COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
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

Thursday, July 1, 2021

The Honorable Daniel Carey, MD, MHCM
Patrick Henry Building
1111 East Broad Street
Richmond, VA 23219

The Honorable Jeremy McPike
The Honorable Jeffrey Bourne
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Secretary Carey, Senator McPike, and Delegate Bourne,

Chapter 42 (HB 5043 and SB 5038) of the 2020 Acts of Assembly directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with the Department of Criminal Justice Services and other stakeholders, to create and submit a state plan for the Marcus alert system. The language states:

> *By July 1, 2021, the Department, in collaboration with the Department of Criminal Justice Services and law-enforcement, mental health, behavioral health, developmental services, emergency management, brain injury, and racial equity stakeholders, shall develop a written plan for the development of a Marcus alert system. Such plan shall (i) inventory past and current crisis intervention teams established pursuant to Article 13 (§ 9.1-187 et seq.) of Chapter 1 of Title 9.1 throughout the Commonwealth that have received state funding; (ii) inventory the existence, status, and experiences of community services board mobile crisis teams and crisis stabilization units; (iii) identify any other existing cooperative relationships between community services boards and law-enforcement agencies; (iv) review the prevalence of crisis situations involving mental illness or substance abuse, or both, including individuals experiencing a behavioral health crisis that is secondary to mental illness, substance abuse, developmental or intellectual disability, brain injury, or any combination thereof; (v) identify state and local funding of emergency and crisis services; (vi) include protocols to divert calls from the 9-1-1 dispatch and response system to a crisis call center for risk assessment and engagement, including assessment for mobile crisis or community care team dispatch; (vii) include protocols for local law-enforcement agencies to enter into memorandums of agreement with mobile crisis response providers regarding requests for law-enforcement backup during a mobile crisis or community care team response; (viii) develop minimum standards, best practices, and a system for the review and approval of protocols for law-enforcement participation in the Marcus alert*

system set forth in § 9.1-193; (ix) assign 8 of 8 specific responsibilities, duties, and authorities among responsible state and local entities; and (x) assess the effectiveness of a locality's or area's plan for community involvement, including engaging with and providing services to historically economically disadvantaged communities, training, and therapeutic response alternatives.

In accordance with these items, please find enclosed the report for Chapter 42 of the 2020 Acts of Assembly. Staff are available should you wish to discuss this request.

Sincerely,

Alison G. Land, FACHE
Commissioner
Department of Behavioral Health & Developmental Services

CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

Written Plan for Chapter 42, House Bill 5043 and Senate Bill 5038 of the 2020 Acts of Assembly

Abbreviated State Plan for the Implementation of the Marcus-David Peters Act

Submitted by the Marcus Alert State Stakeholder Group

Thursday, July 1, 2021

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

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Preface

By July 1, 2021, the Department, in collaboration with the Department of Criminal Justice Services and law-enforcement, mental health, behavioral health, developmental services, emergency management, brain injury, and racial equity stakeholders, shall develop a written plan for the development of a Marcus alert system. Such plan shall (i) inventory past and current crisis intervention teams established pursuant to Article 13 (§ 9.1-187 et seq.) of Chapter 1 of Title 9.1 throughout the Commonwealth that have received state funding, (ii) inventory the existence, status, and experiences of community services board mobile crisis teams and crisis stabilization units, (iii) identify any other existing cooperative relationships between community services boards and law-enforcement agencies, (iv) review the prevalence of crisis situations involving mental illness or substance abuse, or both, including individuals experiencing a behavioral health crisis that is secondary to mental illness, substance abuse, developmental or intellectual disability, brain injury, or any combination thereof, (v) identify state and local funding of emergency and crisis services, (vi) include protocols to divert calls from the 9-1-1 dispatch and response system to a crisis call center for risk assessment and engagement, including assessment for mobile crisis or community care team dispatch, (vii) include protocols for local law-enforcement agencies to enter into memorandums of agreement with mobile crisis response providers regarding requests for law-enforcement backup during a mobile crisis or community care team response, (viii) develop minimum standards, best practices, and a system for the review and approval of protocols for law-enforcement participation in the Marcus alert system set forth in § 9.1-193, (ix) assign specific responsibilities, duties, and authorities among responsible state and local entities, and (x) assess the effectiveness of a locality's or area's plan for community involvement, including engaging with and providing services to historically economically disadvantaged communities, training, and therapeutic response alternatives.

View the full Act here.

Executive Summary

The Marcus-David Peters Act (HB 5043 and SB5038) is named in honor of Marcus-David Peters, a young, Black, biology teacher and VCU graduate who was fatally shot by Richmond Police in 2018 in the midst of a behavioral health crisis. It was introduced by Senator McPike and Delegate Bourne, and was signed into law in November 2020 by Governor Ralph Northam. The Act modifies the Code of Virginia to add § 9.1-193 "Mental health awareness response and community understanding services (Marcus) alert system, law-enforcement protocols", which outlines the role of the Department of Criminal Justice (DCJS) and local law enforcement in the development of three protocols for behavioral health crisis situations; sets seventeen goals for law enforcement participation in the Marcus Alert system; assigns purview between DCJS and the Department of Behavioral Health and Developmental Services (DBHDS); and requires localities to develop a voluntary database. The Act also modifies the Code of Virginia to add § 37.2-311.1 "Comprehensive crisis system, Marcus alert system, powers and duties of the Department related to comprehensive mental health, substance abuse, and developmental disability crisis services"**.** This requires DBHDS to develop a comprehensive crisis system based on national best practice models composed of a crisis call center, community care and mobile crisis teams, crisis stabilization centers, and the Marcus Alert system. It also requires DBHDS, in collaboration with DCJS and a range of stakeholders, to develop a written plan for the development of the Marcus Alert system, which is represented in this document.

The implementation of the Marcus-David Peters Act refers to the Act in its entirety, including state components of the comprehensive crisis system (e.g., regional call centers, STEP-VA mobile crisis).

A local Marcus Alert system, which is the responsibility of localities to implement, is primarily defined as a voluntary database, three protocols, and the plan for law enforcement engagement with the system and how community coverage will be achieved leveraging both state and local crisis supports. Protocols and plans must meet the minimum standards described in Section III of this plan and be approved.

The state implementation plan is the result of a collaborative process between DBHDS, DCJS, other state agency partners, and the Marcus Alert State Planning Stakeholder Group (heretoafter referred to as "the workgroup"). A full list of workgroup members is available in Appendix A. In total, the group was comprised of 45 stakeholders from across Virginia, representing local governments, non-profits, private and community providers, individuals with lived experience, and advocates. Each stakeholder represented

different perspectives in the areas of mental health, substance use disorder, developmental disabilities, law enforcement, developmental disabilities, and social justice and racial equity.

The state plan includes four sections. The first section provides background on Virginia's behavioral health crisis system, a summary of the planning group and process, and a current landscape analysis. The landscape analysis includes, as required, a catalog of existing CIT programs, crisis stabilization programs, cooperative agreements between law enforcement and behavioral health, a review of the prevalence and estimates of crisis situations across Virginia, and current funding for crisis and emergency services. The second section describes components of the implementation plan that are statewide (including the comprehensive crisis system as well as statewide aspects of the Marcus Alert system). It also includes a four-level framework for categorizing crisis situations, regional coverage by STEP-VA mobile crisis teams and associated Medicaid rates, 988/regional call centers, a statewide Equity at Intercept 0 Initiative, and statewide training standards. The third section describes the requirements for localities to implement their local Marcus Alert systems, which include the local planning process, minimum standards and best practices for local law enforcement involvement in the Marcus Alert system, descriptions of different ways to achieve local community coverage, and the system for review and approval of protocols. Finally, the fourth section provides frameworks for accountability and responsibility across state and local entities and how the success of the implementation will be assessed.

Background

Virginia's Behavioral Health Crisis Service Continuum

The workgroup agreed that the behavioral health crisis services continuum includes a recognition that behavioral health crises are common and can happen to anyone, and a robust, specialized community response system similar to fire, law enforcement, and EMS is warranted.

A robust crisis response system is a collaborative effort across governmental agencies and healthcare payers and providers to ensure that an appropriate, health-focused response is available to *anyone*, *anywhere*, *anytime*. Community-based crisis supports include someone to call, someone to respond, and somewhere to go, with all three of these support categories being therapeutically appropriate and tailored for behavioral health emergencies.

- "Someone to call" means that there is an easily identifiable access point that does not require special knowledge or past experience in a crisis situation, preferably with text, phone, and web-based access. This access point is coordinated with but distinct from 911. The person on the other end of the line is trained to respond therapeutically to behavioral health crises, and there is language access available to provide services to all Virginians. This access point not only provides phone intervention but also serves as an access point to the full crisis continuum.
- "Someone to respond" means that 24/7/365 there is someone available to respond in person (including use of real-time telehealth services) to provide on-scene stabilization services, assessment, and planning.
- "Somewhere to go" refers to a specific place that turns no one away and provides a range of crisis supports that are appropriately matched to the risk of harm of the situation. This includes accepting walk-ins and law enforcement drop-offs to avoid jail or other detention, including involuntary transfers.

Virginia's crisis system should include equitable access for all Virginians, providing specific supports for all disability types with an ongoing quality improvement focus around addressing race-based health disparities. Race-based health disparities are assumed to be present (versus presumed to be absent or only arising in rare, unexpected circumstances) in the system and are assessed and monitored in a way that is transparent with the community users and potential users. Leadership across the crisis continuum and oversight bodies should be diverse, including a focus on Black-led, BIPOC-led, and peer-led behavioral health providers and decision makers. Building a crisis system that is effective and accessible includes

consideration of indirect, systemic influences on the emergence and stabilization of law enforcement as the *de facto* crisis response. These influences include:

- Historical lack of mental health funding (rendering low access to behavioral health crisis care for all Virginians);
- Criminalization of mental illness and federal and state policies associated with use of illicit substances;
- Lack of safe and affordable housing for vulnerable Virginians (i.e., behavioral health crises are observable in public spaces due to lack of privacy), and many more.

In this landscape, Black Virginians, Indigenous Virginians, and Virginians of Color experiencing a behavioral health crisis have even less access to the already difficult-to-access behavioral health crisis supports. They may also have family and natural supports with increased hesitancy to seek emergency supports until a crisis has escalated to an unmanageable situation, and will be less likely than their white counterparts to be met with a therapeutic, health-focused response when help is sought. A crisis system that is less accessible, less therapeutic, or more restrictive for certain races, ethnicities, or disability types is not a crisis system that works.

Virginia's crisis system represents a shift away from today's *de facto* reliance on law enforcement and emergency room settings to respond to behavioral health emergency situations. The way a fire response would be expected at a fire, a behavioral health response is the default component of a behavioral health response. Specialized teams such as Crisis Intervention Teams (CIT)[1] are a key part of the system linking individuals in crisis to care safely, but they are not a substitute for the behavioral health crisis care itself.

Virginia's comprehensive crisis system should include a community-based crisis continuum and a number of Marcus Alert-related supports for diversion from law enforcement involvement to the community-based crisis continuum.

State Planning Workgroup

A state planning workgroup was formed to drive the development of the statewide Marcus Alert plan, with a number of stakeholder groups required to be involved per the Act. A full list of workgroup members is provided in Appendix A. The full workgroup met 12 times between January and May 2021.

[1] Crisis Intervention Teams are teams comprised of law enforcement officials trained in crisis intervention techniques to health individuals experiencing mental health crises to access treatment and divert for justice involvement when possible.

General topics reviewed and discussed included Virginia's emergency services system, Virginia's Crisis Intervention Team (CIT) programs, CIT Assessment Centers (CITACs), some recent pilots in Virginia at 911 dispatch and co-responder models, implicit bias, peer roles throughout the continuum, considerations for youth, community accountability, and models from other states and cities. There was general agreement early in the workgroup regarding the adoption of the following values to guide the planning process:

1) Health-Focused
2) Safety through Empowerment and Recovery Orientation
3) Equitable Access
4) Polycentric Governance
5) Transparency, Community Engagement, and Accountability

The following work streams were ultimately formed to create more detailed proposals for consideration in the state plan.

1. The Community Input work stream focused on ensuring that there was community involvement in the development of the state plan, as well as required at the local planning level. This work stream held three community listening sessions and conducted a survey of individuals with lived experiences. Survey results are included in Appendix D.
2. The Triage work stream focused on the role of 911/Public Safety Answering Points (PSAPs) and the development of a general framework that could be used to triage and communicate about behavioral health calls and responses across sectors (dispatch, law enforcement, behavioral health).
3. The Response Options work stream focused on identifying minimum standards and policies and procedures for law enforcement responses and co-responder models.
4. The Equity at Intercept 0 work stream focused on addressing racial and other bias at Intercept 0 (i.e., behavioral health crisis services) and developed a framework to bolster equal access to crisis care, cultural competency in crisis care, and the development of Black-led, BIPOC-led, and peer-led crisis services and supports at Intercept 0.
5. The Data and Reporting work stream focused on identifying key outcomes, including racial disparities, to inform quality improvement over time.
6. Finally, the Local Roadmap work stream focused on the development of documentation and processes for localities to engage in to develop their local implementation plans, submit plans for approval, approval process at the state level, and the coordination of local and state oversight for the implementation of the Marcus Alert.

Current Landscape Analysis

To catalog the current crisis system, a survey was disseminated to community services boards (CSBs), CIT programs, law enforcement agencies, and PSAPs. More details of this survey and of Virginia's current crisis system can be found at DBHDS's website.

Community Services Board Respondents

Through STEP-VA, community services boards (CSBs) have been situated as the primary gateway to the public behavioral health system.

Almost all CSB respondents (93%) indicated that there is at least one CIT assessment center (CITAC) within their respective catchment areas. CITACs primarily serve as non-hospital locations where crisis evaluations can occur and law enforcement can transfer custody of individuals under an emergency custody order (ECO).[2] The second most common crisis system component reported among CSB respondents was a youth mobile crisis team. This is not surprising given the recent investments in youth MCTs through STEP-VA. Similarly, the third most common crisis component, the REACH mobile crisis team, has been prioritized in recent years due to its intersection with the Department of Justice Settlement Agreement. Currently, among CSB respondents, the prevalence of co-response teams, which partner behavioral health professional with traditional first responders like emergency medical services or law enforcement, is low. Some localities may choose to start co-response teams or enhance their capacity in order to ensure community coverage for Level 3 or 4 Marcus Alert calls. No CSB respondents reported having peer-operated respites within their respective catchment areas. There were also no novel police-mental health collaborations reported.

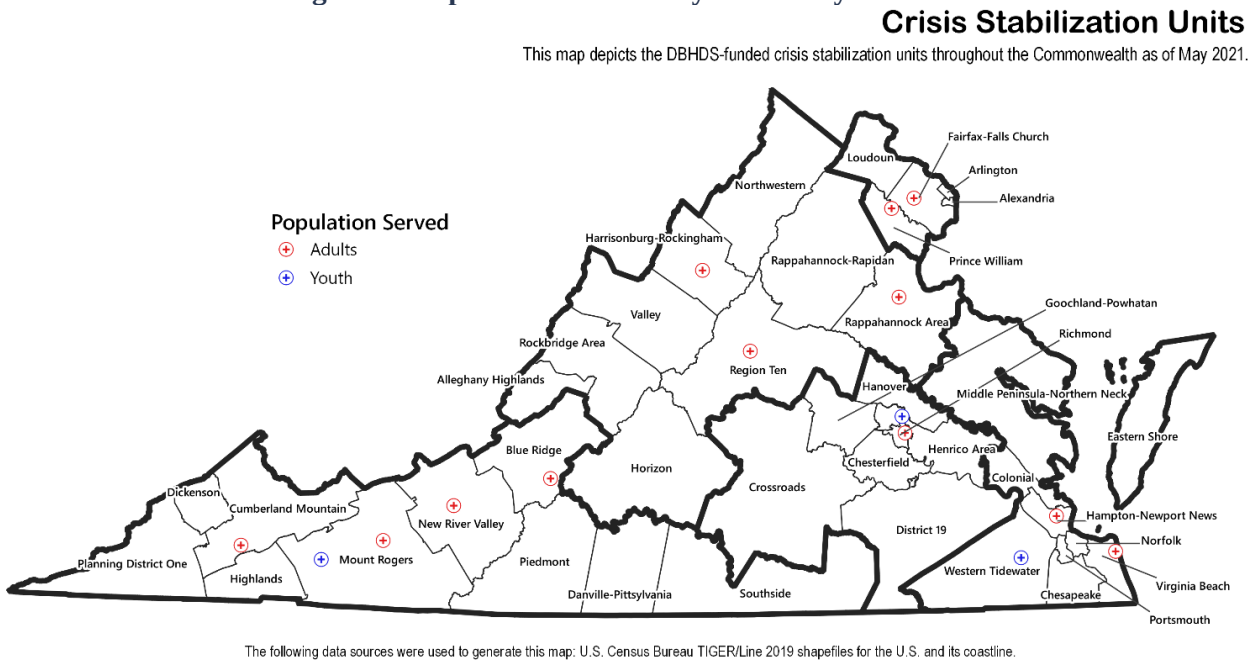
Crisis Stabilization Units

Crisis stabilization unites (CSUs) are an essential component of a comprehensive crisis system. They play a key role in supporting individuals who may require an extended period of out-of-home care – but not the sort of high-acuity care provided in inpatient psychiatric hospitals – to return to their pre-crisis baselines. This crisis system component is currently available throughout the Commonwealth as a

[2] See the CITAC Respondents section for additional information about the services that they offer and the populations that they serve.

regional asset, meaning that all CSBs within a given DBHDS region utilize the CSU. All DBHDS-funded CSUs that are currently available throughout the Commonwealth are depicted in Figure 1.[3]

Figure 1. Map of CSUs Currently Funded by DBDHS[4]



CSUs that are funded by DBHDS are considered a regional asset, and, currently, there are at least two CSUs in each DBHDS region. Nonetheless, each DBHDS region does not have at least one CSU for youth: neither DBHDS Region 1 nor DBHDS Region 2 have at least one CSU for youth. Furthermore, the maximum licensed bed capacity for each of these residential treatment locations is no greater than 16 beds (see Table 1).

