disABILITY LAW CENTER OF VIRGINIA

Protection & Advocacy for Virginians with Disabilities

BETWEEN CUSTODY AND CARE

THE FLAWED INVOLUNTARY COMMITMENT SYSTEM IN VIRGINIA

Image Description: A line drawing of a blue pair of handcuffs

APRIL 2026

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EXECUTIVE SUMMARY

In Virginia, the involuntary commitment process is a sprawling, complicated path that thousands must navigate every year to access mental health care in times of crisis. At the disAbility Law Center of Virginia, we receive frequent complaints about the process. As noted throughout this report, no state agency collects data or assesses the process to determine whether there are patterns of concern that can be addressed.

As a result, dLCV surveyed people who were either actively navigating this process or had recently done so. This report contains an analysis of the first 79 surveys. We recognize that this is a small percentage of the people who annually experience the commitment process in Virginia. Our surveys are ongoing; we will update our analysis and recommendations on a regular basis.

We found that most Virginians encountering this process have not had the process explained to them, including their right to appeal. Also, individuals with physical disabilities and developmental disabilities reported a lack of accommodation and effective communication throughout the process, but particularly with law enforcement. Finally, respondents shared heartbreaking accounts of traumatic and prolonged restraints, even when they did not pose any active danger.

To address these findings, dLCV recommends:

- policy changes to limit the use of restraint;
- enhanced training for all personnel involved in the process; and
- protocols and plain-language materials to ensure that people are adequately informed of the process, as well as their rights.

> *"I felt left out of the process, even though I was an integral part of it."*
>
> *–S.*

INTRODUCTION

The disAbility Law Center of Virginia (dLCV) is the Commonwealth's Protection and Advocacy Program, tasked with providing a wide range of services to Virginians with a wide range of disabilities. Historically, dLCV has received countless complaints from individuals concerned with Virginia's involuntary commitment process. Following recent changes to the mental health services system, including pilot programs for non-law enforcement transportation and the Marcus Alert legislation, we began to see some specific trends emerge. Chief among these were reports that individuals remained handcuffed for hours or days during the early stages of the process, while still in police custody.

A BRIEF DESCRIPTION OF THE INVOLUNTARY COMMITMENT PROCESS

When an individual is experiencing a mental health crisis, either they or someone else can ask for help. If the person does not want treatment and someone else asks for treatment on their behalf, that person most commonly calls Emergency Services or 988. When Emergency Services (usually provided by a Community Services Board, or CSB) or a Law Enforcement Officer respond to a crisis, they will assess the situation. Law Enforcement Officers can be city or county police officers or sheriff's deputies.

To transport or detain a person in crisis, a Law Enforcement Officer must get an **Emergency Custody Order (ECO).** The ECO can be issued by a magistrate—a local official who reviews complaints brought by law enforcement or the general public—but most of the time, the police will issue a "paperless ECO" and have the magistrate "sign off" on the ECO at a later time. [i] The ECO starts an **8-hour period**, during which the Law

Enforcement Officer transports the individual to an emergency room or CSB "pre-screener." [1]

The **pre-screener** is a trained mental health clinician who usually works for the CSB. The pre-screening will take place at the local CSB office, hospital Emergency Room, community Crisis Receiving Center, or other location where their needs can be evaluated. **This pre-screening must occur within the 8 hours allotted by the ECO.** The pre-screening should be based on whether the individual meets one or more of the following legal criteria:

1. Due to mental illness, they are a danger to themselves.
2. Due to mental illness, they are a danger to others.
3. Due to mental illness, they are unable to protect or care for themselves.

In addition to the mental health evaluation, pre-screening also includes a medical evaluation, screening for Urinary Tract Infections (which can sometimes appear as psychiatric symptoms), and screening for drug use. These tests can tell providers whether an individual will be best served in a psychiatric or medical setting, as well as factors important to an individual's care.[ii]

If the pre-screener finds that the person meets the above criteria, they will submit their evaluation to a magistrate who signs off on an official **Temporary Detention Order, or TDO.**

At this point, the person can still decide to be hospitalized voluntarily. Deciding to be voluntarily admitted may have some benefits, like not having a history of involuntary commitment, and not having to surrender one's firearms[iii]

Once the magistrate signs off on the TDO, a **"bed search"** begins. The CSB pre-screener will use the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Bed Registry to find a provider who is willing and able to provide inpatient mental health services to the person. If possible, the person will go to a hospital that is in or close to their home community, but this is not possible in every case.

[1] If the individual does need inpatient care and a hospital bed cannot be located within 8 hours, the ECO can be extended 4 hours.

When a person is admitted involuntarily to a hospital under a TDO, **that TDO stays in effect for 72 hours[2]**. Before the TDO expires, the person must have a hearing before a judge, called a "special justice," who will determine based on the evidence provided whether the person will be hospitalized for longer.

During the TDO period, the hospital must evaluate the person to see if they need to be involuntarily hospitalized for a longer time. If the hospital believes this is the case, they may petition the special justice for involuntary commitment. The person has the right to request voluntary commitment at this point.

If the court grants a petition for involuntary commitment, the hospital can hold and provide treatment to an individual for up to 180 days. The exact time limit of the commitment order may vary. When the order is about to expire, the hospital can petition for re-commitment if they think longer hospitalization is needed.

