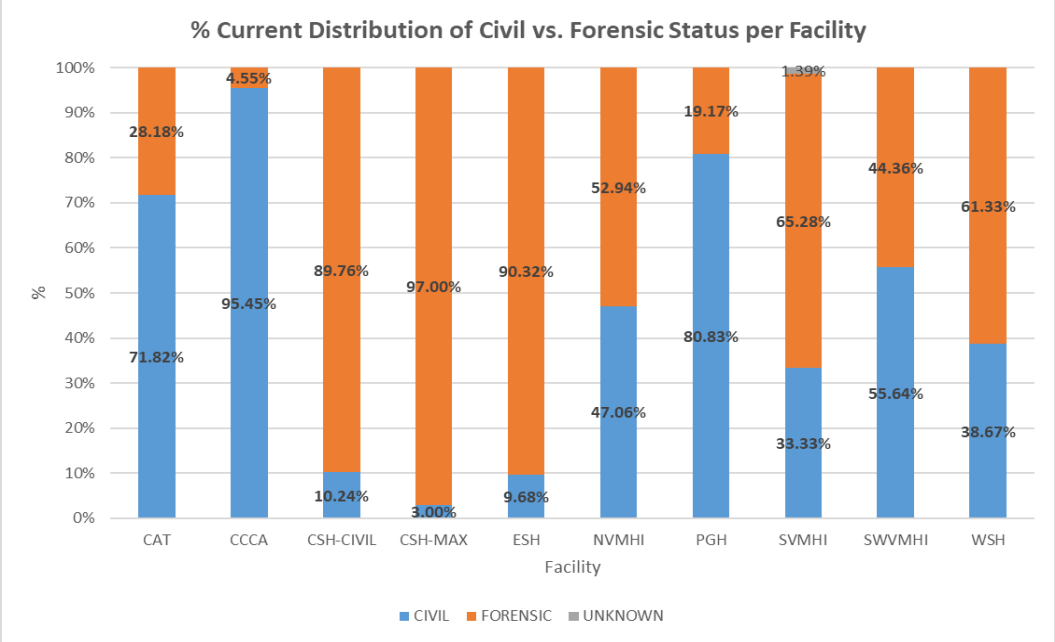


Fiscal Year	DOC	Comp & Sanity Eval	Restoration	Emergency Treatment from Jail	NGRI New Inpatient	NGRI Revoked	NGRI Revocation Evaluation	NGRI Voluntary	Unrestorably Incompetent	Total
FY14	28	156	509	372	58	17	N/A	3	4	**1147**
FY15	19	141	520	469	90	22	N/A	3	2	**1266**
FY16	6	156	607	443	88	25	N/A	4	3	**1332**
FY17	12	187	608	642	89	29	N/A	6	7	**1580**
FY18	9	200	650	806	63	26	N/A	2	10	**1766**
FY19	10	77	732	836	75	35	N/A	9	6	**1780**
FY20	8	78	746	770	61	23	N/A	2	5	**1693**
FY21	9	96	780	765	56	20	N/A	8	4	**1738**
FY22	8	121	982	758	68	24	N/A	9	4	**1974**
FY23	10	156	1225	750	73	39	N/A	5	8	**2266**
FY24	20	132	1263	788	83	40	5	3	4	**2338**
FY25	10	129	1246	734	71	19	11	7	13	**2240**
Total	**149**	**1629**	**9868**	**8133**	**875**	**319**	**16**	**61**	**70**	**21120**

The increase in forensic admissions is primarily driven by inpatient orders for restoration of competency to stand trial. A significant proportion of these admissions, 29.5 percent of admissions between FY 2022 to FY 2025, were for only misdemeanor offenses. These minor charges, such as Trespassing and Disorderly Conduct, are commonly considered "nuisance crimes" and are often associated with people who are chronically mentally ill.



There is also concern that individuals with behavioral health disorders are arrested and booked for these minor charges because the pathway to treatment (i.e., through jail and subsequent forensic admission) is perceived to be faster than the civil TDO and commitment process and requires less law enforcement time. This practice leads to an overall criminalization of the mentally ill. It also results in longer lengths of inpatient admission for individuals who could have been treated faster through the civil system. With a finite number of hospital beds available, increases in forensic admissions result in fewer beds for civil admissions. As of June 4, 2026, 63.6 percent of patients in Virginia state hospital beds were of a forensic legal status, with some hospitals operating as primarily forensic hospitals. A snapshot of the distribution of civil and forensic patients across state facilities for June 4, 2026, is provided below.