Table 1. Adult and Youth CSU Licensed Maximum Bed Capacity

Operating CSB	Licensed Maximum Bed Capacity
Adults	
Blue Ridge	16
Cumberland Mountain	16
Fairfax-Falls Church	16
Hampton-Newport News	11

[3] Note that the CSU that is currently located within the Prince William CSB catchment area will be closed shortly, it will be replaced by a new CSU located within the Fairfax CSB catchment area.
[4] Note that the Brandon House CSU that is currently located within the Prince William CSB catchment area will be closed shortly; it will be replaced by a new CSU located within the Fairfax CSB catchment area.

Harrisonburg-Rockingham	7
Mount Rogers	8
New River Valley	7
Prince William	6
Rappahannock Area	12
Region Ten	16
Richmond	16
Virginia Beach	16
Youth	
Mount Rogers	8
Richmond	8
Western Tidewater	5

Mobile Crisis Teams

Among the CSB respondents, five reported having a mobile crisis team that serves adults within their respective catchment areas. The majority of these teams (80%) are staffed with certified pre-admissions screening clinicians and master's-level clinicians. Slightly less than half of the CSB respondents' adult teams (40%) have peer support professionals among their staff. The hours of operation for the CSB respondents' adult teams varied widely, with some CSBs open 24 hours and others only 12 and/or closing on weekends. Nonetheless, CSB respondents indicated that the majority of their respective teams (80%) offer phone consultations outside of normal hours of operations.

As noted above, youth mobile crisis teams were one of the most prevalent components of a comprehensive crisis system reported by CSB respondents (68%). As with adult teams, the majority of CSB respondents' youth teams (78%) include master's-level clinicians on their respective staffs.

Only one youth team currently operates 24 hour per day, seven days per week. However, unlike adult teams, the CSB respondents' reports suggest that it is more common for youth MCTs to be available on Saturdays and Sundays. Nonetheless, only one CSB respondent indicated that its youth team is available twenty-four hour per day, seven days per week (New River Valley CSB).

Co-Response Teams

Chesterfield CSB was the only CSB respondent that reported having a co-response team with emergency medical services. However, in Fairfax County, emergency medical technicians within the fire department participate in a co-response team. Chesterfield's team is only dispatched when a direct referral from emergency medical services or law enforcement is received in response to an overdose. This response is available for eight hours per day on Monday through Friday; it is not available on Saturdays or Sundays.

In Fairfax County, the emergency medical technicians within the fire department participate in the co-response team. The behavioral health members of the team include a certified pre-admissions screening clinician and a peer support professional. This team is available six days a week (Monday through Saturday) for eight hours per day. The behavioral health professionals who are part of the team do not complete CIT training; instead, they complete Mental Health First Aid training. [5] The behavioral health professionals do not ride along in the same vehicle. Fairfax CSB reported that this co-response team is dispatched collaboratively by the CSB and emergency services.

Among the 28 CSB respondents, four indicated that their CSB currently participates in a co-response team (beyond a pilot phase) with law enforcement. One concern that emerged from the workgroup was the ability of specialized teams to provide adequate coverage. To that point, CSB respondents were asked to indicate the hours that their law enforcement co-response teams currently operate. The majority of the CSB respondents' law enforcement co-response teams (75%) operate for eight hours per day Monday through Friday.

All CSB respondents reported that their law enforcement co-response teams are staffed with certified pre-admissions screening clinicians; half reported that their teams include master's-level clinicians. The CSB respondents reported that all of their respective teams require the behavioral health members to complete CIT training.

For the majority of the CSB respondents' law enforcement co-response teams (75%), participating in the team is a permanent duty assignment for the law enforcement members. Furthermore, three of the four CSB respondents' teams have behavioral health clinicians and law enforcement ride together in the same vehicle. Per CSB respondents, two of their respective teams have law enforcement members wear soft uniforms (one respondent did not respond to this question). Three of the teams' law enforcement members wear gun belts (again, one respondent did not respond to this question).

Upcoming Crisis System Components

Sixteen of the 28 CSB respondents indicated that crisis system components would be added to their respective CSB catchment areas during FY 2022. Of those 16 CSBs, the majority (88%) plan to add at least one adult mobile crisis team.

[5] A skills-based training course regarding mental health and substance use issues.

Stepping Up Initiative

For the stake of comprehensiveness, CSB respondents were asked if any jurisdictions within their catchment areas participate in the Stepping Up Initiative. The Stepping Up Initiative is a county-level effort to reduce the prevalence of individuals with mental health diagnoses in jails that is sponsored by the Council of State Governments Justice Center. Five CSB respondents indicated that they have a county that participates in the Stepping Up Initiative within their respective catchment areas.

Crisis Intervention Team Respondents

Currently, there are thirty-eight CIT programs throughout the Commonwealth. They are primarily organized by CSB catchment areas. By partnering with neighboring CIT programs, all CSBs have access to CIT.

The vast majority of CIT respondents indicated that neighboring CSBs do not participate in their respective programs. Still, Loudoun CIT reported that Alexandria CSB participates in its program. Of course, law enforcement agencies are an essential participant in CIT programs. Multiple law enforcement agencies participate in each CIT program. Representatives from PSAPs are another key participant in CIT program. In fact, 83% of CIT respondents indicated that they have PSAP participants in their respective programs.

Core CIT training consists of 40 hours. Curricula vary by CIT program, however, DBHDS has published guidance regarding essential elements of a CIT program. Often CIT programs offer advanced training beyond the base 40 hours for those who are interested. Slightly more than half of the CIT respondents (53%) noted that they do not offer advanced training beyond 40 hours.

Crisis Intervention Team Assessment Center Respondents

CITACs are an essential component of a comprehensive crisis system that allows law enforcement to transfer custody of an individual under an emergency custody order (ECO). Most CITACs are coordinated by CIT program coordinators; however, that is not always the case, so the CITAC respondents are presented separately here.

Though CITACs are typically thought of as location for discretionary law enforcement drop-offs, a variety of professionals can refer individuals to a CITAC for crisis evaluation and other services. For instance, many respondents indicated that their primary CITACs accepted referrals from CSB case managers (53%), private behavioral health providers (47%), hospital emergency department staff (47%),

EMS (37%), and fire and rescue (37%). Almost half of respondents' primary CITACs (47%) also accept self-referrals. Some respondents noted that their CITACs also accept referrals from public and private grade schools, colleges and universities, primary care physicians, and parole and probation officers. Several respondents indicated that their respective CITACs only serve individuals who are under an ECO.

Public Safety Answering Point Respondents

PSAPs will be charged with altering the way in which they triage calls involving behavioral health emergencies (see Triage Framework section). As PSAPs are asked to alter their operations in order to ensure that individuals receive timely, appropriate responses when seeking help for behavioral health emergencies, it is important to ascertain an overview of their current operations.

The survey was distributed to 124 PSAPs that are considered primary by the Virginia Department of Emergency Management's 911 & Geospatial Services Bureau. Among PSAP respondents, the vast majority indicated that they dispatch the traditional first responders: law enforcement (97%), emergency medical services (98%), and fire and rescue (98%). Sixteen of the PSAP respondents indicated that they currently dispatch co-response teams.

Law Enforcement Respondents

The plurality of law enforcement respondents were from police departments (48%). Sheriffs' departments were the second most common type of law enforcement agency (39%). Among the law enforcement respondents were nine college and university police departments and three Virginia State Police Areas. The Virginia State Police were included as a stakeholder since they provide backup for smaller agencies that may not offer 24/7 coverage.

The majority (87%) of law enforcement respondents indicated that their agency does not currently participate in a co-response team; none of the respondents reported previously having a CRT that could not be sustained. Nonetheless, most respondents (86%) indicated that their agency currently participates in CIT training. Interestingly, slightly less than half of law enforcement respondents (43%) indicated that their agencies train 100% of their officers in CIT.

Since law enforcement officers are one of the first responders that are usually dispatched by PSAPs, the inventory survey sought to elucidate the existing relationships among law enforcement respondents and the PSAPs in their respective geographical areas. Forty-five percent of LE respondents indicated that they receive transferred calls from PSAPs (two respondents did not respond to this question). In planning for

the Marcus Alert system, it is important to note that one law enforcement respondents noted that they are transferred calls from a PSAP in Maryland.

Current Crisis System Utilization

Currently, crisis evaluations are only conducted by certified pre-admissions screening clinicians (also known as pre-screeners) that are employed by or contracted with CSBs. Table 2 displays crisis evaluations throughout the Commonwealth. In FY 2020, a total of 74,805 crisis evaluations were performed. Thirty percent of those crisis evaluations resulted from ECOs, and 31 percent of those evaluations resulted in temporary detention order (TDO) for involuntary psychiatric hospitalization. Note that these counts do not necessarily represent a count of distinct individuals who have interfaced with the crisis system since one individual may have more than one crisis evaluation over the course of 12 months.

Table 2. FY 2020 Crisis Evaluations

Month	Total Crisis Evaluations	Emergency Custody Orders		Temporary Detention Orders	
		Total	Percentage of Total Crisis Evaluations	Total	Percentage of Total Crisis Evaluations
July 2019	6,927	1,963	28%	2,042	30%
August 2019	7,100	2,166	31%	2,196	31%
September 2019	7,131	2,047	29%	2,179	31%
October 2019	7,426	1,989	27%	2,062	28%
November 2019	6,432	1,754	27%	1,833	29%
December 2019	6,301	1,852	29%	1,868	30%
January 2020	6,764	1,956	29%	1,954	29%
February 2020	6,590	1,816	28%	1,907	29%
March 2020	5,582	1,800	32%	1,831	33%
April 2020	4,360	1,714	39%	1,757	40%
May 2020	4,805	1,827	38%	1,873	39%
June 2020	5,387	1,917	36%	2,010	3%
Totals	**74,805**	**22,801**	**30%**	**23512**	**31%**

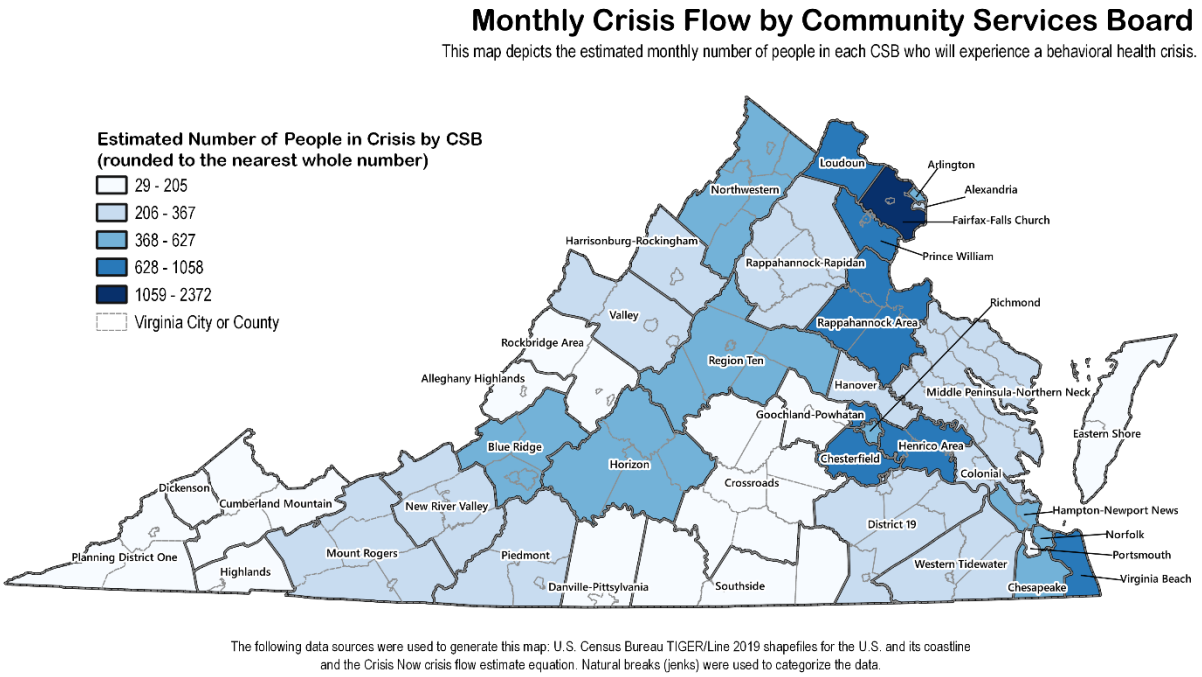
Projected Crisis System Utilization

Virginia's crisis system is undergoing a transformation, with the development of a Marcus Alert system playing a major role. The new Crisis System (or Marcus Alert) will use the Triage Framework to alter the way in which responses are dispatched when individuals dial 911(and, eventually, 988) for behavioral health emergencies. The triage framework is a quick guide for dispatchers at PSAPs and regional 988 crisis call centers to assess the urgency with which a response to a behavioral health crisis is needed.

Meanwhile, the Triage Level of Care Utilization Standards (LOCUS) is a longer assessment, endorsed by the Crisis Now model[6], that is used to determine the appropriate level of care required to help individuals experiencing crises return to their baseline functioning. The LOCUS assesses six dimensions: risk of harm, functioning, co-morbidity, environment, treatment history, and engagement.

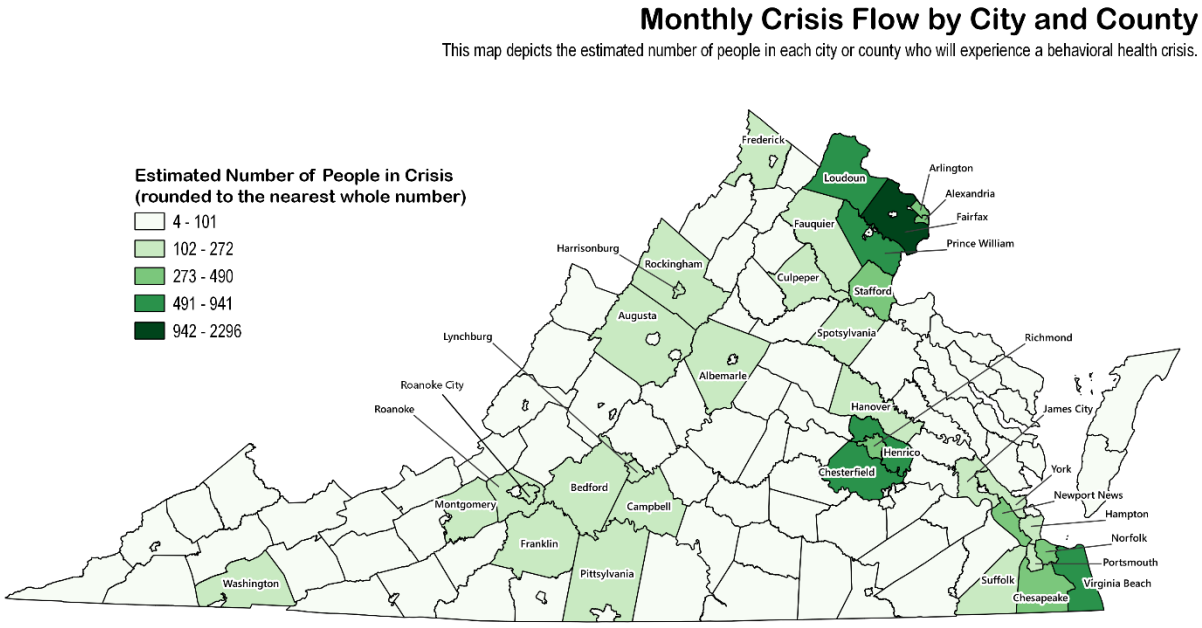
[6] https://crisisnow.com/wp-content/uploads/2020/02/CrisisNow-BusinessCase.pdf

Figure 2. Map of Estimated Monthly Crisis Flow by CSB



The following data sources were used to generate this map: U.S. Census Bureau TIGER/Line 2019 shapefiles for the U.S. and its coastline and the Crisis Now crisis flow estimate equation. Natural breaks (jenks) were used to categorize the data.