The person has the right to appeal any of these orders for commitment or re-commitment.[iv]

METHODS

In an effort to better understand the application of the Emergency Custody Order (ECO) and Temporary Detention Order (TDO) processes in Virginia, we surveyed individuals from across the state, both in-person and via an online survey portal, to collect data on their experiences.

We focused our study on four key steps of these combined processes:

1. Interacting with Law Enforcement
2. Receiving initial care in the Emergency Department
3. The Pre-Screening Interview
4. The Magistrate Hearing and Legal Representation

[2] Or slightly longer if the order expires on a Saturday, Sunday, or holiday.

OUTREACH

dLCV conducted in-person surveys throughout Virginia's hospital system and offered an electronic version of this survey available on our website. To date, we collected 56 in-person or mail-in surveys and 23 online forms. As of this report, dLCV has collected 79 responses in total. The majority of these were completed by the individual who was the subject of the commitment, though a small number were completed by guardians, parents, or other caregivers.

dLCV made specific efforts to reach out to self-advocacy organizations serving individuals with multiple disabilities, including VOCAL Virginia, NAMI, the Arc, the Virginia Department for the Deaf and Hard of Hearing, the Virginia Department for the Blind and Visually Impaired, and the Brain Injury Association of Virginia.

DEMOGRAPHICS

The overwhelming majority of individuals—67, 85% - reported mental illness as a primary or co-occurring diagnosis. The next most common was Developmental Disability (DD), including Autism; 16 people (20%) reported DD as either a primary or co-occurring diagnosis. Additional disabilities represented in the sample include: Mobility Impairments (6, 7%); Blindness or Vision Impairment (4, 5%); Deafness or Hard of Hearing (3, 4%); Traumatic Brain Injury (1, 1%); and other conditions (6, 7%). Thirty-four percent of people (27) reported more than one co-occurring disability.

Most of our respondents were white (50 of 79, 63%). This is consistent with overall demographics of the state (the 2020 census reported that 60% of Virginians identified as white). However, it is not clear whether this sample is representative of the overall population of civil committees in Virginia. It does not appear that any state or local agency is collecting this information; it is not publicly available from either law enforcement or Department of Behavioral Health and Developmental Services (DBHDS).

Forty-four of our respondents (55%) identified as female, while 31 (39%) identified as male and 4 (5%) did not respond. One person in the sample identified as a Transgender Man. Like race, there are no publicly available statistics on the gender of civil committees. When compared with recent census figures, it appears that our sample is slightly skewed towards female respondents, which may have had an impact on overall responses.

It did not appear that a disproportionate number of respondents came from any single geographic area. The most common area where people lived prior to their commitment was Roanoke City (6, 7%), though this is likely the result of where we were able to conduct surveys. Three people reported that they were committed while on vacation from out of state (one from Pennsylvania and 2 from New Jersey).

Eighteen percent of the people we spoke with were homeless at the time of their commitment (14). The people we spoke to who were homeless often explained that not having stable housing directly led to their commitment and prevented their release. This was the case even when, by all appearances, the person was clinically stable.

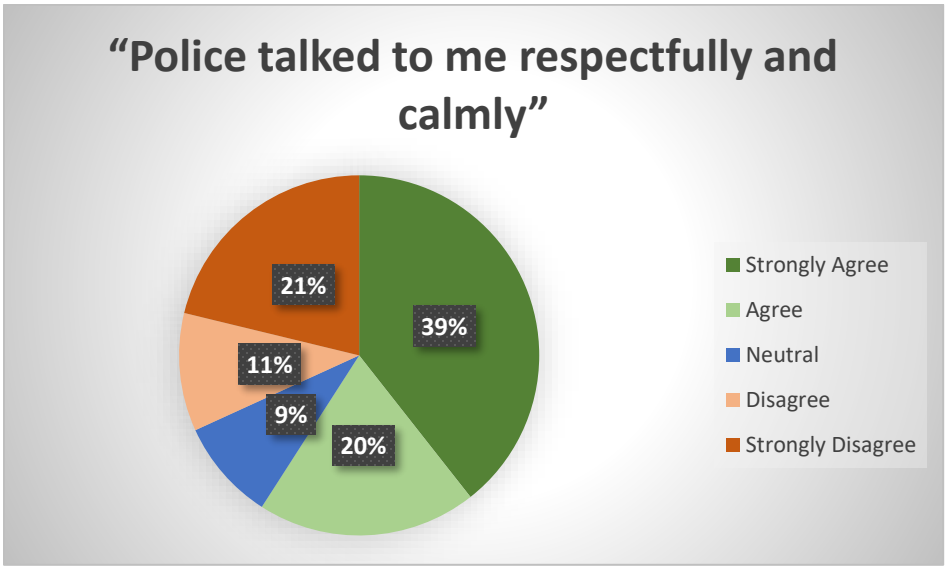
"I was homeless and this felt like a good option." —Richard D.

"[I was held] for 30 days until housing could be found." –Stanley G.