Staffing Recruitment and Retention

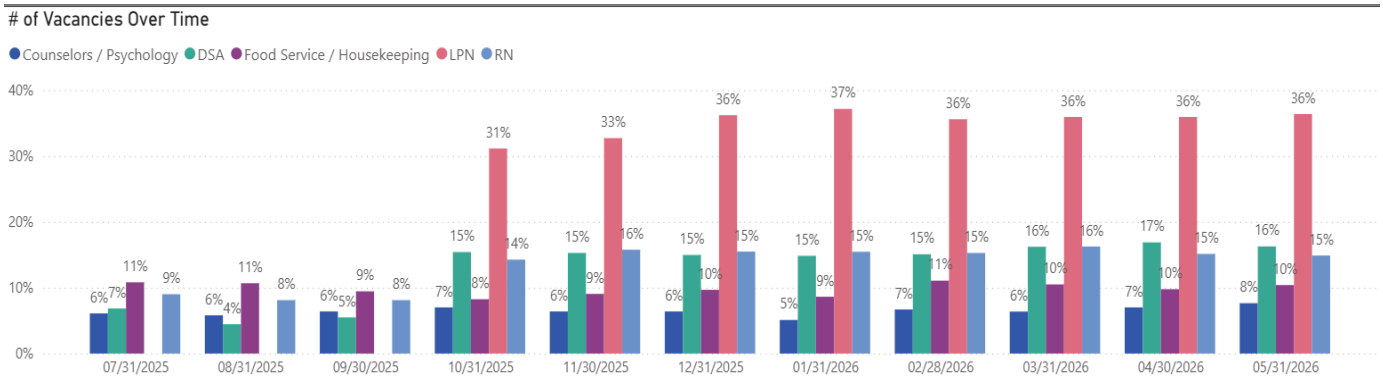
State hospital recruitment efforts and vacancy rates improved in FY 2026, with remaining recruitment and retention challenges largely concentrated in a few facilities facing regional market shortages. Targeted strategies have steadily reduced vacancies across critical roles, including nursing and direct care. However, the system continues to operate at or above 95 percent of total bed capacity, with many hospitals exceeding 100 percent of staffed capacity—well above the national optimal operating level of 85 percent needed to maintain safety and quality. Sustained operation at this level places significant strain on staff and resources.

Between FY 2013 and FY 2019, rapid growth in admissions under the Bed of Last Resort, combined with the COVID-19 pandemic, severely challenged recruitment and retention. Vacancy rates for direct care roles sometimes exceeded 60 percent, leading to heavy reliance on contract staffing. DBHDS used contract staff broadly beginning in July 2021, but discontinued contracts for direct care roles in FY 2025. Contracted LPNs and RNs are now used only at hospitals with vacancy rates above 30 percent. Overall contract utilization has decreased, reflecting a stronger classified workforce.

Despite progress, substantial barriers to recruitment and retention persist, including safety concerns, aging physical infrastructure operating beyond expected life, high patient acuity, mandatory overtime, and compensation challenges. Ongoing focused efforts are required to ensure a stable and skilled workforce capable of meeting the needs the state hospital system.

Facility Vacancy Rates by Position Type July 2025 – May 2026

OKR	07/31/2025	08/31/2025	09/30/2025	10/31/2025	11/30/2025	12/31/2025	01/31/2026	02/28/2026	03/31/2026	04/30/2026	05/31/2026
Counselors / Psychology	6.09%	5.81%	6.39%	7.01%	6.39%	6.39%	5.10%	6.69%	6.37%	7.01%	7.64%
DSA	6.84%	4.45%	5.48%	15.41%	15.27%	14.96%	14.83%	15.07%	16.22%	16.88%	16.26%
Food Service / Housekeeping	10.82%	10.68%	9.45%	8.25%	9.05%	9.67%	8.62%	11.07%	10.49%	9.77%	10.40%
LPN				31.13%	32.71%	36.19%	37.14%	35.58%	35.92%	35.92%	36.36%
RN	9.01%	8.11%	8.11%	14.26%	15.77%	15.48%	15.45%	15.27%	16.25%	15.13%	14.88%