Figure 3. Map of Estimated Monthly Crisis Flow by City and County



The following data sources were used to generate this map: U.S. Census Bureau TIGER/Line 2019 shapefiles for the U.S. and its coastline and the Crisis Now crisis flow estimate equation. Natural break (jenks) were used to categorize the data.

Figure 4. Map of Estimated Monthly Youth Crisis Flow by CSB

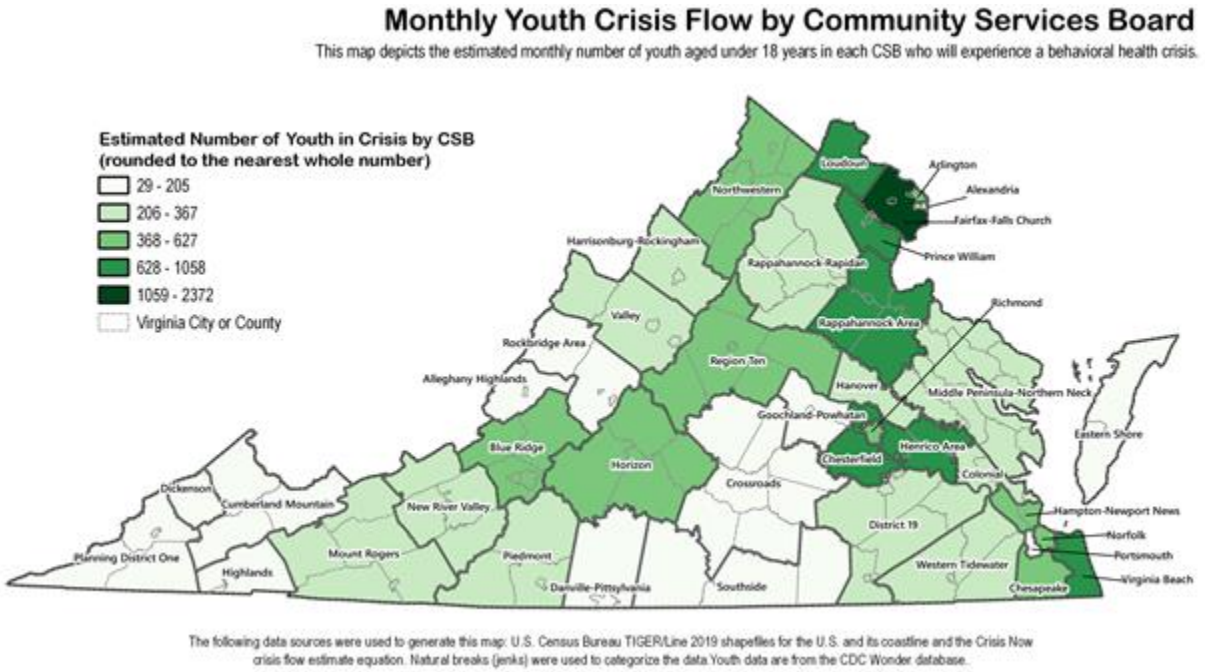
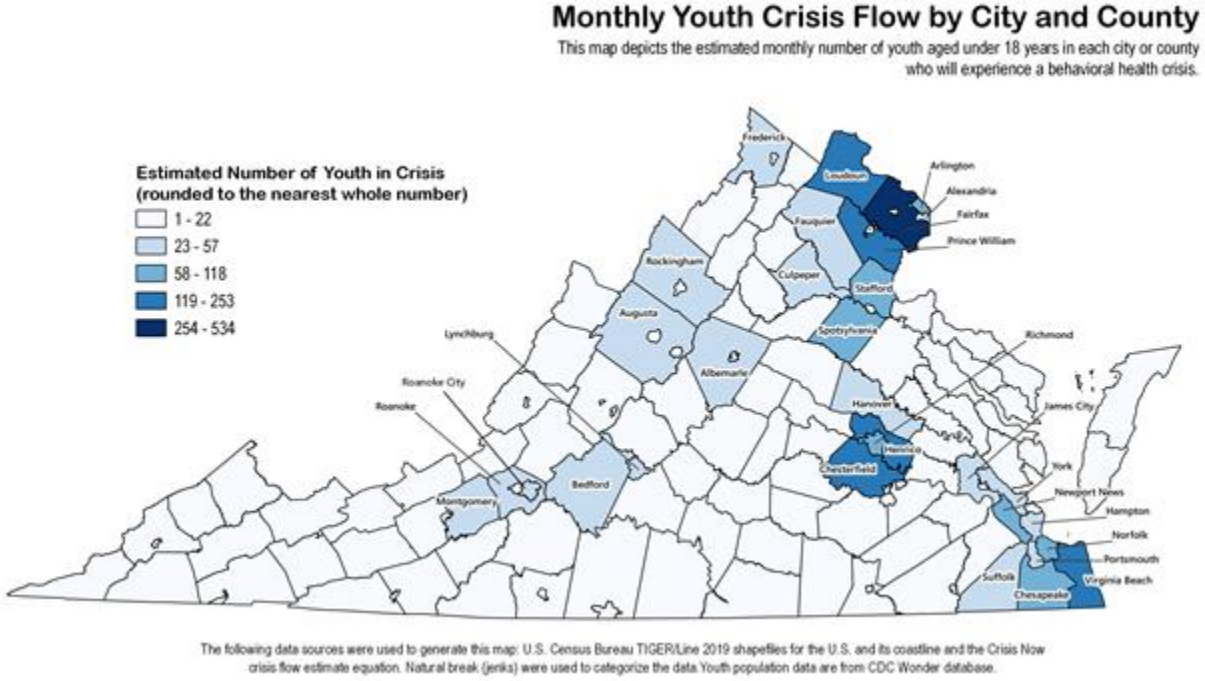


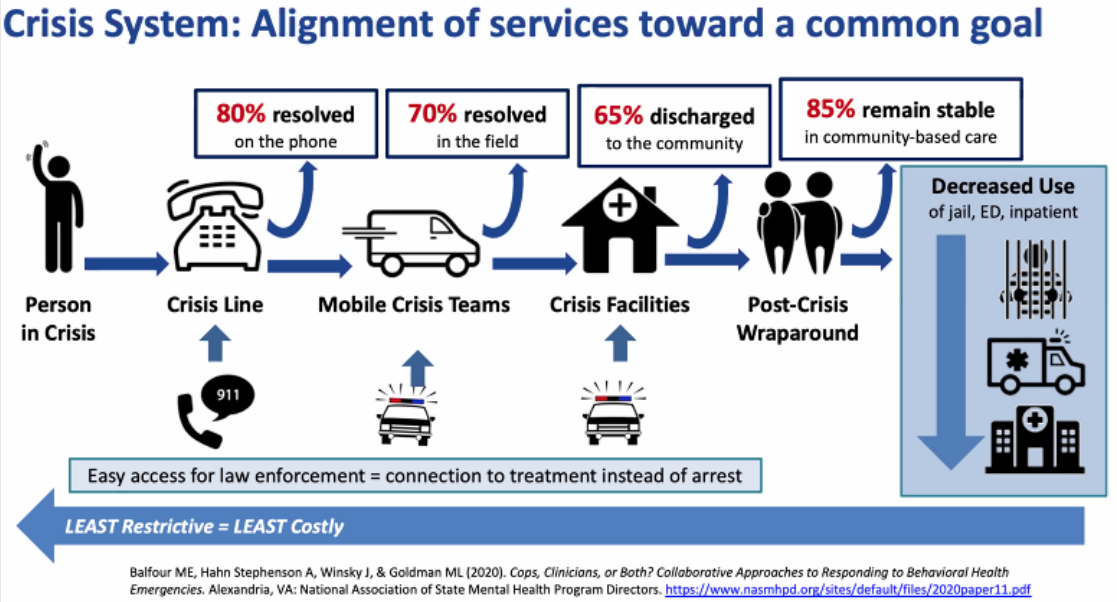
Figure 5. Map of Estimated Monthly Youth Crisis Flow by City and County



As is depicted in Figure 6, with a comprehensive crisis response system in place, a large proportion of crises could be resolved with appropriate intervention by a qualified clinician over the phone. The remaining crises could likely be resolved in the field, and a small proportion would need to be resolved in crisis receiving center with individuals being discharged to the community once back at their baseline.

Of the estimated number of individuals who will flow through the crisis system across the Commonwealth, over 13,000 crises may be resolved over the phone, 2,300 in the field, and 600 in crisis facilities. Ideally, of the estimated monthly crises, no more than 350 crises would result in individuals receiving institutional care in hospital EDs or inpatient psychiatric facilities or being taken to jail.

Figure 6. Crisis System Alignment toward Decreased Use of Institutions



Current State and Local Funding for Crisis and Emergency Services

An overview of state and local funding for crisis and emergency services is provided below in Table 3. The comprehensive crisis continuum defined in the Act is conceptualized as cross-disability. Yet, existing appropriations are disability-specific, which can limit blending of funding. DBHDS is currently working with its partners to implement this crisis continuum. It is modeled after CRISIS NOW. Table 3 reflects how the system is currently under construction with several key elements of funding coming online in FY22.

Table 3. Crisis and Emergency Services State and Local Funding

Component of the Crisis System	Funding Line Description	Amount	Status
Regional Call Centers			
	Call Center Staff (general fund; 790)	$4,697,020	Forthcoming (July 1, 2021)
	988 tax	$0.12 per line (total unknown)	Forthcoming
	Dispatch software (DOJ Trust Fund)	$5,000,000 (one time) $500,000 ongoing	Current

Mobile Crisis Teams			
	REACH Adult*	$13,303,980	Current
	REACH Child/Adult*	$10,117,757	Current
	Youth crisis and psychiatry (funds two regional programs)		
	STEP-VA Children	$5,800,000	Current
	STEP-VA SMI with cognitive impairment	$2,000,000	Current
	STEP-VA Adult	$6,154,924	Forthcoming (July 1, 2021)
Marcus Alert (local protocols and teams)			
	Marcus Alert initial areas (general fund)	$3,000,000	Forthcoming (July 1, 2021)
Place-based acute crisis care			
	Adult CSUs		Current
	Youth CSUs		Current
	CITACs		Current (planned changes are forthcoming)
Emergency Services			
	CSB reported general fund expenses	$28,400,000	Current as of 2019
	CSB reported local funding for ES	$13,200,000	Current as of 2019
Medicaid Funding			
	Medicaid reimbursement for ES	$7,900,000	Reported by CSBs for 2019
	New Project BRAVO rates (four crisis services)	(total unknown; 85% FMAP per ARPA may change estimates for general fund)	Forthcoming (December, 2021)

*This includes crisis stabilization/therapeutic group homes as well.

Estimates for CSB emergency services are based on 2019 CSB expenses. CSBs utilize unrestricted general funds for this Code-mandated function (there are not specific appropriations directed to emergency services). The majority of emergency services costs are for personnel. On average, each CSB reported 16.18 emergency evaluators, both part-time and full-time, or one evaluator for every 12,993 people in that CSB's catchment area. CSBs serving mostly rural populations have an average of 14.1 evaluators, or one evaluator for every 10,241 people served. CSBs serving mostly urban populations have an average of 19 total evaluators, or one evaluator for every 16,948 people served.

There is a positive correlation between the number of full-time evaluators and total expenditures for both urban and rural CSBs, but there is almost no correlation between the number of full-time evaluators and total funding – a finding consistent with insufficient funding for emergency services. Further study of this issue, with more reliable data, is necessary. CSBs cannot continue to function at substantial losses for a function that is required of them by law

Equity at Intercept 0 Initiative

Equity issues in both behavioral health crisis care and law enforcement must be addressed through the implementation process. Intercept 0 is part of the Sequential Intercept Model, which demonstrates how individuals with mental health disorders and substance use can be diverted from the criminal justice system at different intercept points (e.g., arrest, initial court hearings, re-entry). Intercept 0 is considered the "ultimate intercept," in that there is no "intercept" required at all. When individuals receive appropriate behavioral health services in their communities, law enforcement involvement is often unnecessary. Projecting out further, if individuals had access to preventive and early intervention behavioral health services, including crisis planning, and other arrangements to identify and intervene in crises proactively, even processes such as ECOs and TDOs would be expected to significantly decrease in frequency over the long-term. Unfortunately, there are verified health disparities in access to behavioral health care and the behavioral health system, including racial disparities. Although the Marcus Alert protocols are expected to make positive impacts on interactions between law enforcement and individuals in behavioral health crisis, there will be variability in these programs across the state, and many officers will likely be armed with lethal weapons such as firearms as well as less lethal tools.

Thus, the success of the implementation of the Act relies on significant effort to increase access to behavioral health crisis supports and ensure that those behavioral health crisis supports are culturally informed and providing crisis services that are responsive to the individual and family context. The Equity at Intercept 0 Initiative will seek to address significant concerns and lived experience of some marginalized communities.

The Initiative will help to ensure that small private providers, particularly those already underrepresented in the behavioral health care system, remain viable and increase in number. The Equity at Intercept 0 initiative focuses on:

- The development of partnerships between Black owned/led, BIPOC owned/led, and peer owned/led crisis service businesses and the public regional mobile crisis hubs;
- professional development and supports for crisis service training with a focus on anti-racism, disability justice, and language access; and

- analysis and reporting of race-based and other health disparities in crisis services in Virginia and ensuring that equity is a central consideration in planning, oversight, and evaluation of the success of the Marcus Alert system.

Another initiative that will be formed is a statewide Black-led Crisis Coalition. This coalition will have opportunities for broad membership and will have responsibility for reviewing outcomes twice yearly and providing input (including written response included in the General Assembly yearly report). This Coalition will take a view broader than just Intercept 0 services regarding Marcus Alert performance and development; more details about the Crisis Coalition's accountability responsibilities are in the accountability section.

Statewide Training Standards

Training standards will be defined and managed at the state level and integrated into existing training and oversight processes to ensure appropriate accountability. This includes simultaneously developing requirements, such as new behavioral health crisis trainings associated with STEP-VA and new oversight requirements for DCJS to review and approve training academy lesson plans (beginning 2022). Additional best practices and training recommendations are provided for local implementation consideration. State partners will also work to offer best practice trainings of a voluntary nature whenever possible as the implementation continues, leveraging resources from all involved sectors to ensure that the minimum standards are feasible across the state and that opportunities for additional training are not limited only to well-resourced localities.

Behavioral Health Required Competencies and Trainings

These requirements are in addition to any DBHDS licensing, DMAS regulatory, or Department of Health Professions (DHP) regulatory expectations that may apply to the services being provided. All required core competencies for behavioral health mobile crisis response will be integrated into the statewide training requirements on an annual basis. A statewide training structure that is being implemented, these training requirements are considered the most up-to-date source of information on core competencies for behavioral health participants in the crisis system. All crisis providers under agreement with the regional hubs will be held accountable for these competencies, and compliance with these requirements will be managed through DBHDS oversight of the regional crisis hubs (this is a contractual relationship). Training plans will be updated regularly and have monitoring mechanisms in place to ensure that all participants have initial training, booster trainings, annual refresher training, and updated training when requirements change on an annual basis. Compliance will be monitored. Supervisory staff will be

expected to have the same knowledge as line staff and to use that knowledge to impact and evaluate performance. There must be a mechanism for ongoing clinical review and supervision.

Law Enforcement Required Competencies and Trainings

Law enforcement required competencies and trainings were developed in consideration with broader criminal justice reforms also passed at the same time as the Marcus-David Peters Act. Specifically, new language in §9.1-102 states that DCJS shall:

> *59. Establish compulsory in-service training standards for law-enforcement officers in the following subjects: (i) relevant state and federal laws, (ii) awareness of cultural diversity and the potential for bias-based profiling as defined in §52-30.1, (iii) de-escalation techniques, (iv) working with individuals with disabilities, mental health needs, or substance use disorders, and (v) the lawful use of force, including the use of deadly force only when necessary to protect the law-enforcement officer or another person,*
> *60. Develop a uniform curriculum and lesson plans for the compulsory minimum entry-level, in-service, and advanced training standards to be employed by criminal justice training academies approved by the Department when conducting training, and*

Additional new language in §9.1-112.1 states:

> *A. Any criminal justice training academy approved by the Department shall employ the uniform curriculum and lesson plans developed by the Department pursuant to §9.1-102 for all training offered at the academy intended to meet the compulsory minimum entry-level, in-service, and advanced training standards established by the Board pursuant to §9.1-102. No credit shall be given toward the completion of the compulsory minimum training standards for any training that does not employ the uniform curriculum and lesson plans.*

Given these parameters, the following are identified as core competencies for law enforcement.