LAW ENFORCEMENT

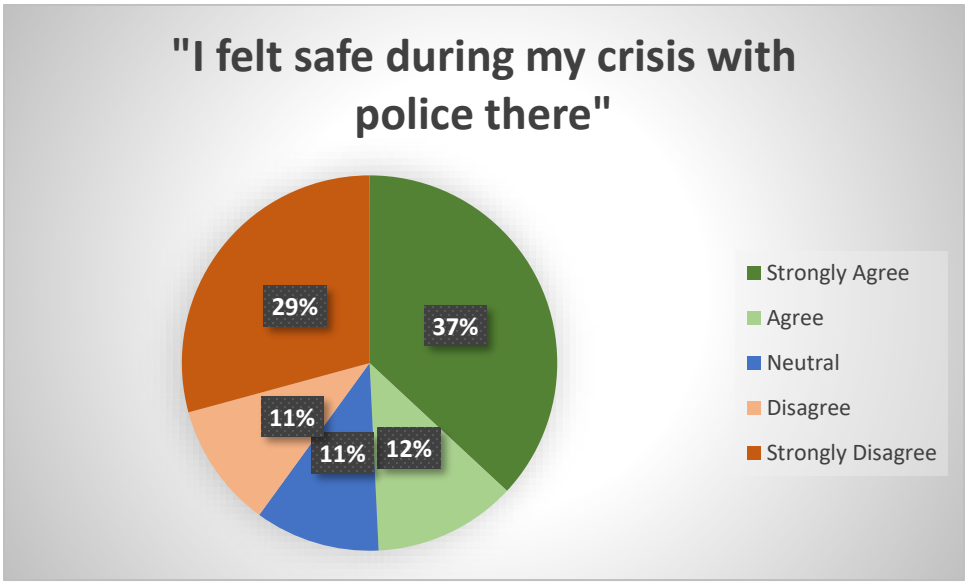
Eighty-one percent of people we surveyed encountered police during the involuntary commitment process.

People in our sample reported higher satisfaction with law enforcement than with any other part of the process; people receiving services in southwest Virginia reported especially high satisfaction with police. We must note that this satisfaction with law enforcement does not paint a full picture. People with the worst police interactions, notably death or serious injury, would not have reached mental health hospitals to complete surveys, which likely skews satisfaction upward[v]. Still, it is encouraging to know that, for this sample at least, experiences with law enforcement have been largely positive.



Most respondents reported that they either “somewhat” or “strongly” agreed with the statement “Police talked to me respectfully and calmly.”

Fewer respondents agreed that they “felt safe during [their] crisis with police there.” Nearly 30% strongly disagreed they felt safe with police present. Several first-hand accounts described tasering, racist threats, and being physically dragged by police.

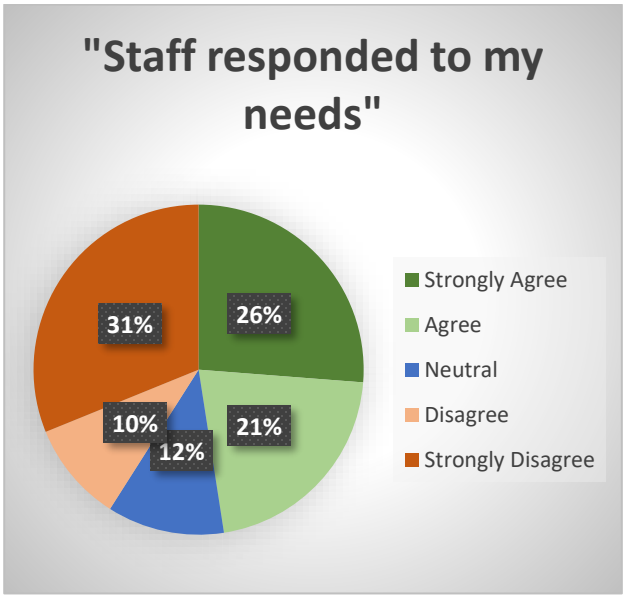


EMERGENCY DEPARTMENT

Seventy-six percent of respondents went through an Emergency Department (ED) as part of the ECO/TDO process. Several of those who said they did not go to an ED reported that they were directly admitted to psychiatric units or hospitals instead.

> *"It is a system that bullies the person in crisis and does not care what their wishes are for personalized care outside of a facility. In my experience it could potentially dissuade someone from seeking emergency care if they will ultimately have their rights suspended by the legal system." —Anonymous*

While most who responded agreed that staff were available when needed, fewer than half felt that staff were responsive to their needs, with 31% "strongly" disagreeing with the statement "[ED] Staff responded to my needs."



Thirty-three percent strongly disagreed that staff treated them with dignity and respect.

One respondent said that the process did not take her specific needs into account and felt disjointed:

"I felt like I was being detailed and had to tell little bits and pieces rather than a continuum." — Anonymous

HANDCUFFS

Respondents reported being handcuffed during transport, being handcuffed to hospital beds, and being denied disability accommodations.

> *"I was handcuffed alone in the back of the police vehicle used to transport me from the ER to the hospital. I don't think handcuffs were necessary at all." –Anonymous*

One individual who is Deaf reported:

"Officer clamped handcuff on my wrist until blood splattered… cuffed to both the bed and my feet… Nurse ordered police to take both cuffs off my hands so I can communicate. The cuffs stayed on my feet until I was transferred..." –Deborah M.

Another person with arthritis reported:

"I asked to be cuffed in front because of arthritis in my neck… deputy refused and caused severe pain." –Denise T.

A significant number of respondents reported being handcuffed to their bed for long stretches during the process. This was reported especially often among individuals with developmental disabilities.