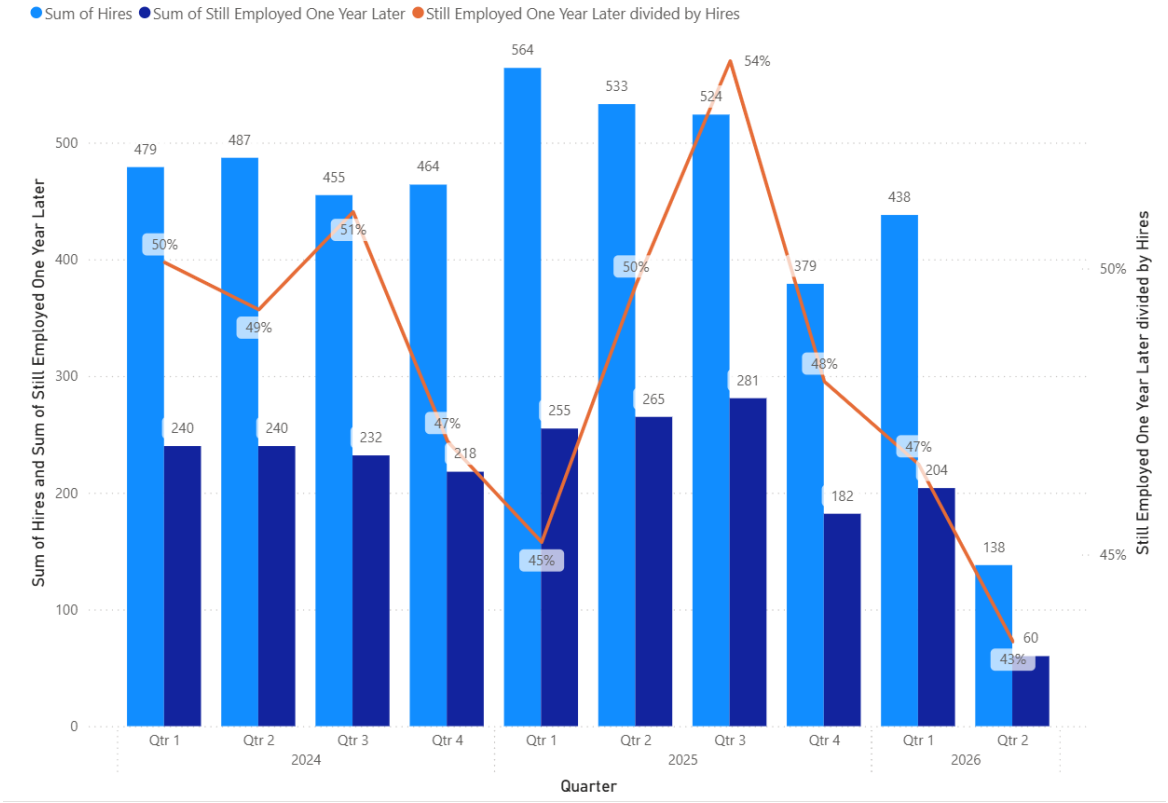
Critical vacancies in state facility roles have decreased systemwide to acceptable levels. DBHDS continues to explore and implement strategies to address ongoing national staffing shortages.

Turnover in Facilities for the Quarter of March 31, 2025

Turnover by Length of Service	FY 2022	Turnover %	FY 2023	Turnover %	FY 2024	Turnover %	FY 2025	Turnover %	Month
Length of Service	**1,358**	**29%**	**1,789**	**38%**	**1,983**	**37%**	**1,125**	**23%**	**115**
Tenure less than or equal to 5 years	1,080	57%	1,357	64%	1,590	60%	869	36%	91
Tenure more than 5 years and up to and including 10 years	144	15%	198	21%	153	16%	101	12%	8
Tenure more than 5 years and up to and including 20 years	86	8%	141	14%	137	14%	86	10%	9
Tenure more than 20 years	48	6%	93	12%	103	13%	69	10%	7

Turnover is trending downward. However, it remains notably high within the first five years of service. Additionally, there has been an increase in retirements during the current year.