Table 4. Advanced Marcus Alert Training Topics

	DCJS Uniform Curriculum Requirements[7]	Advanced Marcus Alert Training[8]
De-escalation training and techniques	Yes	
Working with individuals with mental health and substance use disorder	Yes	
Working with individuals with developmental disabilities	Yes	
Cultural diversity, bias-based policing, implicit bias	Yes	

[7] This includes both basic and in-service requirements.
[8] These advanced training requirements are for all professionals involved in the crisis response system, including law enforcement, behavioral health, and call takers.

Use of force in context of behavioral health crises	Yes	
Relevant state and federal laws	Yes	Yes*
Cultural humility and historical trauma		Yes
Disability justice perspective		Yes
Anti-racism perspective, advanced mitigation of race-based discrimination		Yes
Intersections of race and behavioral health, intersectional training regarding risk assessment, guardian vs. warrior, race, implicit bias, explicit racism, criminalization of behavioral health disorders, and mitigating implicit bias in the context of behavioral health crisis response		Yes
Intersections of de-escalation, implicit bias, and wellness/burnout (across occupations)		Yes

**Relevant state and federal laws may exceed time constraints of basic requirements, in which case all relevant state and federal laws for the Marcus Alert which are not integrated into basic law enforcement training will be included in the advanced Marcus Alert training curriculum development.*

Because any trainings beyond what can be integrated into the basic and in-service trainings are ultimately discretionary at the local level, partnerships will be formed with regional training academies to ensure that these trainings are at a minimum available across the state.

Dispatch Training Standards

As state planning progressed, it quickly became clear that 911 dispatchers will play a great role in determining the immediate need for services in a behavioral health emergency. Therefore, minimum training standards in behavioral health, acuity levels, and interventions will be needed for all PSAP dispatchers in the Commonwealth. As part of the development of the 988 regional call centers, DBHDS will develop an RFP and select a vendor to develop a high-quality training curriculum meeting all National Suicide Prevention Lifeline standards as well as a module specific to the Marcus Alert procedures and basic Marcus Alert components and topics. Dispatch staff are also recommended to complete the Advanced Marcus Alert training.

Public Service Campaign

A collaborative public service campaign during state fiscal year 2022 is required per the Act. The planning group determined that the primary information which needs to be provided to the public is the 988 number as an access point to the behavioral health crisis continuum, Throughout the planning process, it was evident that a primary concern and reason for not reaching out for help is due to a fear of involuntary hospitalization, being handcuffed, and a lack of control over the outcome once help has been

called. However, the best way to ensure that behavioral health needs are met in a preventive manner is to call for help early in the crisis cycle. A parallel is made between public service campaigns for stroke awareness, which focus on identifying the first/earliest signs of the condition and reaching out quickly. This approach, combined with targeted outreach and community engagement, may deserve consideration for the details of the public service campaign for the launch of 988.

Section III: Local Marcus Alert System Requirements

Guidelines for Local Planning Group Formation and Initial Planning

The Community Roadmap outlines the details of the five steps of the local planning process. The five components are:

1) **Form a local team.** The Roadmap includes supports for identifying and engaging stakeholders, including those who have not historically been at the planning table, and setting a shared vision for the future.
2) **Conduct research and discovery.** The Roadmap requires a guided analysis of key aspects of the community relevant to the implementation of the Marcus Alert.
3) **Gather community input.** The Roadmap provides a framework for sharing information with community members about the parameters of the State Plan options and requirements and eliciting the input of community members.
4) **Assess fit of options with goals and capacity.**
5) **Add resources and action, submit plan**. A standard document for submitting the required components of the plan is provided.

Voluntary Database Requirement for Each 911 PSAP

The Act requires each locality establish a voluntary database (§ 9.1-193. Mental health awareness response and community understanding services (Marcus) alert system, law-enforcement protocols.) Localities can determine solutions based on consultation between 911, behavioral health, and law enforcement. Localities may consider software solutions which allow for individuals to provide information to 911 dispatch, build a database related to existing lists (e.g., hazard lists or information associated with addresses), or create a new database that meets the requirements state in the Act. Localities should consult with their legal counsel to ensure that decisions made regarding the voluntary database comply with HIPAA. The state planning group and a number of additional stakeholders described interest in a statewide database that includes linkages to phone numbers, addresses, and/or names. The Act, however, authorizes this as a local requirement that is housed at the local level.

Protocol #1: Transferring Calls from 911 to 988

Protocol #1 refers to the development of policies and procedures for 911 to divert calls to 988. This diversion is required at urgency Level 1 (Routine) and is recommended to be included as a key response option at Level 2 (Moderate). "Full diversion" refers to the transfer of a call without any required follow up with the response being fully in 988's oversight. Another consideration for the coordination of 911 and 988 was referred to by group members as the "Poison Control Model." This model is recommended at Level 2 and is potentially appropriate at Level 3, presuming coordination for in-person response is included as part of the model. From a 911 perspective, Poison Control-related protocols are similarly based on urgency, with phone coordination and alternative response (I.e., non-EMS dispatch) as the appropriate response for some situations based on Emergency Medical Dispatch (EMD) triage levels. A comprehensive description of Poison Control protocols across Virginia is much beyond the scope of this report, rather, the purpose of highlighting the model is for localities to make comparisons and consider parallels between these protocols and the goals of the Marcus Alert at various levels of urgency.

As emergency medical dispatch protocols (EMDs) become required across the state (see § 56-484.16:1), it is possible that more standard recommendations or considerations between the interface between mobile crisis responses and 911 call centers will emerge in commercial EMDs that are used in Virginia. To meet the minimum standards for Protocol #1, PSAPs must integrate the four-level urgency triage framework into their technical specifications and set policies and workflows to ensure that calls can be transferred from 911 to 988. The minimum standard is that Level 1 calls are diverted to 988. For Protocol #1, it is recommended that Level 2 calls are also coordinated between 911 and 988, and that a Poison Control Model be explored as a potential parallel for coordinating between entities.

Protocol #2: Law Enforcement Backup for Mobile Crisis

Protocol #2 requires an agreement between each regional mobile crisis hub and any law enforcement agency that provides back-up assistance. Over time, it is expected that 988 will experience increased use and call volume, which will ultimately include increased call volume at all levels of acuity.
In order to define roles and responsibilities between parties in this agreement, it may be important to consider that law enforcement plays multiple roles in responding to behavioral health crises. These three roles are:

- **"Treatment before tragedy" legal custody function** where law enforcement is the only party authorized to take individuals into custody involuntarily and transport them for a mental health evaluation (pre-screen).

- **"Treatment before tragedy" physical restraint function** where, in addition to being the authorized party per Virginia code, law enforcement is also the party with the skills and authority to physically restrain a person to stop an attempt to harm oneself or to transport them to treatment or assessment using restraint.
- **To serve in a protective capacity for bystanders, family members, or other third parties** including behavioral health clinicians if the individual in crisis is posing a risk to others or behaving in a manner that is so unpredictable that bystanders, family members, or third parties cannot reasonably predict whether their safety is at risk or not.

These functions are not mutually exclusive or clearly articulated. Yet, the state planning group determined distinctions must be made in guiding law enforcement policies and procedures for serving as back up for behavioral health responses. Behavioral health professions are guided by ethics similar to "do no harm" and other provisions to refrain from endangering public health, safety, and welfare and only providing interventions that have a therapeutic purpose. These principles are not inconsistent with, but also not identical to "protect and serve" responsibilities of law enforcement, as "do no harm" focuses more on one identified individual (i.e., the person experiencing the behavioral health crisis or to whom behavioral health services have been called).

Co-responder teams and other coordinated activities between behavioral health (QMHPs, clinicians, and peer support specialists) and law enforcement require a detailed understanding of professional responsibilities and ethics and should, ultimately, have a shared understanding of what interventions are used and why, and in what governmental interest, particularly when there are multiple governmental interests at play. Further, research on implicit bias demonstrates that racial bias exists in risk assessments, wherein ambiguous behaviors are interpreted as more risky when displayed by Black or Brown individuals as compared to white individuals, as well as more risky when displayed by men as compared to women (white women being perceived as lowest risk, Black men being perceived as highest risk). Decision-making processes for clinicians and decision-making processes for law enforcement are invariably changed when the other arrives on the scene, as the law enforcement officer now must provide for the safety of the clinician, the individual in crisis, and any other third parties. The clinician must now consider actions taken on their behalf by law enforcement (i.e., use of force against an individual in crisis to protect a clinician) when ensuring that they meet their ethical responsibility to do no harm and provide only therapeutic interventions. Finally, implicit bias is exacerbated under stress and time pressure, which is considered a normative part of responding to crisis situations. The same requirements will be a part of these agreements statewide, although there may be additional details or differences in these relationships.

Marcus Alert Protocol #2 will ensure that there are clear expectations between the mobile crisis regional hub and any law enforcement back up. The regional mobile crisis hubs will take the lead on structuring

these agreements with law enforcement partners. This may be one standard agreement which could be signed by any law enforcement agency able to provide back up as needed within that area. These agreements can be developed over the first twelve months of Marcus Alert implementation, from July 1, 2021 to July 1, 2022. Regional call center locations are below. These represent the fiscal agents and services may be subcontracted.

Region 1: Region 10 Community Services Board
Region 2: Fairfax-Falls Church Community Services Board
Region 3: New River Valley Community Services Board
Region 4: Richmond Behavioral Health Authority
Region 5: Western Tidewater Community Services Board

Agreements between the regional call centers and law enforcement agencies providing backup must also include the four technical components to request backup in the most efficient manner possible.

- Procedures for communicating between behavioral health and law enforcement to provide details of the scene and ensure that there is shared understanding of the situation and the request for back up before back up arrives (i.e., treatment before tragedy custody function, treatment before tragedy restraint/force function, or protection for other individuals involved from an individual in crisis posing a safety risk to others).
- Clear information regarding what training any back-up sent will have.
- Responsibilities for both parties under the MOU.

The Evaluation Task Force, which will be working with the PSAPs in the initial areas during the first half of FY2022, will be a key group in detailing the additional technical specifications needed to ensure call transfer and communication procedures. It is recommended, but not required, that agreements include provisions that staffing patterns will support sending back up officers voluntarily trained in CIT or advanced Marcus Alert protocols.

Protocol #3: Specialized Law Enforcement Response for Behavioral Health Crisis

Even as robust crisis care builds across Virginia, law enforcement will continue to interface with individuals in behavioral health crisis in the near future. These interactions cannot be reliably predicted, systematically avoided, or always accompanied by a mental health professional or peer support specialist. This state framework will ideally ensure that law enforcement and other first responders have the skills needed to respond to behavioral health crises in a general sense, with the primary role and goal of connecting individuals in behavioral health crisis to behavioral healthcare quickly and safely.

The Marcus Alert approach for Protocol #3 is built around an organizational approach provided (see graphic on the next page) in the 2020 National Association of State Mental Health Program Directors

(NASMHPD) report, "Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies."

Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2020paper1l.pdf **(Balfour, 2020)**

Marcus Alert Protocol #3 requires an approved plan addressing the four areas in the diagram above. There is not currently evidence of a single protocol or stand-alone program to provide this function for communities, instead, it is accepted that it is a systems problem and protections should be built into all levels of the system to continually decrease risk of tragedy. Protocol #3 is required by July 1, 2022 statewide. A specialized response must be available by that date, even if additional community coverage by teams is expected beyond that date (e.g., if an area has a full implementation date of 2024 or 2026). It is assumed that most agencies will integrate this protocol into existing policies, like "Response to Persons with Mental Illness" policies. Minimum standards for defining this specialized law enforcement response are provided below in the Minimum Standards and Best Practices for Law Enforcement Involvement in the Development of the Marcus Alert system.

Guidelines for Achieving Community Coverage

Per the Act,

> *C. 1. No later than December 1, 2021, the Department shall establish five Marcus alert programs and community care or mobile crisis teams, one located in each of the five Department regions. No later than July 1, 2023, the Department shall establish five additional Marcus alert system programs and community care or mobile crisis teams, one located in each of the five Department regions. Community services boards or behavioral health authorities that serve the largest populations in each region, excluding those community services boards or behavioral health authorities already selected under subdivision 1, shall be selected for programs under this subdivision.*

The Department shall establish additional Marcus alert systems and community care teams in geographical areas served by a community services board or behavioral health authority by July 1, 2024, July 1, 2025, and July 1, 2026. No later than July 1, 2026, all community services board and behavioral health authority geographical areas shall have established a Marcus alert system that uses a community care or mobile crisis team.

The initial Marcus Alert programs will be developed in the following areas:

Region 1: Orange, Madison, Culpeper, Fauquier and Rappahannock Counties (Rappahannock-Rapidan Community Services)
Region 2: Prince William County (Prince William County Community Services)
Region 3: City of Bristol and Washington County including the Towns of Abingdon, Damascus, and Glade Spring (Highlands CSB)
Region 4: City of Richmond (Richmond Behavioral Health Authority)
Region 5: City of Virginia Beach (Virginia Beach Human Services)

Then, all localities must establish all three protocols by July 1, 2022, but the provision of mobile crisis teams and community care teams can be phased in over the following five years (final date of July 1, 2026).

The areas serving the largest population in the region and therefore required to implement the full Marcus Alert (protocols by July 1, 2022 and community coverage by July 1, 2023) by July 1, 2023, will be from the following CSB catchment areas:

Region 1: Rappahannock Area Community Services Board
Region 2: Fairfax-Falls Church Community Services Board
Region 3: Blue Ridge Behavioral Healthcare
Region 4: Henrico Area Mental Health and Developmental Services
Region 5: Hampton-Newport News Community Services Board

Achieving full compliance with the Marcus Alert requirements may vary based on the community coverage approach taken. As described in the state components of the plan, reliable statewide coverage by STEP-VA/BRAVO mobile crisis teams is estimated to be in place by July 2023. Although STEP-VA coverage (one-hour response time, with up to 90 minutes allowed in rural areas) meets the overall requirement for some coverage by mobile crisis, as areas define their specialized responses, a range of mobile response teams are also expected to be developed at the local level. The local approach should be designed with community input, cross-sector collaboration, and local government leadership involvement (beyond law enforcement, behavioral health, and PSAP leadership), because community coverage can be achieved in a number of ways, specifically by connecting protocols and other resources to the network of STEP-VA/BRAVO mobile crisis teams or by developing additional local teams. Beginning with the group implementing in July 2023, areas that select to implement on a voluntary basis will receive support from DBHDS each year. If less than one area per region self-select to implement for July 2024 or 2025,

areas will be selected based on readiness factors. It is expected that, if sufficient funding is available, areas may choose to implement on an earlier timeline overall.

Response Options for Specialized Responses and Community Coverage

In addition to the Poison Control Model and mobile crisis team coverage through STEP-VA/BRAVO teams, there are three types of community care teams to consider.

Telehealth/Remote Behavioral Health Response

Telehealth approaches to response have some overlap with the Poison Control Model, but show evidence of success in collaborations between law enforcement and behavioral health in other parts of the country. For example, in Texas, the Harris County Sheriff's Office implemented a telepsychiatry pilot program with patrol deputies in December 2017. That program evolved into a pilot telehealth program called the Clinician and Officer Remote Evaluation (CORE) program. Telehealth was selected as an approach due to the ease of access, the safety of the approach, the cost of the approach, and concerns about workforce shortages in behavioral health. This program considered telehealth a "force multiplier," based on the idea that, through the purchase of iPads and setting up policies and procedures, they could leverage nine mental health clinicians to meet the mental health needs of individuals encountered by 100 patrol officers in a large geographical area. the Harris County Sherriff's Department recommend CIT training for all officers utilizing the system, noting that the techniques needed to work with individuals in a behavioral health crisis are "diametrically opposed" to traditional law enforcement tactics as described in the Memphis Model for CIT.

Harris County Described Steps for Implementing a Telehealth Connection Program:

1. Identify the need and interest: talk with law enforcement and behavioral health
2. Identify a qualified behavioral health agency willing to provide the service. You may want to start with mobile crisis teams already providing emergency evaluations.
3. Secure funding to purchase equipment.
4. Decide on the video conferencing software to use.
5. Decide on the wireless carrier to use. Assess area for "dead zones."
6. Start with a small pilot.
7. Select officers who are enthusiastic about the program.
8. Decide on data capture/tracking to assess the program's effectiveness.
9. Train personnel - law enforcement and behavioral health - on hardware and software. [9]

[9] *Source: Dr. Don Kamin, Director, Institute for Police, Mental Health & Community Collaboration, New York State*

Increased STEP-VA/BRAVO Teams

A locality may seek primary coverage by STEP-VA/BRAVO teams, but seek a more rapid response for more urgent situations. Local team development may be comprised of additional mobile crisis teams, employed locally or contracted with local private providers, with agreements to provide additional coverage for a more rapid response than the STEP-VA/BRAVO benchmark of one hour. Any mobile crisis teams developed locally would need to be under an agreement with the regional hubs to ensure coordinated dispatch.