"My adult special needs child ended up with cuts on his wrists from handcuffs" –Anonymous

"A police officer handcuffed both of my hands to my hospital bed and left me that way for hours." –Anonymous

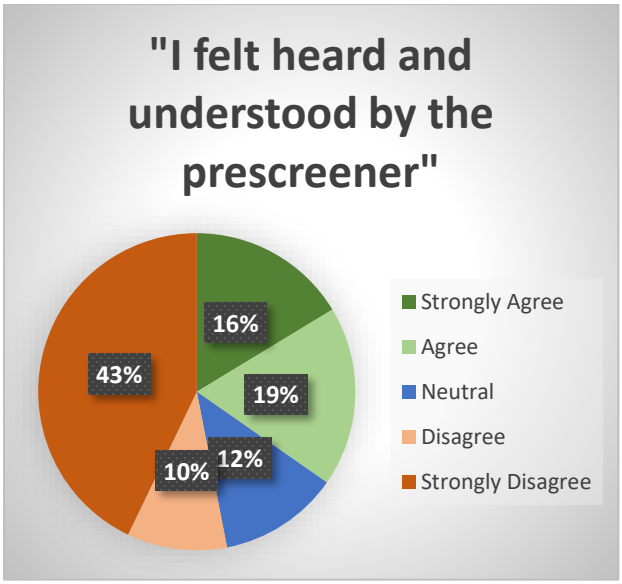
Our findings show that restraints were not rare exceptions but routine practice. The use of restraints of any kind during involuntary commitment should be rare and only to prevent immediate harm. The practices reported to dLCV are unacceptable and must be reassessed at the local and state levels.

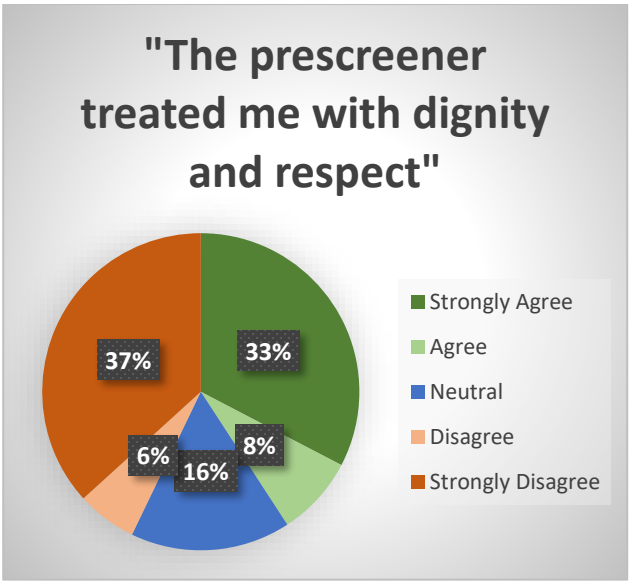
PRE-SCREENING

Many of the people we spoke to (29%) did not remember whether they had spoken to a pre-screener. It seems that this uncertainty was often the result of people meeting with lots of different medical staff and having trouble understanding each staff's role. Several people also reported that, by this point in the process, they were so sedated, they didn't remember anything.

Forty-three percent of people strongly disagreed and 10% somewhat disagreed that they felt heard or understood by pre-screeners. In a similar question, a large proportion of respondents agreed with the statement "The prescreened treated me with dignity and respect," with 33% stating that they "strongly" agreed and 8% stating that they "somewhat" agreed.

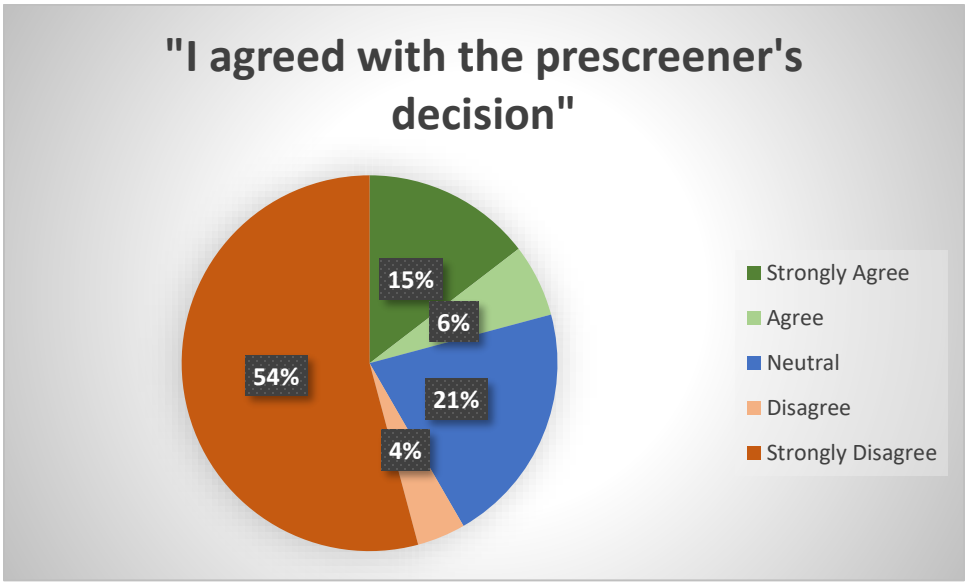
"Pre-screener asked if I took daily walks… I have no legs and am in a wheelchair." –J.





Fifty-four percent of people who met with pre-screeners reported that they "strongly" disagreed with the pre-screener's ultimate decision on whether to recommend involuntary hospital, with another 4% "somewhat" disagreeing. The fact that we interviewed so many people who were actively or very recently going through this process may have skewed this number somewhat. Still, the issue remains that individuals do not feel empowered in this process.