Rate of Employment Retention After One Year



While hiring has increased and recruitment efforts have contributed to reduced vacancy rates, employee retention remains an area requiring continued focus and improvement. To address this, DBHDS has implemented a range of strategies aimed at enhancing employee tenure and promoting workplace satisfaction.

Efforts and Initiatives to Address the Unintended Impacts of the 2014 Law Changes

LIPOS (Local Inpatient Purchase of Services) Program

- These are contracts with private hospitals to provide acute, short-term psychiatric inpatient services instead of admitting individuals to state hospitals. DBHDS continues to monitor the utilization of LIPOS by Community Services Board (CSB) regions and private hospitals.
- In FY 2026, DBHDS estimates that the allocated $7,688,182 in LIPOS funds and an additional $2,006,910 in other funds will be used to divert state hospital admissions.

Discharge Assistance Program (DAP) Funds

- These specialized funds are used to procure services and supports for individuals in state hospitals that are experiencing extraordinary barriers to discharge. Most frequently these supports include appropriate or specific residential care. DBHDS submits an annual report on DAP to the General Assembly pursuant to Item 301 B of the Appropriation Act.

- In FY 2026, DBHDS estimated that $38 million in DAP funds will be used.

Diversion and Discharge Programs

- DBHDS has a variety of agreements with CSBs and private providers to provide safe discharge housing and services for individuals discharging from state hospitals, as well as opportunities to divert individuals from state hospitalization. These include partnerships with nursing homes and assisted living facilities, contracts for transitional group homes and supportive housing, and specialized programs for individuals with dementia, older adults, and individuals who have experienced a traumatic brain injury.
- In FY 2026, it is estimated that $24 million from various sources will be used for these programs.
- In FY 2026, an additional $8 million has been utilized to develop 104 mental health group home beds. All beds are developed. All but four beds are currently receiving patients. Several of the programs have wait lists. An allocation for an additional 16 beds has been identified and a contract was recently signed. DBHDS submits quarterly reports to the General Assembly on the status of these beds.
- In FY 2026, DBHDS also developed 16 more youth diversion and discharge beds with a focus on those youth ages 17-21.

Contracts for Private Beds

- DBHDS currently holds a contract with a hospital system that serves youth and includes five hospitals. This contract funds both diversion of individuals to these inpatient beds, rather than a state hospital, as well as care at residential treatment centers upon discharge.
- In FY 2026, DBHDS estimates that $600,000 in funding will be utilized on this contract.

The CSBs in each region have regional admissions protocols for contacting alternative hospitals prior to requesting admission to the state hospital. These protocols identify alternative hospitals to be contacted based on: 1) number of crisis stabilization beds, 2) number of private hospitals, and 3) capacity of those hospitals to serve individuals with specialized and intensive needs. On average, emergency services staff contact 25 to 30 private hospitals prior to seeking admission to the state hospital. Over the past several years, DBHDS worked with CSBs and private hospitals to develop the Virginia Crisis Connect platform. This platform allows for CSBs to refer seamlessly within the system to many private facilities, as well as state facilities.

Extraordinary Barriers to Discharge List

DBHDS monitors the number of individuals in state hospitals who are clinically ready to discharge, but who have a non-clinical barrier to discharge, such as the need for housing or services, on the Extraordinary Barriers List (EBL). On January 1, 2025, the EBL was redefined to focus on those with true extraordinary barriers to discharge. The list is now defined as individuals who meet one or more of the following criteria:

- Clinically ready for discharge for 31+ days with a primary discharge need of Willing Provider, Guardianship, and/or Individual or Guardian opposed to discharge;
- Patients with a civil legal status who have been identified as clinically ready for discharge for 16+ days with a primary need of DD Waiver Process or Other; or
- Patients with other barriers not resolved after escalation.

DBHDS provides specialized consultation and technical assistance to state hospitals and CSBs to overcome barriers to discharge. The EBL is monitored by all levels of DBHDS leadership weekly. The EBL saw a high of 251 patients in May of 2019. A goal was set to maintain the EBL list at seven percent, or below, of the total state hospital census for the day it was reviewed.