Community Care Teams

Community care teams are defined by the Act as,

> *"Community care team" means a team of mental health service providers, and may include registered peer recovery specialists and law-enforcement officers as a team, with the mental health service providers leading such team, to help stabilize individuals in crisis situations. Law enforcement may provide back up support as needed to a community care team in accordance with the protocols and best practices developed pursuant to § 9.1-193. In addition to serving as a co-response unit, community care teams may, at the discretion of the employing locality, engage in community mental health awareness and services.*

Under the legislation, localities and cooperative regions have the flexibility to choose specific aspects of how they structure any community care teams within the definition above. The decision to invest in additional mobile crisis teams (beyond those available regionally through STEP-VA), community care teams, or both, is multifaceted and may be based on local resources, local need, community feedback, and other considerations. While community care teams are not required to contain law enforcement officers as members of the primary response team, communities may choose to do so because current Virginia codes require law enforcement for the service of emergency commitment documents. For the simple reason that law enforcement *may* end up involved in any emergency mental health crisis that reaches triage Levels 3 or 4, considerations for the appearance, response, and cooperation of law enforcement are detailed in the following response options.

What follows is a description of team members to be considered for community care team composition, definitions for the approach taken by types of teams which meet the definition for community care teams, and examples and references regarding these different approaches to community care teams. Workforce challenges are understood and may impact the ability to staff personnel at the level of recommended best practice, but this should not be viewed as a barrier to or recommendation against implementing a co-response program.

Community Care Team Composition: Team Members
Law enforcement officer. A law enforcement officer assigned to a community care team as a permanent duty assignment should have a minimum of one year working in the field as a certified officer and have completed CIT training. It is recommended that the law enforcement officer is self-selected (or even chosen through competitive process) and supervisor approved for the assignment. Law enforcement officers serving on a community care team should maintain updated knowledge and training of special topics to include but not limited to: advanced CIT training modules (youth, geriatrics, etc.), refresher training in ID/DD and acquired brain injury skills and techniques, and any refresher training as indicated by local, regional, or state Marcus Alert staff. A recommended best practice is for law enforcement officers to seek specialized training in recognition and de-escalation for all previously listed topics and seek to become a trainer (when applicable) and create opportunities for cross-discipline training in their locality.
Mental Health Professional. A mental health professional assigned to a community care team should have at least one year of clinical experience (independently licensed not required). Mental health professionals include Qualified Mental Health Professionals (QMHP), licensed mental health professional (LMHP) or those working towards credentials (eligible). Best practice recommendation would include experience with crisis response and/or assessment and an established working relationship with local law enforcement agencies. Prior to inclusion on a co-response team, mental health professionals must meet all requirements for appropriate licensure and/or certification, as required by state and local law, guidelines, and policy to conduct mental health crisis work through a Community Service Board in the Commonwealth of Virginia. Many master's degree programs in the fields of Social Work, Counseling, and Psychology contain content specific to defined need populations (e.g. children and youth, developmental disabilities, etc.). When those content areas have not previously been part of an education program for the team's mental health worker, the best practice would include additional focused training and/or education that supports crisis intervention for all populations of need that are likely to be encountered in the worker's response area.
Peer Recovery Specialist. Certified Peer Recovery Specialists must have a consistent period of recovery commensurate with the human resources policy of the employing stakeholder. Recommended best practice is at least one (1) year experience, post-certification, with crisis response in a career or volunteer capacity. It is recommended that Peer Recovery Specialists complete CIT core training, preferably with the local CIT program. Peers serving on a community care team should be Certified Peer Recovery Specialist through DBHDS. Recommended best practice will include previous experience employed or volunteering and/or partnering with mental health jail diversion programs and having direct experience and knowledge of the Virginia emergency commitment process. Peer Recovery Specialists will maintain all requirements necessary to maintain their Certification in the Commonwealth of Virginia.
Emergency Medical Service Provider. Emergency Medical Service providers shall have a current certification as an emergency medical technician through VDH and recommended best practice includes previous field experience responding to active mental health crisis calls and existing partnerships with police and mental health stakeholders in the local community. Emergency medical providers, if part of a community care team will be expected to maintain their certification through VDH and will have active agency representation on the local cross-agency group. Best practice recommendations include participation in advanced mental health awareness and response training, at least annually, and focused training on the identified needs for underserved populations within that team's service area.

Community Care Team Members with Other Specialties. The number of specialties in behavioral healthcare and crisis response make it impossible to provide minimum recommendations for every possible classification of response team members. A minimum recommendation for *any* member regardless of specialty however, would be for current credential or licensure (where applicable), consistent active participation within the cross-sector group, and seeking additional specialized training and experience related to mental health crisis response and any identified needs of the local population. In any case, the requirements and processes for additional specialties team members should be included in policies and memorandums of agreements between team partner agencies.

All Team Personnel. To meet the minimum standards identified in the Code of Virginia for SB5038 and HB5043 of the Virginia Special Session I, all full-time/permanent duty community care team personnel must complete Advanced Marcus Alert training (through the state-sanctioned cross-disciplinary version or with other advanced trainings that integrate the topics listed in the Statewide Training Standards into crisis response training). This education and training may be accomplished at the local level or alternatively may require collaboration amongst regional resources and/or require additional support from state agencies.

It is also recommended that members of community care teams include cross-discipline familiarization to include data sharing and security, scene safety, common language protocols (i.e., protocols that do not rely on jargon from within one discipline that may be less familiar to other team members), and cross-discipline policies and procedures for field activities and responsibilities.

Different Community Care Team Approaches

Co-responder team. Co-responder teams are comprised of a law enforcement officer and a mental health professional. Co-responder teams are recommended at the highest risk/acuity level (Level 4) and are also an option at Level 3. In addition to general team member descriptions above, for law enforcement officers working as part of a co-response team, every effort should be made to ensure that any officer participating in a ride-along or other co-response capacity (even when not assigned to permanent duty) meet the same recommended minimums. Additionally, any officer assigned as a permanent duty co-responder should have access to additional and advanced training for recognition and de-escalation of individuals who have intellectual and developmental disabilities or acquired brain injuries, more frequently and/or beyond the minimum often included in the core CIT training.

Co-Responder Team: Team Approach
Response: it is recommended that the law enforcement officer and mental health professional will arrive at the scene at the same time (ride along model) or very close to the same time (coordinated response). Because of resource considerations and geography, it is understood that some communities may experience more challenges with creating a ride along co-responder team. Recommended best practice is for law enforcement and mental health to arrive together in an unmarked vehicle. Law enforcement and mental health staffing for this position are full time duty assignments. It is understood that resources may not allow this practice in some communities therefore it is suggested as a best practice guidelines for communities where this model is a good fit for the area (i.e., it is not

suggested that this model be used if a full time co-responder team could not be supported due to the population size).
Presentation: There is general universal agreement that characteristics of police uniforms are important in how police officers are perceived as well as how police officers behave. Yet, there are varying viewpoints regarding what the costs/benefits of different "messaging" of different uniform types. A crisp, professional uniform (including factors such as being unwrinkled and belt appearing secure) has been shown to communicate authority, power, and competency and may be a protective factor against assaults on police officers in contexts separate from behavioral health crisis. A "soft" uniform that is less formal than a typical duty uniform is expected (but not proven) to send messages regarding friendliness and approachability. Interestingly, research on soft uniforms specifically, for example, in the youth correctional setting, demonstrates that the primary impact of the uniform is on the behavior of the officer. In general, it is thought that a soft uniform may provide easier initial communications in some circumstances while still allowing officers access to all necessary safety equipment—as a specific illustration, many soft uniforms have the appearance more so of a paramedic uniform (polo shirt with insignia/professional logo), cargo pants, communication device visible on chest, baseball-style cap). Because of the resources in some communities and the nature of the team assignment (permanent duty vs. available responder), it is not feasible to make a soft uniform a minimum requirement or standard, however it should be considered when feasible. It is recommended that mental health professionals on co-responder teams be easily identifiable as mental health professionals both for the professional purpose of identification to persons in crisis as well as any potential law enforcement officers that could respond to crisis scenes of high acuity (e.g., by wearing an easily identifiable lanyard/identification card). Recommended best practice is that law enforcement officers assigned to the co-responder team as a full-time duty assignment wear a modified uniform that takes into account the authority displayed by a traditional uniform and how that may affect the ability to create rapport and support de-escalation for the person in crisis. There are many variations of this including inner vs. outer vest carriers, "class A" shirts and pants vs. polo (or other) shirts and more casual slacks or pants. Nothing in this section however, should be construed to indicate that the best practice suggests removing any necessary safety equipment from any law enforcement officer. Decisions to alter equipment or uniforms will be a local responsibility and all team members must abide by the policies and direction of their agencies.
Intervention: Co-responder teams are unique in that they work as a collaborative unit. In general, the law enforcement officer ensures scene safety and the mental health professional leads the communication and intervention with the person in crisis. This should not be construed to mean that the law enforcement officer cannot/should not use their own mental health training and rapport building skills. The circumstances of the call for service, the tenure of the co-responders' working relationship, level of experience, and other variables may influence the amount of time it take to make a "safe scene" determination that is acceptable to both responders. Programs should demonstrate policies and/or protocols that make the clinical lead a priority for co-responder teams.

Community Care Team without law enforcement. Community Care Teams outside of the "co-responder team model" are an option for communities to choose as their crisis response model and may be comprised of any combination of professionals listed above capable of providing support during behavioral health crises. Community Care Teams may also fill a more expansive role at the discretion of the locality, and work with a population across a wider spectrum of acuity, including providing community based, preventive services and outreach. Due to this, a community care team may be staffed and equipped in any number of combinations that support responses for varying acuity levels of

individuals. First, the response/approach of community care teams without law enforcement as members of the team is described.

Community Care Team (without Law Enforcement) Approach
Response: Team members arrive at the scene at or about the same time. The arrival of team members may be affected by the composition of the team, current availability of team members, and local choice of response team transportation vehicle. Local variations and choices will determine the ability to arrive on scene together. The recommended best practice is for all team members to arrive together in a single vehicle, and if possible, a van or other vehicle that can allow for supplies, transport, etc. Best practice recommendation is that staffing for any positions on the team is done in a full-time capacity, thus ensuring that all parts of a team are available together for service calls.
Presentation: The composition of the team plays a significant role on how the team "presents" itself. Because this configuration does not involve law enforcement, street clothes or a very basic uniform are common. Some programs present in a way that allows for comfort, mobility, and a level of relatability or casual dress, such as screen printed hoodies. EMT members may wear existing uniforms. It is recommended that members of community care teams be easily identifiable as team members both for the professional purpose of identification to persons in crisis as well as if law enforcement is called to the scene as back-up (all area law enforcement who may be called on to serve in a back-up capacity should be made aware of the presentation of the community care team).
Intervention: Depending on local team composition and transportation choices it is impossible to determine who may arrive on scene first. Community care interventions focus on providing immediate support and linking individuals to the appropriate supports and services. Some countries refer to teams similar to this as "street triage" teams. This could involve attending to minor injuries if an EMT is part of the team, supporting a transport to a crisis receiving or assessment center, supporting the individual with peer support, or providing general support (including meeting basic needs such as food, water) and awaiting a mobile crisis response or clinical assessment.

The Preventive Community Care Team, with Law Enforcement, Approach A key feature of this model is that preventive community care teams have responsibilities outside of an immediate response to calls for service, and carry a "caseload" of individuals, providing diversion, connection to services, ongoing visits, and support during times of high stress (e.g., following a call for crisis). A positive, empowering team culture and collaborative relationships with other groups is likely a key factor in the development, success, and sustainability of a community care team. Although cross-sector quarterly meetings are required regardless of the Marcus Alert approach taken, preventive community care teams with law enforcement often meet on a weekly basis, and these meetings are inclusive of cross-agency partners. Key partnerships for preventive community care include adult protective services, fire and rescue/EMT, and the local school system.

Preventive Community Care Team (with Law Enforcement) Approach
Response: Preventive community care teams have responsibilities outside of an immediate response to calls for service, and carry a "caseload" of individuals, providing diversion, connection to services, ongoing visits, and support during times of high stress (e.g., following a call for crisis). Regarding the

immediate response, community care teams provide on-scene responses similar to those described above (community care team, no law enforcement, and co-responder team), with a focus on diversion and connecting individuals to needed services. Best practice recommendation is that staffing for any positions on the team is done in a full-time capacity, thus ensuring that all parts of a team are available together for service calls. Because of the ongoing nature of the response, it is likely that the team will take a flexible approach to who attends service calls and whether team members go on any calls alone (e.g., to individuals who are well known to the team).
Presentation: If a locality is committing to a permanent duty assignment as part of a preventive community care team, a soft uniform should be considered (see further discussion and details under co-responder team description). Non-law enforcement team members commonly wear street clothes or business casual dress (with identifying features, such as a lanyard and ID badge). Therefore, it is recommended that mental health professionals on community care teams to be easily identifiable as team members both for the professional purpose of identification to persons in crisis as well as any potential additional law enforcement resources that could respond to crises of high acuity.
Intervention: Depending on local team composition and the call for service, interventions may vary. For higher acuity situations, law enforcement likely secures the scene prior to other interventions. Community care interventions focus on linking individuals to the appropriate supports and services. EMT or fire/rescue members may attend to minor injuries, social workers may work with the individual in crisis or family members to determine next steps (e.g., transport to a crisis receiving or assessment center).

Additional Considerations for Community Care Teams

Many crisis response philosophies aim to decrease or remove law enforcement from crisis response. The current emergency custody statutes in Virginia (Code §37.2-808/9) specify that only law enforcement officers may take involuntary custody in emergency situations for mental health crises and complete the associated custody documents (ECO/TDO). While this can be accomplished by requesting police as a backup to crisis calls that are initially handled by a behavioral health-only response, the existing procedures in the Commonwealth may initially rely on law enforcement agencies to participate actively in all responses. It is not recommend that law enforcement automatically be included in a community care team, only that if they are included, that certain training and experience benchmarks be met to ensure the highest potential for successful outcomes. The intent of these team descriptions are to provide a set of considerations that help communities create localized response programs that meet certain consistent benchmarks while also best serving the needs of their local community. It is important to realize that neither every potential situation nor possible combination of personnel can or even should be outlined in this initial set of guidelines. A recurring theme shared by members of the larger workgroup for this project is the disparity between communities in Virginia and how those differences highlight very different challenges which can also be exacerbated by a wide spectrum of resource availability.

Currently, a paradigm shift regarding whether, and to what extent, law enforcement support is needed to ensure safety during most behavioral health crises, is in progress. It is well known that the current

Virginia landscape includes an over-representation of “deep end” or emergent calls due to lack of access to crisis care in the community. In other words, the crises that are observed by current emergency services and law enforcement first responders are often emergent and mental health clinicians perceive a need for a safety related support much of the time.

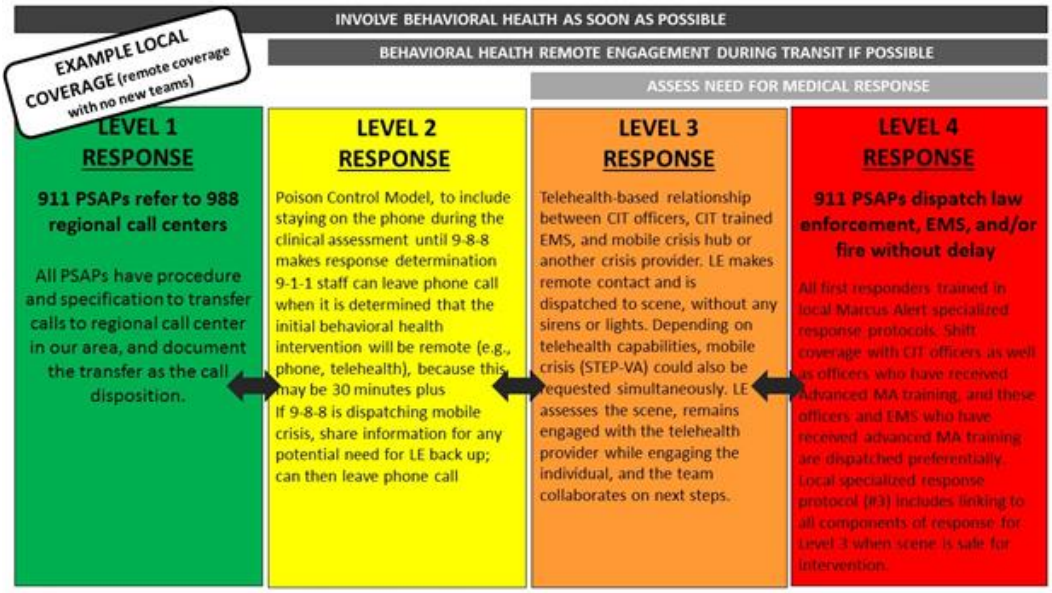
For people on the front lines, hearing about research statistics does not increase feelings of safety and security. Although specific actionable options were not identified at a state level during the planning period, there are safety-related supports from alternative paradigms that deserve further attention. Safety-related supports are an important part of the mobile crisis response system, but they are not synonymous with law enforcement. A safe and secure environment is achieved when all individuals involved feel protected from harm and do not feel that they are being threatened, intimidated, or discriminated against. Thus, as paradigms related to safety related supports expand, the role of level of care screening, operationalization as civilian supports, therapeutic alternatives, or, a law-enforcement based safety-related support such as ability to use non-lethal force (i.e., a plain clothed officer with a Taser) will continue to be explored. Over the course of implementation, calls for crisis response will begin to occur earlier in the crisis cycle and the overall ratio of emergent crisis calls will stabilize and become more predictable.