Sixty-five percent of people who met with a pre-screener said voluntary hospitalization was not offered, and 65% said the TDO process was not explained. Understanding the process and having the option for voluntary hospitalization are critical components for maintaining individual's rights and securing necessary agreements to a successful therapeutic process.



Respondents confirmed that they did not receive adequate information about this process.

"I received no paperwork about the hearing or any of my rights during my entire 18 day stay." —Marie K.

"If I'm not aware [of the process], I can only imagine the other people that they're taking advantage of." —Jared D.

Three individuals reported that they were explicitly denied voluntary hospitalization, despite seeking it and asking for this during their later hearing.

"I was told I couldn't stay voluntary. I was committed."—Billie W.

"Came in voluntary and within 24 hours was TDO'd." –Jared D.

"I was unable to volunteer myself fairly. The judge to appeal and I would like a copy of the records. I gave the lawyer before the hearing to appeal the hearing she gave me a wrong telephone number. I was ignored by lawyer." —Lynn B.

The above responses show a denial of meaningful participation in decisions about care. For individuals to get accurate pre-screening and make informed decisions about voluntary hospitalization, it is critical that these interactions be improved.

COMMITMENT HEARING AND ATTORNEY

THE HEARING

Only half of respondents reported meeting with a magistrate. A handful of respondents (particularly at The Pavilion and UVA Medical Center) spoke to us before their hearing had taken place. Many other people reported that they were not able (or not allowed) to attend their own commitment hearings, though some reported court-appointed attorneys attending in their place.

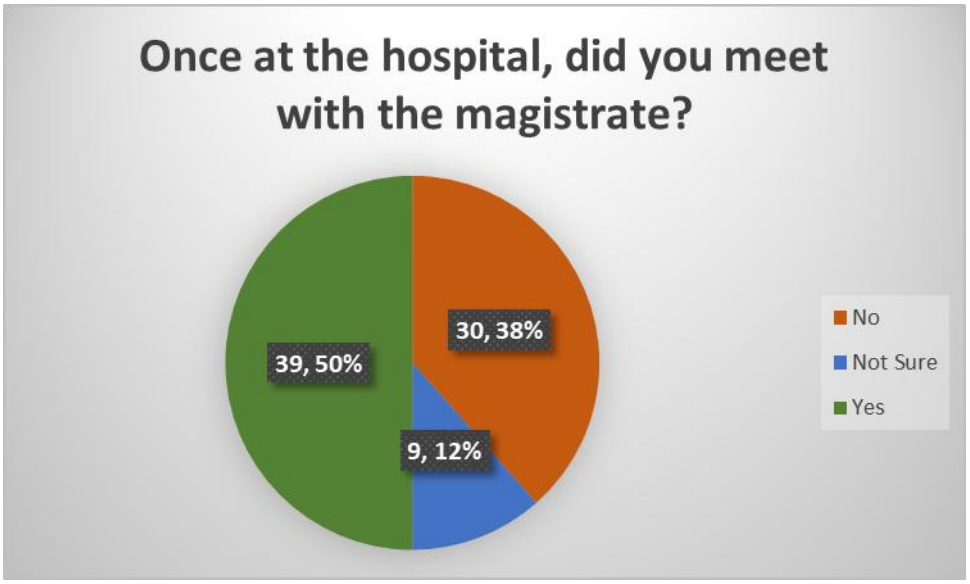
> *"Although I requested an in-person hearing, I was not given one and I was not given the opportunity to participate in, view, or hear the virtual hearing that apparently took place …I thought I would get an in-person hearing, but it later became clear that they had simply committed me." —Marie K.*

Three people told us that they had been so heavily medicated they were not awake for their hearing.

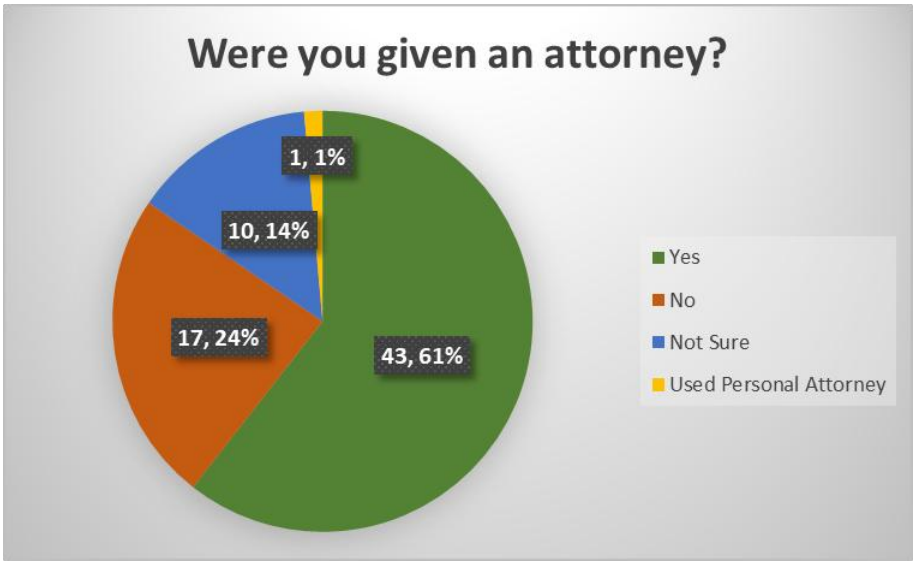
"[I was] Hazy because of medication… Felt I wasn't able to speak as much as I wanted to." – Anonymous

Some people alleged that the hearings they were entitled to simply did not occur.