Statewide EBL as of 6/2/2025

Discharge Barrier	# of Patients
A Willing Provider	**62**
Assisted Living Facility (ALF)	21
Group Home/Transitional Placement	14
Memory Care	6
Nursing Home (NH)	16
Permanent Supportive Housing (PSH)	3
Intellectual/Developmental Disability (ID/DD)	2
DD Waiver Process	**2**
Guardianship	**9**
Individual/Guardian/AR unwilling to Discharge	**6**
Other	**4**
Grand Total	**81**

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 the 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. The chart below shows the estimated costs for temporary detention in state hospitals for FY 2014 - FY 2026 (through May).

Total Cost for TDO Bed Days by Fiscal Year at State Hospitals

	Total Civil TDO Bed Days	Average cost for a Bed Day	Total Cost for Civil TDO Bed Days
FY 2014	156,331	$727.84	$113,784,576.00
FY 2015	159,552	$771.74	$123,133,143.00
FY 2016	159,276	$830.59	$132,293,086.00
FY 2017	160,561	$859.05	$ 137,930,449.00
FY 2018	157,609	$937.24	$147,717,252.00
FY 2019	271,502	$834.91	$226,678,709.57
FY 2020	261,686	$902.68	$236,217,975.04
FY 2021	249,629	$957.57	$239,037,927.52
FY 2022	178,876	$1,212.20	$216,833,412.27
FY 2023	175,084	$1,166.47	$204,231,042.25
FY 2024	181,107	$1,217.80	$220,552,169.43
FY 2025	187,779	$1,242.03	$233,227,569.52
FY 2026*	176,570	$1,191.44	$210,037,561.00

*FY 2026 amounts projected based on the first 11 months of FY 2026

Length of Stay for Civil TDO Admissions, FY 2014 to FY 2026 (first two quarters)

Fiscal Year	ALOS for Individuals Under a Civil TDO at Admission
FY 2014	57.6
FY 2015	47.7
FY 2016	36.8
FY 2017	36.3
FY 2018	33.7
FY 2019	37.1
FY 2020	37.9
FY 2021	46.9
FY 2022	66.0
FY 2023	60.1
FY 2024	68.8
FY 2025	60.2
FY 2026 (projected)	58.7

Conclusion

The 2014 ECO and TDO law changes were intended to guarantee that every Virginian in acute psychiatric crisis could access timely inpatient care. While the reforms improved safeguards, they also produced long-term pressures on Virginia's behavioral health system, most significantly within the state hospital network. Civil TDO admissions increased sharply after implementation, and despite recent progress in restoring bed capacity, state hospitals continue to operate at or near maximum census.

The rapid growth in forensic admissions has further reduced the availability of civil beds. More than 60 percent of state hospital patients are now under forensic court orders, many for restoration of competency, including for lower-level offenses. This trend strains hospital capacity, contributes to longer lengths of stay, and limits access for civil patients. It also reflects broader systemic issues, including workforce shortages, inconsistent community-based resources, and reliance on legal pathways - rather than clinical ones - to secure treatment.

As a result, some individuals who are assessed to need inpatient care are being released without treatment. Factors contributing to this include limited community capacity, challenges securing placement for individuals with specialized needs, private hospital admission denials, and a systemwide culture of risk aversion. Together, these pressures highlight the ongoing need for coordinated investment across community services, crisis infrastructure, and inpatient resources to ensure that Virginia meets its statutory obligations and provide safe, timely care.

Appendices

Appendix A: Overview of SB 260 (2014)

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 extended the maximum period of emergency custody to eight hours from four hours with a possible two-hour extension, 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 "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" hospitals for temporary detention*: Under §§ 16.1-340.1 (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 the 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 hospital for an additional four hours following admission for 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 specified that these provisions expire on June 30, 2018. SB 673 of the 2018 legislative session repealed the expiration of this provision allowing it to be used beyond 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 (jail inmates), 19.2-182.9 (NGRI acquittees on conditional release) and 37.2-809 and 37.2-814 (adults).
- *Acute Psychiatric Bed Registry*: § 37.2-808.1 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 hospitals, public and private residential crisis stabilization units, and health care providers working in an emergency room of a hospital, clinic or other facility rendering emergency medical care could access information about psychiatric bed availability through the bed registry and this information.