Examples of Local Plans for Community Coverage

Community coverage by a mobile crisis response can be achieved a number of ways, and all approaches do not require the development of local-specific teams, due to the regional coverage by STEP-VA mobile crisis teams. Below are some examples of how communities may achieve community coverage across the levels of risk. These approaches may be appropriate as follow-up to Level 4 responses, wherein a law enforcement or EMS response is required to precede a behavioral health intervention. These examples for coverage presented on the following pages are provided as a guiding heuristic and to demonstrate the types of approaches considered acceptable at the different urgency levels, as well as to demonstrate the coverage provided by STEP-VA/BRAVO teams. The local protocols themselves will be much more detailed regarding operationalization of the approach.

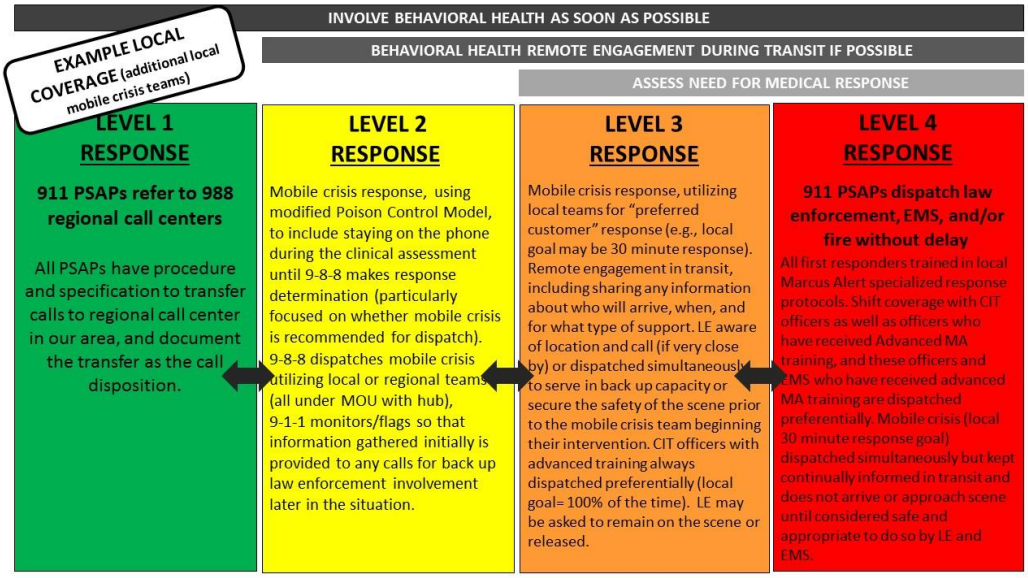
First, an example of how community coverage can be achieved with STEP-VA/BRAVO teams and supplemental procedures:

Figure 7. Community Coverage via STEP-VA/BRAVO MCTs Only



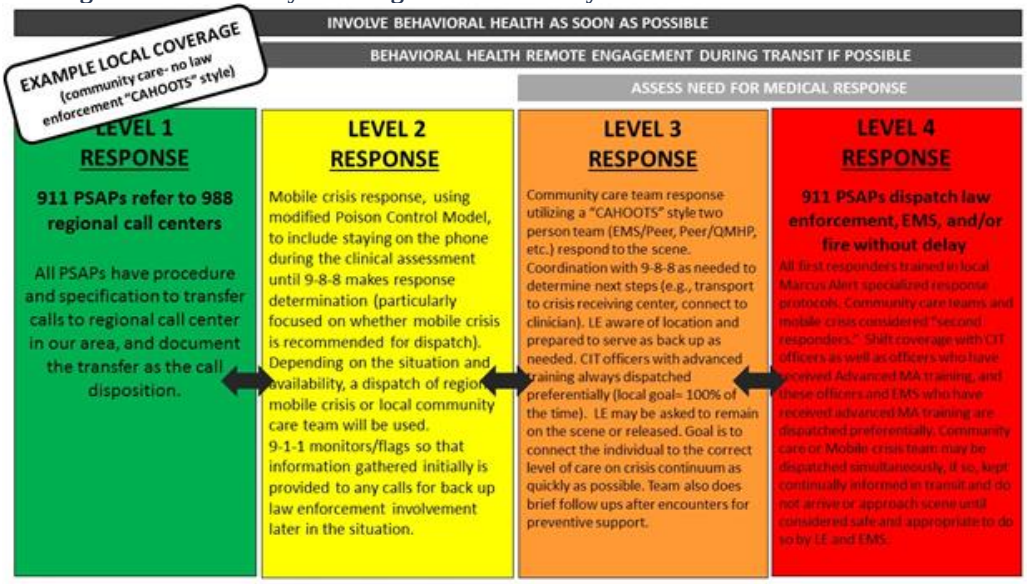
Second, an example of how coverage could be achieved by increasing the number of mobile crisis teams in your area (dispatched by the regional hub with a response time quicker than 1 hour):

Figure 8. Community Coverage via Additional, Local MCTs



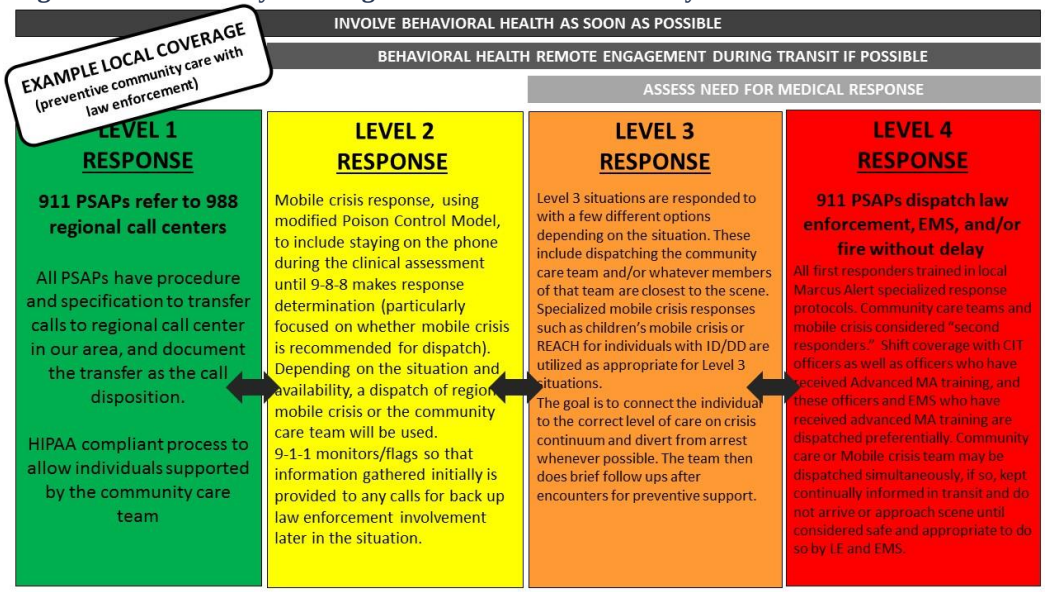
Third, an example of achieving coverage using a community care team without law enforcement, often considered a "CAHOOTS" style team (which can consist of any combination of community care team member types):

Figure 9. Community Coverage via Community Care Team without LE Members



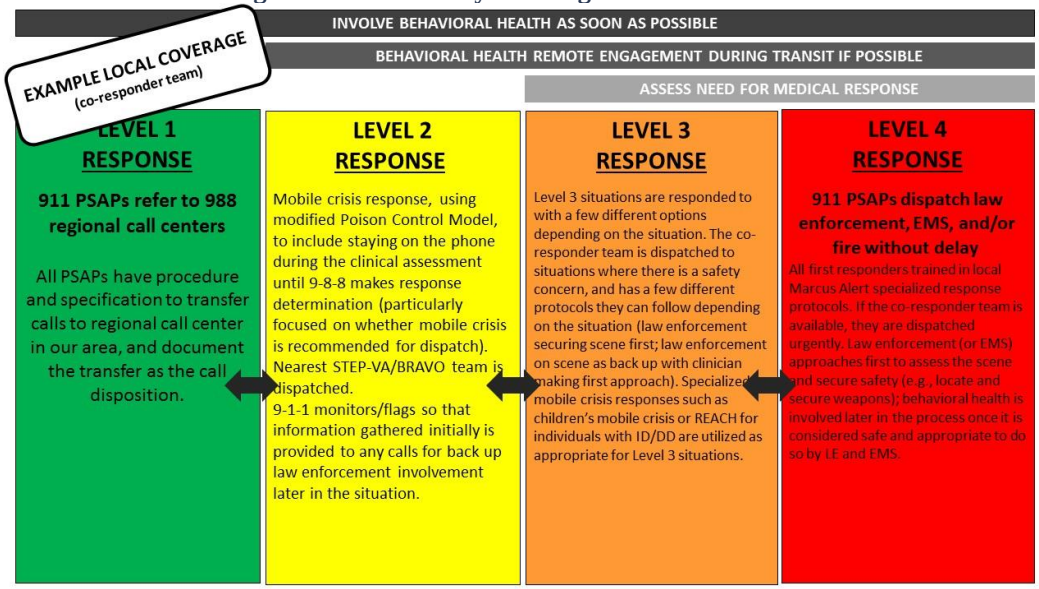
Fourth, an example of community coverage with a preventive community care team with law enforcement:

Figure 10. Community Coverage via Preventive Community Care Team with LE Members



Fifth, an example of community coverage including a co-responder team:

Figure 11. Community Coverage via a CRT with LE



These arrangements are not the only configurations to accomplish the requirements of the Act. There are likely other arrangements that meet the minimum standards and best practices that are not reflected here.

Minimum Standards for Local Marcus Alert Systems (across Protocols 1, 2, and 3):

- *Voluntary database is available for residents to provide information, updated regularly, confidentiality and privacy is considered with local legal staff.*
- *The four-level framework is adopted for standard communication and response planning across professions.*
    - *Level 1 calls must be diverted to 988.*
    - *Level 2 calls are coordinated with 988; local plans must include provisions for including behavioral health as a first responder (see Response Options section).*
    - *Level 3 calls include multiple response options across agencies/entities, including a behavioral health-only response option.*
    - *Plan must include provisions for how Level 3 calls will be handled for adults, youth, and individuals with developmental disabilities.*
    - *Level 4 calls include law enforcement or EMS, an "emergent response" that is not delayed.*
    - *The four-level framework is integrated into the CAD by the PSAP by July 2022.*

- *All agencies within the area comply with state training standards.*

- *Memorandums of agreement (consistent with the state requirements) are developed between the call center hub and any responding law enforcement agency (Protocol #2).*
- *Submission of a plan for specialized law enforcement response addressing these four areas: leadership/organizational, basic training, intermediate training, and specialized and advanced training.*
    - *Specialized response across all four levels is behavioral health-informed.*
- *Policy regarding Marcus Alert response being utilized whenever a situation is identified as a Marcus Alert 1, 2, 3, or 4 situation (even if not initially identified).*
- *Appropriate coverage and preferential deployment of CIT-trained officers and officers with advanced Marcus Alert training is outlined.*
- *Attendance at cross-sector quarterly local meetings occurs regularly.*
- *Submission of quarterly data (additional details under development) adheres to requirements.*

Best Practice Considerations for Local Marcus Alert Systems

In addition to meeting the minimum standards,

- *Include community stakeholders in the planning process for community coverage, with a focus on stakeholders who have been impacted by the current system (such as those in a jail re-entry program, families who have lost loved ones to a mental health crisis or a police encounter, and individuals who have lived experience and are from a racial or ethnic minority background).*
- *Take a systems view and, when resources are constrained, build behavioral health-focused supports as a priority over other investments.*
- *Build on and integrate with other existing and emerging services and supports, such as the STEP-VA mobile crisis teams, current CIT programs and initiatives, Assertive Community Treatment or homeless outreach providers in the area.*
- *Ensure there are behavioral health-only approaches available at Level 3 for youth and individuals with developmental disabilities, particularly if there is a law enforcement lead for your locality's adult Level 3 primary response option.*
- *Consider partnerships across jurisdictional boundaries, particularly when it increases efficiency (e.g., for any telehealth-based coverage).*
- *Consider a "layered" approach, with investments aligning with community values vs. the selection of one specific team type only.*
- *Level 2 calls follow a poison-control model with 988, unless community care teams have a special function at Level 2 (e.g., "frequent utilizers" case management function).*

- *Level 3 calls involving youth are coordinated with 988 and specialized children's mobile crisis teams.*
- *Level 3 calls involving individuals with ID/DD are coordinated with 988 and specialized developmental disability mobile crisis teams/REACH program.*
- *Back-up officers sent under agreements with regional hubs will be voluntarily CIT trained and have received the advanced Marcus Alert training.*
- *At the systems level, considerations include intersections of behavioral health crisis and community policing policies and initiatives, guardian vs. warrior trainings, use of force continuum and how behavioral health crises and de-escalation are built into the use of force policy, implicit bias trainings and policies, and officer wellness supports and culture.*
- *All law enforcement officers received eight-hour mental health first aid.*
- *Provide ongoing de-escalation training for all officers, including basic and intermediate.*
- *Interactive, scenario-based de-escalation training specific to mental health scenarios, with a focus on time as a tactic, at least yearly.*
- *Provide advanced workshop based trainings on cultural humility and cultural competence.*
- *Agencies have coverage each shift by an appropriate amount of officers who have completed 40 hour CIT training in context of voluntary participation, aptitude/interest in working with individuals in behavioral health crisis, and supervisor approval. These supports can be provided in an "on call" format based on agency staff and size, but should be available for response. CIT recommends that 20% of officers are trained to achieve adequate coverage, percentage of appropriate coverage will vary based on side of agency.*
- *Agencies have coverage each shift by an appropriate amount of officers who have completed the advanced/intersectional Marcus Alert training.*
- *LE integrates special requirements regarding mental health, developmental disabilities, and substance use across key agency policies such as use of force and bias-based policing.*
- *Have a high level of engagement in cross-sector quarterly meetings and data-driven quality improvement processes at the local level.*

Local Plan Submission, Review, and Approval

There are two supplemental documents important for local plan development and submission. This includes the Community Roadmap and the Marcus Alert Local Plan. The Community Roadmap provides a pathway, with both required and optional exercises, for local plan development. The Marcus Alert Local Plan is the packet of documents submitted for approval. A web portal for submission is under development and will be on the DBHDS website: https://dbhds.virginia.gov/marcusalert. If for any reason

the web portal is inaccessible, communication, questions, or a PDF of the application can be submitted to marcusalert@dbhds.virginia.gov (note: plans submitted in this format will receive follow up technical support to submit in the preferred format). An overview of the submission requirements from the Marcus Alert Local Plan document are provided here.

Figure 12. Checklist for a Completed Marcus Alert Local Plan Submission
Below are the components required to achieve compliance with the Act by July 1, 2022.

1	Documentation of Sections 1-4 of the roadmap (when "decide and document" is noted, it should be included in your summary)*	July 1, 2022 statewide	Text submission
2	List of stakeholder group members*	July 1, 2022 statewide	Excel file upload
3	Triage crosswalk connecting 4 urgency levels to PSAP specifications*	July 1, 2022 statewide	Text submission (4 separate text boxes for 4 levels) and PDF upload
4	Copy of Protocol #1*	July 1, 2022 statewide	PDF upload
5	Copy of Protocol #2*	July 1, 2022 statewide	PDF upload
6	Copy of Protocol #3*	July 1, 2022 statewide	PDF upload
7	Triage crosswalk connecting 4 urgency levels to responses/protocols 1,2, 3*	July 1, 2022 statewide	Text submission (4 separate text boxes for 4 levels) and PDF upload
8	Checklist of minimum standards and best practice considerations for law enforcement involvement	July 1, 2022 statewide	PDF checklist
9	Statement on accountability for quarterly cross sector meetings and quarterly data reporting*	July 1, 2022 statewide	Text submission
10	Contact information for application overall and core reporting, PSAP reporting contact, and law enforcement reporting contact*	July 1, 2022 statewide	Individual text boxes for contact information
11	Statement of barriers, needs, or concerns for implementation*	Optional	Text submission

**These components must be submitted by initial areas by October 15, 2021 for December 1, 2021 implementation*

Figure 13. Checklist for a Completed Marcus Alert Local Plan Submission
Below are components required by areas' phased-in coverage date as well as additional compliance components.