> *"I was TDO'd, but never had a hearing or a lawyer, and never met with a judge, which I'm pretty sure is illegal. I was initially told I was voluntary, only later to be informed by a police officer that it had been changed to involuntary, with no explanation as to why. I was sent to a state hospital without a hearing or a lawyer." —Anonymous*



Most respondents reported that they were assigned a court-appointed attorney for their hearing, with only one respondent reporting that they used their personal attorney. Twenty-four percent said they were not assigned an attorney.



THE ATTORNEY

The people we surveyed told us that, of all the stages of the involuntary commitment process, they were most unhappy with their attorneys. Most people in the survey reported that they did not feel they were represented fairly, nor did their attorney know them or meet

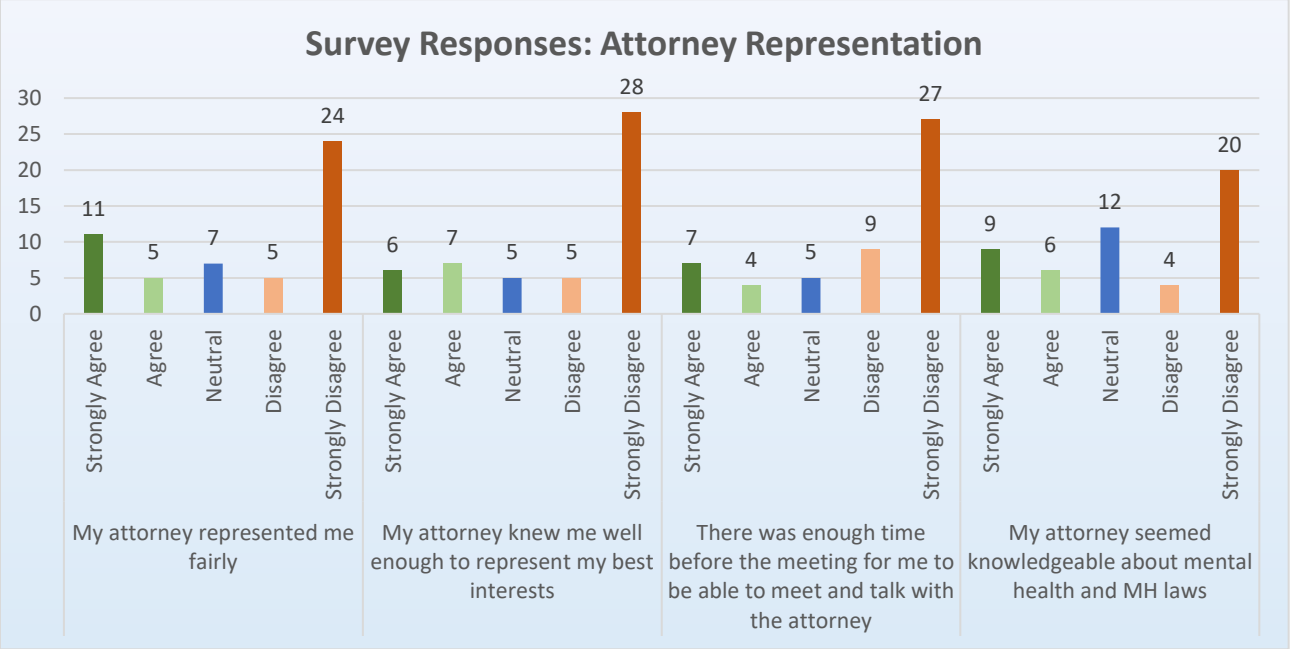
with them for long enough to do so. Sixty-five percent said they were not even given their attorney's contact information.

Quotes describe attorneys as "rubber stamps" or "just there as a formality."

"[The attorney was] just there as a formality more than anything. The attorney just kind of sat there… Unless you're a speed talker and can talk faster than the judge can say no [you don't get a say]." –Debbie

"I still don't understand what happened… they pulled me in last… they said 'we've already rendered our decision and are really just informing you.'"—Seb

"The judge decided I needed to stay in the hospital. He was not concerned with anything I had to say or my attorney had to say. My attorney didn't know me at all and certainly did not take the time to ask me about anything. Now, I have a "black mark" on my record simply because no one would speak with me." –Doruss S.



A small group of respondents did report satisfaction with the hearing itself.

"[I] Was made voluntary at the hearing and was very satisfied with that… voluntary was what I wanted." —Anonymous

"I feel that despite not wanting to be in the hospital it was the correct decision at the time due to my situation and my mental health." –Shamesha C.

Two guardians reported that the process was further complicated due to the client's DD diagnosis.

"As legal guardian, I had no ability to assist nor advocate for her." —Amanda P.

"They overrode me and talked my child into staying longer than anticipated." —Anonymous

Another responded reported that she uses American Sign Language and was not given appropriate access to an interpreter during the hearing.

"Met with judge, attorney, doctors and other staff. [Video Remote Interpretation] using laptop was extremely poor. Freezes. crashes. The room was stifling hot when judge said you have serious mental illness; I am placing you… I was shocked and passed out for a minute or so then I came to, the battery for laptop died and I was never given a chance to respond." —Deborah M.

