

Access to Care: When Every Minute Matters

The Right Response at the Right Time

Part 2 of 2 - October 2026

Executive Summary

Early access to behavioral health care can prevent many concerns from escalating.

But crises still happen.

A person may experience suicidal thoughts, severe depression, psychosis, overwhelming anxiety, a substance use crisis, or another behavioral health emergency. A family member may realize that someone they love is no longer able to keep themselves safe.

In those moments, knowing where to turn - and being able to reach help quickly - can make all the difference.

Richmond and the broader Region 4 community have developed a comprehensive continuum of crisis services with multiple pathways to behavioral health support. Depending on an individual's circumstances and needs, that continuum may include telephone support, mobile response, community-based intervention, immediate assessment, short-term stabilization, or inpatient care.

Within that larger continuum, this report highlights three RBHA programs that provide critical points of access and intervention: Emergency Services, the Crisis Receiving Center, and the Crisis Stabilization Unit.

Each serves a different purpose, but all share a common goal: helping individuals receive the right level of care, at the right time, in the least restrictive setting that can safely meet their needs.

A behavioral health crisis does not have a single solution - and no one program represents the full continuum of care.

Different Needs Require Different Responses

No two behavioral health crises look exactly alike, and no single service can meet every need.

Some individuals may benefit from telephone or mobile support. Others need immediate in-person assessment, several hours in a safe environment, short-term residential stabilization, or - in the most serious circumstances - hospitalization.

RBHA's Crisis Care Services are part of a broader regional continuum designed to provide multiple levels of intervention and connect individuals with care appropriate to their circumstances.

This report focuses on three points within that continuum: **Emergency Services, the Crisis Receiving Center, and the Crisis Stabilization Unit.**

FY26 CRISIS ACCESS

2,021 Emergency Services evaluations

1,304 Crisis Receiving Center admissions

482 Crisis Stabilization Unit admissions

Behind each number is a moment when an individual, family, or community needed immediate behavioral health support - and a system needed to respond.

One Point of Immediate Access

Crisis Receiving Center

The Crisis Receiving Center (CRC) provides adults experiencing a behavioral health crisis with 24/7 walk-in access - no appointment or referral required.

Individuals can remain for up to 23 hours while a multidisciplinary team assesses their needs and works with them to determine what should happen next.

But the CRC is intentionally different from an emergency department.

When someone arrives overwhelmed, staff recognize that completing paperwork or immediately beginning an assessment may not be what the person needs first.

They may need a meal.

A shower.

Clean clothing.

A quiet place to rest.

Then the work can begin.

FRONTLINE VOICE

People do not have to arrive knowing what service they need. They only need to know that they need help.

Nursing staff, psychiatric nurse practitioners, clinicians, and peer support specialists work together with the individual to complete psychiatric and clinical assessments, develop a safety plan, and identify the most appropriate next level of care.

Whenever it can be done safely, the team seeks the least restrictive option.

When Short-Term Stabilization Is Needed

Crisis Stabilization Unit

For some individuals, brief or community-based crisis intervention may not provide enough support, while acute hospitalization may be more restrictive than necessary.

The Crisis Stabilization Unit (CSU) provides another option within the continuum: voluntary, short-term residential treatment for adults experiencing psychiatric crises whose needs can be safely managed outside of a hospital.

During an average five-to-seven-day stay, individuals participate in an intensive treatment process that can include psychiatric evaluation, medication management, nursing care, individual and group therapy, safety planning, primary care consultation, discharge planning, and connection to follow-up services.

Staff describe individuals arriving with depression, suicidal thoughts, anxiety, mania, psychosis, grief, major life stressors, or simply feeling overwhelmed and unable to manage what they are facing.

By discharge, staff frequently see symptoms significantly reduced.

But another change can be just as important.

People leave with a plan.

With resources.

With coping skills.

And, often, with hope.

The CSU serves as an important alternative to more restrictive treatment and is intentionally designed to help prevent hospitalization whenever an individual's needs can be safely managed in a short-term residential setting.

When Safety Becomes the Primary Concern

Emergency Services

Emergency Services provides another critical function within the crisis continuum, assessing individuals when concerns about safety or the severity of psychiatric symptoms may require a higher level of intervention.

Most behavioral health crises do not result in involuntary hospitalization.

Emergency Services staff work first to understand what is happening, assess risk, identify existing supports, connect people to available resources, develop safety plans, and determine whether the crisis can be safely managed in the community.

When someone is experiencing severe symptoms of mental illness that create significant danger to themselves or others - and they are unable or unwilling to consent to needed inpatient treatment - a more restrictive intervention may become necessary.

In Virginia, an **Emergency Custody Order, or ECO**, allows an individual to be taken into custody for the purpose of receiving an emergency behavioral health evaluation. The person is not being arrested. A certified CSB prescriber evaluates the individual and considers the level of risk, decision-making ability, available supports, and whether the person can safely follow treatment recommendations.

A **Temporary Detention Order, or TDO**, is pursued only when acute inpatient psychiatric care is determined to be necessary for safety and the individual cannot or will not voluntarily consent to that care.

Emergency Services clinicians do not issue TDOs. They conduct the evaluation and make a recommendation to a magistrate.

IMPORTANT DISTINCTION

The goal of Emergency Services is not hospitalization. The goal is safety - and connecting the individual with the least restrictive care that can safely address the crisis.

Earlier Access Creates More Options

One of the strongest messages from crisis staff is also one of the simplest:

Do not wait until a behavioral health concern becomes an emergency to seek help.

Crisis staff regularly encounter a common misconception that the hospital is the only place to receive help during a behavioral health crisis.

It is not.

Today's broader crisis continuum offers multiple pathways and levels of support, including services that can intervene before hospitalization becomes necessary.

When someone is willing and able to participate in treatment, earlier intervention provides more choices. When symptoms have escalated to the point that an individual can no longer safely make those choices, the options become more limited.

This is one reason a comprehensive crisis continuum matters: the response can be matched to both the individual's needs and the severity of the crisis.

A Story of the Continuum in Action

One individual arrived at RBHA's Crisis Receiving Center seeking help for both mental health symptoms and substance use.

The CRC was not the final destination.

It was the doorway.

After a psychiatric evaluation and medication adjustment, the individual transitioned to the co-located Withdrawal Management Unit. From there, they moved into the HOPE program for specialized treatment addressing both mental health and substance use needs.

As stability increased, the individual stepped down again - this time to the Women's Residential Treatment Center.

Treatment continued through Intensive Outpatient Services, Case Management, and Outpatient Psychiatry.

One crisis encounter became a pathway through multiple levels of care.

With each transition, the intensity of treatment changed to match the individual's needs. Eventually, the individual was able to maintain recovery and manage mental health symptoms more effectively in the community.

The goal was never simply to resolve the immediate crisis. It was to connect that person with the care needed for what came next.

Part of a Larger Continuum of Care

The Crisis Receiving Center, Crisis Stabilization Unit, and Emergency Services represent three important components of a much broader crisis response system.

Across that continuum, individuals may connect with care through a variety of pathways and receive different levels of intervention based on their needs. The appropriate response may be telephone support, mobile or community-based intervention, immediate assessment, short-term stabilization, ongoing treatment, or hospitalization when safety requires it.

What connects these services is not a single doorway or destination.

It is a shared commitment to matching the response to the individual.

Key Takeaway

The goal is not simply to resolve the immediate crisis. It is to provide the right intervention at the right time, in the least restrictive appropriate setting, and create a connection to the care and support that comes next.

When every minute matters - access matters, too.