1	Updates/changes to any other materials listed above	Yearly or when changes occur	Varies by component
2	Revised triage crosswalk connecting 4 urgency levels to responses/protocols 1,2,3 and community coverage	Phased implementation date	Text submission (4 separate text boxes for 4 levels)
3	Description of community coverage and team types*	Phased implementation date	Text submission
4	Logic Model	Phased implementation date	PDF upload
5	Data collection plan (crosswalked with future guidance)	Phased implementation date	Text submission
6	Local QI process description	Phased implementation date	Text submission
7	Budget (if any)*	Phased implementation date	Line item budget entry

Note: the specifics of the components that are part of the phased implementation submission are subject to change following initial implementation in first 5 areas
**These components must be submitted by initial areas by October 15, 2021 for December 1, 2021 implementation.*

Submission review is expected to take four to six weeks. Reporting requirements will go into effect October 1, 2022 (quarter 1 of implementation). Data submission testing with initial areas will occur on an ongoing basis during development. It is estimated that statewide data submission testing period will take six months (running through approximately March, 2023). When testing period ends, data are interpreted as valid representation of activities occurring under the Marcus Alert. Reporting is required quarterly.

Section IV: Evaluation and Accountability Plan

Marcus Alert Evaluation Task Force

The importance of evaluation and accountability for performance of the Marcus Alert system at both the local and state level was supported across the stakeholder group. Given the complexities of the different data and reporting structures at the local and state level across behavioral health, PSAP, and law enforcement, as well as overlapping projects like the crisis call center data platform development, ongoing work with technical experts from each sector will be required to launch the state-level evaluation of the Marcus Alert. This will be managed by a Marcus Alert Evaluation Task Force, comprised of DBHDS and DCJS technical and program leads, the crisis call center platform vendor, technical and program leads from initial area PSAPs, initial area program leads, and one subject matter expert from the initial workgroup in each of these areas: law enforcement, CIT, equity, and regional mobile crisis hub/988.

Key Indicators and Outcomes

A general survey was sent to stakeholder group members regarding perceptions and priorities for the evaluation of the success of the Marcus Alert system and implementation. Sixteen stakeholder group members completed the survey, so it cannot be assumed that these results reflect the view of all group members. All responses will be provided to the Evaluation Task Force for their ongoing planning. First, respondents were asked to rate the importance of evaluating (using a "five star" rating scale) six general domains of outcomes related to the Marcus Alert. The table is organized by domain, with domains listed in order of highest average rating of importance to lowest average rating of importance.

Domain	Average Rating (out of 5)
Data points related to locality's compliance with training requirements and other requirements (such as having approved protocols)	4.21
Data points related to law enforcement diversion and the development of new teams such as community care teams and other diversion teams	4.21
Data points related to racial disparities in access and outcomes	4.00
Data points related to 988 and the behavioral health crisis system (intercept 0)	3.86
Data points related to voluntary/involuntary status, restraint, use of force, and safety	3.79
Data points related to community engagement (including involvement in planning and awareness of resources and services)	3.71

These ratings were consistent with general discussions regarding the importance of compliance and accountability, measuring development of the system over time, and the importance of considering racial

disparities. Group members were also asked to consider potential key measures and outcomes within each of the six domains. The most frequently endorsed measures are listed here. The Evaluation Task Force will need to determine the feasibility and operationalization of these measures.

Compliance with Local Requirements

- *Number or percentage of areas with complete, submitted plans by July 1, 2022*
- *Number of percentage of areas with approved Protocol #1, 2, and 3 by July 1, 2022*
- *Percentage of crisis behavioral health providers who receive required training*
- *Percentage of PSAP staff who receive required training*
- *Percentage of LE officers who receive required training*
- *Number or percentage of staff across professions who take the advanced MA training*

Behavioral Health System Development and Diversion

- *Number of mobile crisis teams formed and responses*
- *Number of community care teams (no law enforcement) formed and number of responses*
- *Total number of calls going to 988 from the community (this indicates that community members are calling 988 more and more when having a behavioral health emergency)*
- *Total number or percentage of calls going from 911 to 988 (this shows that 911 centers are following protocol of diverting some calls to the 988 center)*
- *Response time for STEP-VA/BRAVO mobile crisis (this shows that the behavioral health only response is arriving within an hour, or could show that the response is getting quicker over time)*
- *Percentage of the time that STEP-VA/BRAVO teams are calling for law enforcement back up (decreases to this over time would indicate increased behavioral health only response and less reliance on law enforcement)*
- *Changes in proportions of level of crisis calls over time (in other words, are people calling earlier in the crisis cycle before it is a level 3 or 4 situation, both for 988 and 911)*
- *State investment in alternatives to law enforcement for crisis care*

Law Enforcement System Changes

- *Law enforcement drop off time decreasing*
- *Number of community care teams with law enforcement formed and number of responses*
- *Number of co-responder programs formed and number of responses*
- *State investment for law enforcement training and development*

Individual and Family Crisis Experiences

- *Decrease in total number of ECOs in areas where MA has been implemented*
- *Decrease in total number of TDOs in areas where MA has been implemented*
- *Rate at which people served by the different team types experience a use of force*
- *Number and/or change over time in injuries*
- *Satisfaction of consumers*
- *Satisfaction of families*

Racial Disparities

- *Racial disparities in calling for LE back up for behavioral health crisis response*
- *Racial disparities in connection to care across team types*
- *Racial disparities in use of control, force, or arrest by LE when LE responds alone*

- *Racial disparities in sending 911 calls to 988*
- *Disparities in use of control or force by LE when LE responds alone by different disability types*

Community Awareness

- *Utilization of the voluntary database by locality*
- *Changes in proportions of level of crisis calls over time (in other words, are people calling earlier in the crisis cycle before it is a level 3 or 4 situation, both for 988 and 911)*
- *Community awareness of 988*
- *Satisfaction of sectors involved (providers, law enforcement, schools, hospitals)*

Respondents were also asked to consider different approaches to evaluation during initial implementation of the Marcus Alert. Most responses indicated that taking approximately 12 months to develop a baseline and track data would be a first step in setting up more formal benchmarks or targets. It was recommended that a developmental approach be taken (success measured in change and growth) and that areas of concern (i.e., geographic areas) be identified early so that support can be provided while systems are still under development.

One specific concern regarding data collection was use of restraints such as handcuffs and use of force. Community input indicated that being handcuffed was a key issue in perceived loss of dignity and trauma associated with crisis response. Handcuffs, however, are often required per law enforcement policy for transport, and, as described throughout the report, the governmental role of law enforcement is at times specifically to restrain and transport a person in a "treatment before tragedy" function. The concern with use of force data collection was that any use of force reported would be considered an excessive or inappropriate use of force, and this would reflect poorly on law enforcement even if the use of force was to achieve an appropriate governmental function. A number of options were presented to group members, including collecting the data without any other actions, not collecting this data at all, and collecting the data but attempting to mitigate this risk of misinterpretation. The most commonly endorsed risk mitigation (endorsed by all but one survey respondent) was to measure these outcomes but be very careful to always explain very clearly the role of these actions in law enforcement completing their duties. Other strategies endorsed to a lesser extent (but endorsed) were to consider this primarily as a state level outcome, not an individual area performance metric. Because of these concerns, the details of how these data points would be collected was considered by the group. The use of force categories recommended for reporting are:

- *Empty hand controls (strikes, kicks, takedowns)*
- *OC ("pepper spray") deployed*
- *Baton used*
- *CED/Taser discharged*

- *Service weapon/firearm pointed*
- *Service weapon/firearm discharged*

The additional actions and controls recommended for reporting are:

- *Hand restraints applied and double locked*
- *Leg restraints applied and double locked*
- *Soft hand and/or leg restraints applied and double locked*
- *Released on summons*
- *Arrested*

Regarding end point of the interactions, the following outcomes are recommended:

- *Cleared on scene*
- *Evaluated on scene*
- *Referral to outpatient resources*
- *Voluntary transport to CITAC for evaluation*
- *Involuntary transport to CITAC for evaluation*
- *Transported to 23-hour observation center or CRC*
- *Transported to CSU*
- *Transported for voluntary inpatient psychiatric hospitalization*
- *Transported for involuntary inpatient psychiatric hospitalization*

Local Reporting Requirements

To construct measures as described above, there are three data sources necessary. Each component will be required quarterly, and any requirements that can be built directly into the crisis call center platform will be integrated in that way. The three components are:

1) **Call center data.** 911 PSAPs will be required to submit data on calls classified as Marcus Alert Levels 1, 2, 3, and 4 and their associated call dispositions. Similarly, 988 call center data and associated call dispositions (transfer to 988, dispatch law enforcement, dispatch co-responder team, dispatch mobile crisis, dispatch fire/EMS) will be submitted. Due to the vast variation in how calls are classified and how that information is captured, a state-standard crosswalk will be required to compile data. The Evaluation Task Force will finalize the crosswalk prior to December 1, 2021. Call types, Marcus Alert level, and disposition will be included in the crosswalk for CAD data submissions. 911 PSAP representation on the Evaluation Task Force will ensure that plans are feasible.

2) **Mobile response data (mobile crisis and community care teams).** All mobile crisis response teams (including mobile crisis, community care, co-response) will be provided access to report on encounters

through the crisis call center data platform. The core report is required to be completed whenever a mobile crisis, community care, or co-responder team is dispatched in response to a Marcus Alert situation (Level 1, 2, 3, or 4), regardless of funding source. Due to overlap between CITAC reporting requirements and potential elements required for Marcus Alert reporting, the Evaluation Task Force will consider the feasibility of combining these two reporting requirements to avoid redundancy. Key areas for reporting will likely include basic event information, basic information about the individual in crisis, use of force (with standard definitions), other law enforcement actions taken, transport, and outcome of the field encounter (with standard definitions, focused primarily on connections to different aspects of the crisis continuum).

3) **Law enforcement field response data.** A mobile crisis response will not be provided for every Marcus Alert situation, including situations where it is not identified as a Marcus Alert situation until an officer has already responded. The third reporting requirement seeks to capture data on Marcus Alert situations that do not result in a Marcus Alert team response. There are two ways to gather this data, depending on the operations and communication mechanisms of the PSAP and communications between PSAP and law enforcement. The point of data capture should be considered the point at which the call is cleared by law enforcement in the field. If there is a reporting mechanism from this point back to the PSAP linked to the specific call, it would be best to integrate this reporting requirement into the supplemental CAD call/disposition data submission. If there is not an easy way to facilitate a report back to the PSAP to link the data, then respondents will need to create data records or have a mechanism to access the crisis data platform. The questions are similar to those regarding the general team reporting requirements, but focus the role of law enforcement in linking the individual to the behavioral health system (vs. providing a behavioral health intervention itself) safely and efficiently (time variables, use of force, transport etc.). Law enforcement representation from a range of agency types on the Evaluation Task Force will ensure that plans are feasible.

Marcus Alert Accountability Framework

Because Marcus Alert is a complex law with state and local components, spanning multiple agencies and secretariats, there are three components to the accountability structure: existing accountability structures between local agencies, state agencies, and the General Assembly; cross-sector accountability; and community accountability. The key outcomes, as previously described, will be further operationalized by the Evaluation Task Force and the state stakeholder group at the six month follow up meetings.

Existing Accountability Structures

The most basic compliance and accountability measures will be layered into existing mechanisms. DBHDS communicates and enforces requirements through a Performance Contract with CSBs, and will

have a distinct Exhibit to that Performance Contract for each regional call center. Local law enforcement has accountability to DCJS. Both CSBs and law enforcement agencies have a high level of accountability to their local governments.

PSAPs existing accountability structures are more complex. On the state level, the 9-1-1 Services Board (c.f., Code of Virginia § 56-484.14) and the 9-1-1 & Geospatial Services Bureau within the Virginia Department of Emergency Management are charged with oversight of the statewide transition to NG911. Meanwhile, the Office of Emergency Medical Services within the Virginia Department of Health has purview over the existing EMD accreditation process and the implementation of the new telecommunicator cardiopulmonary resuscitation (T-CPR) and EMD training requirements for all telecommunicators that must be implemented by July 1, 2022 and January 1, 2024, respectively (c.f., Code of Virginia § 56-484.16:1). DCJS also has a role in state-level oversight as it administers the compulsory minimum training standards for law enforcement dispatcher certification. On the federal level, PSAP requirements are promulgated by the National 911 Program within the National Highway Traffic Safety Administration as well as the Federal Communications Commission. Additionally, the Department of Homeland Security Science and Technology Directorate has been charged with managing automated language translation solutions for Text-to-9-1-1. The technology used by PSAPs to handle calls and data also comes with training requirements and certifications mandated by commercial vendors. Moreover, there are several professional organizations (e.g., Association of Public-Safety Communications Officials-International, APCO; International Academies of Emergency Medical Dispatch, IAED; National Emergency Number Association, NENA; etc.) that are constantly striving to improve consistency and interoperability among PSAPs through the issuance of best practices.

Cross-Sector Marcus Alert Accountability (Local)

Shared system (cross-sector) accountability is required in addition to existing accountability at the local and state level. Local cross-sector accountability is likely to be the key factor in the development of the most successful Marcus Alert programs. Local cross-sector accountability should be structured around quarterly multidisciplinary team meetings. The level of organization is suggested as CSB catchment area embedded within DBHDS region, unless otherwise indicated by the structure of the Marcus Alert area.

Regional meetings for the full DBHDS region should be integrated into the local/area quarterly meeting schedule. For example, Q1 local, Q2 regional, Q3 local, Q4 regional. The Marcus Alert (local or regional) coordinator will arrange these meetings, ensure data is available to review, etc. Currently, there is one coordinator position funded per region. As additional coordinator positions are funded, regional

responsibilities can be shared or delegated in the way most supportive of the collaboration. If additional coordinators are not brought into the system, then the initial coordinator position will have a regional responsibility for coordination. The quarterly meeting group should have peer representation (peer providers and/or community member lived experience). This group is not the full stakeholder group, but can have repetition in representation. Any local structures described here can be combined with existing, related structures, so long as all objectives and requirements are met. Cross-sector accountability at the state level will be managed with a MOU between DBHDS, DCJS, and DMAS and quarterly cross-sector meetings.

Critical incident reviews of cases should be required to occur at the program (i.e., local or team) level. Immediate critical incident reviews required per existing oversight (e.g., if use of force always has to be reviewed, then when used in Marcus Alert, that would still trigger the same process). The state plan should have specific requirements for the quarterly meetings without being overly proscriptive. Local program meetings and critical incident reviews would be the avenue to do quality improvement at a local level. Examples of review activities to undertake include:

- *Reviewing call data- examples of calls that were not diverted but could have been (i.e., disposition is MH/transfer, but initial screen did not screen positive)*
- *Review any interactions that end in arrest*
- *Review any interactions that end in injury of anyone*
- *Review any interactions that include use of force*
- *Review any times that back up did not arrive in a timely manner (whether that is behavioral health or law enforcement backup that was called)*
- *Performance of Protocol #3 specifically (i.e., could those situations could have been predicted/diverted earlier)*
- *Public outreach regarding voluntary database utilization rates, public awareness campaign, etc.*

Cross Sector Marcus Alert Accountability (State)

The Act specifically requires these components of state-level accountability:

9.1 (Criminal Justice) Requirements:

> *C. By July 1, 2021, the Department (DCJS) shall develop a written plan outlining (i) the Department's and law-enforcement agencies' roles and engagement with the development of the Marcus alert system, (ii) the Department's role in the development of minimum standards, best practices, and the review and approval of the protocols for law-enforcement participation in the Marcus alert system set forth in subsection D, and (iii) plans for the measurement of progress toward the goals for law-enforcement participation in the Marcus alert system set forth in subsection E.*

37.2 (Behavioral Health) Requirements:

> *D. The Department (DBHDS) shall assess and report on the impact and effectiveness of the comprehensive crisis system in meeting its goals. The assessment shall include the number of calls to the crisis call center, number of mobile crisis responses, and number of crisis responses*

that involved law-enforcement backup, and overall function of the comprehensive crisis system. A portion of the report, focused on the function of the Marcus alert system and local protocols for law-enforcement participation in the Marcus alert system, shall be written in collaboration with the Department of Criminal Justice Services and shall include the number and description of approved local programs and how the programs interface comprehensive crisis system and mobile crisis response, the number of crisis incidents and injuries to any parties involved, a description of successes and problems encountered, and an analysis of the overall operation of any local protocols or programs, including any disparities in response and outcomes by race and ethnicity of individuals experiencing a behavioral health crisis and recommendations for improvement of the programs. The report shall also include a specific plan to phase in a Marcus alert system and mobile crisis response in each remaining geographical area served by a community services board or behavioral health authority as required in subdivision C3. The Department, in collaboration with the Department of Criminal Justice Services, shall (i) submit a report by November 15, 2021, to the Joint Commission on Health Care outlining progress toward the assessment of these factors and any assessment items that are available for the reporting period and (ii) submit a comprehensive annual report to the Joint Commission on Health Care by November 15 of each subsequent year.