APPEAL PROCESS

Individuals under TDO have the right to appeal this decision. However, the respondents in our sample reported barriers to all parts of the appeal process. Only 1 of 79 respondents reported successfully appealing their commitment. Barriers included lack of paperwork, misinformation, incorrect attorney contact information, and sedation.

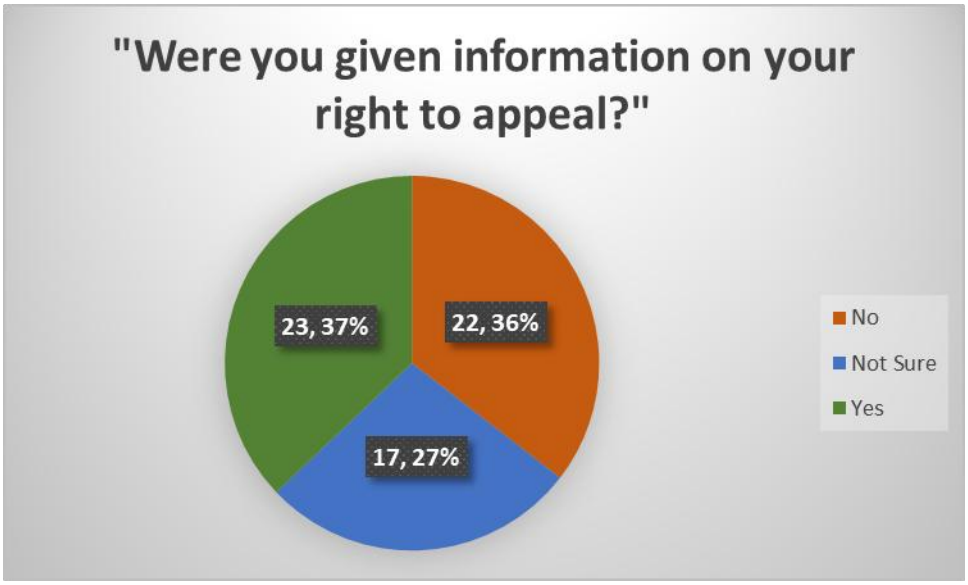
"Social worker said by the time your appeal goes by sentence will be up." —Anonymous

"[I was] too "doped up" to appeal." –Jerry

"I did call [my attorney] and tried to appeal but got no response". —Anonymous

"I have requested an appeal other times I have been in the hospital and have always been able to leave. The problem with the appeal process is it cannot be done until the appropriate persons are available, often a day or two." –Doruss S.

"I had no idea about appeals until reading this survey. I was not offered the opportunity." — Anonymous



Thirty-seven percent of respondents reported that they received information on their right to appeal. An additional 27% were not sure if they received this information. Information on appellate rights should be readily available, in writing, and in an accessible format.

These findings show a systemic failure of due process rights. Most people were not told that they could appeal and did not understand the process. Nearly every individual who reported that they wanted to appeal or who requested an appeal, did not hear back or was told that they could not appeal due to timeline issues. Appeals are a vital part of the involuntary commitment process and must not be treated as optional.

CONCLUSIONS AND RECOMMENDATIONS

While advocacy organizations have actively advocated for changes to the involuntary commitment process in recent years, dLCV is unaware of any other fact-finding efforts that, like ours, took a statewide approach to interviewing people in a range of settings, designed to capture both positive and negative experiences. More research is needed, including improved data collection. dLCV will continue to collect survey responses and will publish regular updates to our report and analysis.

Across the 79 responses we received, several trends emerged that require serious systemic action. Those are:

1. Pre-screeners, hospitals, the courts, and law enforcement are failing to effectively communicate the ECO/TDO process to people going through it—particularly when it comes to appellate rights.
2. Law enforcement and emergency departments are subjecting people with disabilities to prolonged, abusive and often unnecessary restraint.
3. Personnel at all steps of this process do not have the competencies needed to serve people with disabilities. As a result, they routinely violate individual rights.

To remedy these findings, dLCV recommends the following:

1. DEVELOP STATEWIDE STANDARDS THAT LIMIT RESTRAINTS TO TRUE EMERGENCIES INVOLVING IMMINENT DANGER.

Our data shows that restraints were often applied automatically in emergency departments and during transport, rather than as a last resort. This led to individuals feeling panicked, pained, and as if they had done something wrong. Individuals reported that the use of restraints—especially handcuffs—increased their anxiety levels and led to injury. In the case of one deaf individual, handcuffing also presented a significant barrier to communication.

In response, dLCV recommends that the Virginia General Assembly amend current Virginia law to explicitly state the following, and that DBHDS, Virginia State Police (VSP) and Local Law Enforcement policies and protocol be updated to reflect:

- Individuals experiencing a mental health crisis may not be handcuffed during an ECO unless they are presenting an imminent risk of harm to themselves or others and that risk cannot be mitigated in any other way. As soon as the risk is no longer imminent, the individual should be released from restraints. This standard would align with current standards for mental health providers and reaffirms that these individuals are being connected with care—not punished by the criminal justice system.
- All restraints that occur on the grounds of a hospital or crisis center are directed solely by medical staff.
- Virginia State Police and Local Law Enforcement offices must track how long individuals in their care are handcuffed during a behavioral crisis and report this data to the Department of Behavioral Health and Developmental Services, the Office of the Attorney General and the disAbility Law Center of Virginia.

In addition to these state-level legislative changes, dLCV recommends that DBHDS, law enforcement, and legislative workgroups continue to expand the use of "Alternate Transportation" for people in crisis, to further minimize the involvement of law enforcement in a non-criminal process.

2. REQUIRE INITIAL AND PERIODIC TRAINING FOR LAW ENFORCEMENT, PRE-SCREENERS, AND ATTORNEYS ON DISABILITY RIGHTS, ACCESSIBILITY, AND ACCOMMODATION.

Licensed and certified personnel throughout this process are failing Virginians in crisis. There are disturbing patterns apparent throughout the process: individuals whose rights are at risk are silenced in pre-screening, are excluded or sidelined in hearings, are blocked from appeals, and are restrained with handcuffs for extraordinary lengths of time. Together, these create a system of harm rather than of care.

The first step in ensuring quality care must be enhanced training for the professionals involved in civil rights, disability rights, accessibility, and accommodation. This training should be integrated into the current Law Enforcement Crisis Intervention Team (CIT) Trainings, required of all pre-screeners, and all attorneys and magistrates involved in the commitment process. Trainings must cover basic accessibility and accommodation considerations, as well as common "complications," such as "how to serve a client who has a guardian." The training must include reinforcement of protections established in Virginia code, such as the right to have a family member present in an emergency department.

3. DEVELOP PROTOCOLS AND PLAIN-LANGUAGE MATERIALS TO ENSURE THAT PEOPLE ARE ADEQUATELY INFORMED OF THE PROCESS, AS WELL AS THEIR RIGHTS

Our surveys found that individuals going through the ECO/TDO process usually do not understand the process itself, especially the appeal process. One of our respondents said she did not even know that there *was* an appeal process until she read our survey. The right to appeal exists in law but is inaccessible in practice due to sedation, misinformation, and

withheld or overly complex paperwork. The appeals process is not an optional part of the process; yet that is how it is treated.

Additionally, the consistent failure of pre-screeners to offer the option of voluntary admission shows systemic denial of choice. Improved training should result in better protection of individual rights. Moreover, providing self-advocacy tools may be the best way to ensure people's rights are upheld.

dLCV recommends the following:

- DBHDS review its protocols to determine if there are more effective ways to communicate important information to patients—especially when their cognitive abilities may be limited due to temporary effects of mental illness or medication. This is particularly imperative when it comes to the option of voluntary admission and the process of appealing.
- DBHDS develop robust, plain-language materials, including posters for all licensed admissions units. These materials should be available in alternative formats for those with language and accessibility needs.

4. IMPROVE DATA COLLECTION

Throughout our study, we encountered parts of the process that just had no available data attached to them. Without good data, the institutions involved in this process cannot possibly self-evaluate and the Commonwealth at large simply does not know what is happening to people whose civil liberties are being suspended. Areas in which data improvement is needed include:

- Virginia Law Enforcement agencies should collect meaningful data on "Paperless" ECOs, which are orders in which an officer makes the on-site determination to take an individual into custody for psychiatric evaluation without prior authorization or any documented legal order.
- Virginia Law Enforcement agencies should be required to report when a person under an ECO is placed in restraints, including the type of restraints, the officers involved, the duration of restraint, and the behavior requiring restraint. This data is already routinely collected by licensed mental health practitioners as part of accountability and quality assurance measures.

- Emergency Rooms should, similarly, report when a person under an ECO or TDO is restrained while in their care. While this may be documented in an individual's chart, the aggregate information is not statutorily required to be reported to the Virginia Department of Health. For comparison, hospitals and units that are licensed by DBHDS *are* required to collect and report this data. Whether a restraint is documented should not be dependent on where in the hospital a patient is.
- Aggregate data should be collected on which attorneys are being appointed to represent indigent parties in the involuntary commitment hearing and the hearing's outcome.
- The Bar should also record where and how often people are unrepresented in these hearings. While people may choose to represent themselves, it is important to consider whether certain localities are failing to offer individuals the representation they are entitled to.

LONG TERM CONSIDERATIONS

These survey findings show that restraints, lack of information, and exclusion from decision-making are not isolated incidents but patterns that strip people of autonomy and deepen trauma. The heavy reliance on coercion reflects a centralized system where power is concentrated in courts, police, and hospitals, often at the expense of the person in crisis and their community support. Future policy efforts should focus on reducing default reliance on law enforcement and restraints, expanding access to voluntary and peer-run alternatives, and embedding community-based advocates and interpreters at every stage. Interdependence is not only an ethical principle but also a practical safeguard. When people can rely on trusted supporters, peer specialists, and local networks, they are more likely to engage meaningfully in care and less likely to experience re-traumatization.

Virginia can build a crisis system that balances the need for care with legal protections and community-based safety, shifting from control to collaboration.

dLCV looks forward to working with Stakeholders to achieve these short and long-term goals.

To learn more, visit us at www.dLCV.org

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[i] Va. Code § 37.2-808.
[ii] Va. Code § 37.2-816.
[iii] Va. Code §§ 37.2-809, 37.2-809.1, and 18.2-308.1:3.
[iv] Va. Code §§ 37.2-814, 37.2-815, 37.2-817, and 37.2-819.
[v] https://www.dlcv.org/irvo-otieno-report.