To meet these goals of providing comprehensive reporting on the Marcus Alert, the local accountability framework will need to be replicated to a certain extent at the state level, structured through ongoing meetings to occur at least quarterly.

Community Accountability (Local)

The third accountability structure relates to community accountability, and ensuring that there is transparency regarding the Marcus Alert system development and outcomes for community members. At the local level, all described accountability structures are based on the review of de-identified data, which is always reviewed in aggregate. Including racial and ethnic disparities is required. Disability types will also be disaggregated when possible.

In smaller areas, confidentiality and privacy is a key consideration and cannot be compromised. It is recommended that twice yearly, the area stakeholder group must be reconvened by the local program or regional coordinator. Any regional Equity at Intercept 0 leads should also be invited to these meetings to provide updates on the Equity at Intercept 0 initiative. The purpose of these meetings is to report on the performance of the Marcus Alert system, including aggregated outcomes and race-based disparities, to the stakeholder group. Once a year, a stakeholder group liaison (selected from the group, preferably on a volunteer basis) should provide written comments from the stakeholder group regarding recommended improvements to the system. The local or regional coordinator must forward these written comments as well as a written response and any associated action plans from the cross-sector quarterly meeting group. These comments and response must be received by DBHDS by September 1, of each year. All

community stakeholders who are not participating in a paid capacity should be compensated for their time, including the additional time for the role of the liaison.

Community Accountability (State)

Regarding accountability to the broader Virginia community, the plan is for the initial state planning group to meet twice per year, at least through 2026, to review data and make quality improvement recommendations. The Black-led coalition, developed through the Equity at Intercept 0 initiative, will also play a role (attend, review data, make presentations) in these twice yearly meetings, and all participants will receive the data to review prior to the meeting. Both the ongoing state stakeholder group and the Black-led Crisis Coalition will have a chair responsible for compiling responses and recommendations on a yearly basis to provide direct written input into the comprehensive annual report. Any concerns or recommendations raised by the planning group or coalition must be addressed in the implementation plan for the following year and reported back on in the following year's comprehensive report to the Joint Commission on Health Care.

Summary of Accountability Framework

The framework for accountability regarding the Marcus Alert ideally can be leveraged to achieve consistent and robust protections and positive outcomes statewide for all Virginians, while respecting local needs and expertise. The requirement of specific accountability structures and processes at the local level (cross sector and community accountability, through quarterly meetings and ongoing stakeholder engagement) is a key factor in ensuring that local needs are met and that local Marcus Alert systems are able to develop in response to local needs.

At the state level, Virginia DBHDS and DCJS share responsibility for reporting the status of the Marcus Alert to the Joint Commissioner on Healthcare, the Secretary of Health and Human Services, the Secretary of Public Safety and Homeland Security, the Governor's office, the General Assembly, and Virginians in general. In addition to these entities, it is recommended that the Equity at Intercept 0 leads, the Crisis Coalition, the Marcus Alert stakeholder group, and regional mobile crisis hubs be included in the further development and evaluation of statewide implementation. The annual report will include data regarding the performance of the system, including race-based health disparities, as well as written responses from the Crisis Coalition and original stakeholder group. Given these complicated structures and overlapping domains; it is possible that a more formal arrangement should be considered for formation during the initial years of implementation to ensure ongoing accountability.

Summary of State Implementation Plan

This state plan provides the initial framework for the implementation of the Marcus-David Peters Act. The framework takes a continuous quality improvement approach to the ongoing evaluation, development, and improvement of the Marcus Alert system, including the overall performance of the system and the specific performance of the system for Black Virginians, Indigenous Virginians, and Virginians of Color. Throughout initial stages of implementation, additional community input will be needed with a focus on input from marginalized and disproportionately impacted communities, and adjustments to the plan may be needed. Ultimately, the purpose of the Marcus-David Peters Act is to provide a behavioral health response to Virginians experiencing a behavioral health crisis, and individuals with mental health disorders, substance use disorders, developmental disabilities, brain injuries, and their loved ones and natural supports must remain at the center of the conversation. The local and state supports for implementation of the Marcus Alert are summarized in the table below.

Summary of Marcus Alert Components for Virginians in Crisis

Marcus Alert Local Supports	State and Regional Crisis Supports
A voluntary database to provide information to your local 9-1-1 dispatch prior to a crisis (July 1, 2021) if there are things you would like them to know about you	Access to 24/7 crisis support through 9-8-8 by December, 2021, including phone support, connection to appointments, peer supports, assessments, and National Suicide Prevention Lifeline resources
A detailed four-level triage system defined so that all crises are categorized as objectively as possible and connected to the most appropriate response that is available (July 1, 2022)	An in-person response by behavioral health within about an hour when 9-8-8 deems that as the best response (increased coverage towards 24/7 will be built over the next two years)
Assurance that all first responders have training in mental health and de-escalation, as well as knowledge of Marcus Alert protocols (training to begin July 1, 2022)	Assurance that law enforcement agencies called as back up for a behavioral health crisis response are under an agreement and have been trained (July 1, 2022)
Specialty local teams or responses, some of which do and some of which do not involve law enforcement, to respond more urgently than statewide mobile crisis, such as community care teams, co-responder teams, or telehealth solutions (phased dates statewide)	An equity at Intercept 0 initiative with a goal of increasing Black-led, BIPOC-led, and peer-led crisis providers representation in Virginia's behavioral health crisis services continuum, and achieving 24-hour coverage with behavioral health teams through public-private partnerships
Process for transferring calls from local 9-1-1 to the behavioral health 9-8-8 line when a behavioral health only response is needed, and procedures for handling calls in a coordinated fashion (July 1, 2022)	A yearly public report regarding the performance and outcomes of the system, including any racial disparities in access and outcomes and a statement regarding system performance from the perspective of the equity network and coalition (each November)

Developing this array of supports in a manner that is accessible for all Virginians will take time, training, funding, culture and paradigm shifts, extensive collaboration between sectors and across levels

of government, preferably adhering to the recommended polycentric principles, and a commitment to ongoing quality improvement and community engagement.

Addendum: Broader Considerations

A number of broader system considerations beyond the scope of the state plan were raised throughout the planning process. These considerations are described below.

1) Currently, Marcus Alert code requires a "mental health service provider" as part of a community care team. It states that a peer support specialist may be a team member. This may be interpreted in two ways, due to lack of clarity regarding whether a peer support specialist is a type of mental health service provider. There are a number of models that may be an appropriate linkage to care (e.g., "street triage" models) that do not include a clinician. For example, a requirement that a community care team include a human services professional including peer professionals, and clinician being optional, would allow for additional team types.
2) A key issue regards 37.2, (requirement of LE in ECO process). Ability to transfer custody from law enforcement to 23 hour observation facilities may deserve consideration. There are multiple viewpoints on whether, and if so, what, structural or legislative solutions would help relieve pressure on law enforcement related to the ECO process.
3) There are significant costs associated with most aspects of this plan, without clear funding sources. Regarding the funding of behavioral health teams and mobile crisis services, there is a need for all payers, to include Medicare and private insurance, to pay for mobile crisis services when accessed through the public system. There are also significant costs associated with training and time requirements of law enforcement. There will also be costs of this implementation that will fall on local PSAPs, which deserve additional attention because they play an extremely important role in the success of the system which is not as apparent as the role of behavioral health and law enforcement when reading the Act. Across all agencies, there will be costs associated with the increased burden of reporting and documentation, and because evaluation is a key component of the Act (including a focus on health disparities), the importance of reporting and documentation should be highlighted. Concerns for funding in rural areas were specifically raised, where number of crises (and hence, total reimbursement) are generally low and law enforcement agencies only have a very small number of people on staff.
4) To meet the evaluation requirements, there will be a significant burden placed on PSAPs and local law enforcement. The issue was raised that if this flow of information is required, there should be a mechanism for the state to provide personalized feedback/reporting back to the areas.

One solution to this would be one or more regional crisis system analysts for each region who could take on this role. At the state level, most reporting will be aggregated, and although this meets the requirements of the Act, it does not provide benefit to the localities (but does increase paperwork/reporting burden).

5) Throughout the planning process, concerns regarding quality and quality oversight of training and training curriculums were raised. These concerns were not able to be fully addressed as broader quality oversight processes are much broader than the Marcus Alert plan and could not be addressed directly by this planning group.
6) Throughout the planning process, questions were raised regarding whether or not the Marcus Alert protocols would include specific guidance for law enforcement to utilize when determining whether or not a criminal matter, when criminal actions were observed due to law enforcement's presence in one of the defined governmental functions related to behavioral health crisis response, would be pursued. It was determined that the state-level plan did not have scope to include such recommendations, but there is nothing that precludes localities from setting up such recommendations for their own area, as long as there is not a conflict with existing laws and regulations. A "catch-22" was noted, wherein officer discretion was described as a key factor in whether or not charges would be pursued, yet, the group raised concerns that bias would make the results of these discretionary considerations more or less accessible to different groups.
7) Throughout the planning process, concerns related to building coverage for behavioral health mobile crisis response were raised, particularly due to national workforce shortages in behavioral health and the need for 24/7 coverage for a robust response. Significant investments such as loan repayment programs, training programs and pathways to licensure, have a role to play in the success of the Marcus Alert. In the initial implementation phase, trained law enforcement will continue to respond to 911 calls a majority of the time. Additionally, behavioral health provider training standards to include behavioral health emergency triage and de-escalation for law enforcement is important as they will still be responding to level three and level four responses, as well as all calls for service when the behavioral health co-response, mobile crisis teams, or community care teams are not available or on another call. The overall system transformation will take time as behavioral health coverage increases.

Appendix A. Marcus Alert Stakeholder Group Members

Members of the state stakeholder group, including *ex officio* members and proxies, are listed below.

Alex Harris, DBHDS

Angela Hicks, Virginia Beach Human Services

Anika Richburg

Anna Mendez, Partner for Mental Health; Mental Health America of Virginia

Anne McDonnell, Brain Injury Association of Virginia

Anthony McDowell, Henrico County

A'tasha Christian, Guided Paths, Inc.; Virginia Association of Community Based Providers (VACBP)

Ben Breaux

Ben Tyler, Virginia State Police Bureau of Criminal Investigations

Bruce Cruser, Mental Health America of Virginia

Chloe Edwards, Voice for Virginia's Children

Christy Evanko, Virginia Association for Behavior Analysis

Dallas Leamon, Arlington County

Daryl Fraser

Daryl Washington, Fairfax Falls Church CSB

Elizabeth Bouldin-Clopton, VOCAL

Ellen Dague

Eric Blevins, Virginia Department of Health's Comprehensive Harm Reduction Program

Eric English, Henrico Police Department

H. Steve Richardson, Danville Police Department

Harvey Powers, Department of Criminal Justice Services (DCJS)

Heather Baxter, Prince William CSB

Heather Norton, DBHDS

Janelle Gilmer

Jennifer Faison, Virginia Association of Community Services Boards

Jim LaGraffe, Rappahannock-Rapidan CSB

John Lindstrom, RBHA

Jon Holbrook, Abingdon Police

Josie Mace, DBHDS

Kandace Miller-Phillips, Highlands Community Services Board

Kari Norris, Rappahannock Area Community Services Board

Katharine Hawkes, Isabella Health Foundation

Katherine Hunter, DBHDS

Katie Boyle, Virginia Association of Counties (VACO)

Kim Young

Kristen Chesser, Region 1

Lashawnda Singleton, Richmond Association of Black Social Workers

Latasha Simmons, City of Manassas Park Department of Social Services

Lisa Jobe-Shields, DBHDS

Lisa Madron, Prince William CSB

Lois Bias, Bringing Gods Word to Life Ministries

Mark Blackwell, DBHDS Office of Recovery Services

Mary Begor, DBHDS

Melissa Heifetz

Mindy Carlin, Virginia Association of Community-Based Providers (VACBP)

Mira Signer, DBHDS

Myra Anderson, Brave Souls on Fire

Natale Ward Christian, Hampton Newport News CSB

Nicky Fadley, Strength In Peers

Niki Bailey

Nina Marino, DBHDS Office of Child and Family Services

Patrick Halpern, New River Valley CSB

Patty Smith, DMAS

Princess Blanding, Justice and Reformation

Rebecca Holmes, Highlands CSB

Redic Morris, Fairfax County Department of Public Safety Communications

Ryan Banks, Rappahannock-Rapidan CSB

Sabrina Burress, ARROW Project

Sarah Wilson, NAMI Virginia

Stephen Craver, DBHDS

Steve Drew, Newport News Police Department

Steven Willoughby, Region 4

Tamara Starnes, Blue Ridge Behavioral Healthcare (Community Services Board)

Tim Carter, Shenandoah County Sheriff

Tonya Milling, The ARC of Virginia

Toyin Ola, DBHDS

Victor McKenzie, SAARA of Virginia

Wayne Handley, Virginia Sheriff's Association

William Dean, Virginia Beach Police

Appendix B. Glossary of Terms

Abbreviations

The following abbreviations are used throughout the state plan for the implementation of the Marcus Alert system.

APA	American Psychological Association
APCO	Association of Public-Safety Communications Officials
ARPA	American Rescue Plan Act of 2021
BIPOC	Black, Indigenous, and People of Color
BJA	Bureau of Justice Assistance
CAD	Computer-Aided Dispatch
CIT	Crisis Intervention Team
CITAC	Crisis Intervention Team Assessment Center
CMS	Centers for Medicare & Medicaid Services
CRT	Co-Response Team
CSB	Community Services Board
CSG	Council of State Governments
CSU	Crisis Stabilization Unit
DBHDS	Department of Behavioral Health & Developmental Services
DCJS	Department of Criminal Justice Services
DHP	Department of Health Professionals
DMAS	Department of Medical Assistance Services
ECO	Emergency Custody Order
ED	Emergency Department
EMS	Emergency Medical Services
ES	Emergency Services (within a CSB)
FMAP	Federal Medical Assistance Percentage
IACP	International Association of Chiefs of Police
LE	Law Enforcement
MCT	Mobile Crisis Team
MHBG	Mental Health Block Grant
NASMHPD	National Association of State Mental Health Program Directors
NENA	National Emergency Number Association
NGS	911 & Geospatial Services Bureau (within VDEM)
OEMS	Office of Emergency Medical Services (within VDH)
OJP	Office of Justice Programs
PSAP	Public Safety Answering Point
REACH	Regional Education Assessment Crisis Services Habilitation
RMS	Record Management System
SAMHSA	Substance Abuse and Mental Health Services Administration
TDO	Temporary Detention Order
VDEM	Virginia Department of Emergency Management
VDH	Virginia Department of Health

Definitions

23-hour observation center: a home-like atmosphere in which individuals can receive crisis stabilization services for up to 23 hours. A variety of services may be offered, including peer services and medical services. Individuals may be referred to a 23-hour observation center from a CITAC. Such centers may also be referred to an **enhanced CITAC**, a **crisis receiving center (CRC)** or a **psychiatric emergency center (PEC)**. Use of the terms CRC or PEC generally indicate a more robust array of services.

Co-response team (CRT): an interdisciplinary team of first responders and behavioral health professionals that presents when an emergency situation necessitates a behavioral health response. The first responders could be police, fire, or paramedics/emergency medical technicians (EMTs). The behavioral health professionals could be peer recovery specialists, master's-level clinicians, etc.

Crisis Intervention Team Assessment Center (CITAC): a site where individuals can receive pre-admission screening to determine the level of care required to manage their behavioral health emergency. This is a site where law enforcement can bring individuals who are under an Emergency Custody Order (ECO) to be evaluated instead of jail and/or a hospital emergency room. These sites may also provide additional services, in which case they might also be referred to as crisis receiving centers.

Crisis Now Model. The Crisis Now Model is a national model for a comprehensive community based crisis continuum. The components include high-technology regional or statewide call centers, mobile crisis response that can respond 24/7 in the community, crisis receiving centers or other "place based" supports that do not turn people in crisis away, and essential principles and policies including a recovery orientation, trauma-informed care, suicide safer care, coordination with law enforcement, and others. Virginia has been aligning community based crisis investments with the Crisis Now model recently through STEP-VA and Project BRAVO.

Crisis stabilization unit (CSU): a home-like, residential crisis stabilization unit that allows individuals who are experiencing a behavioral health crisis to stay short-term (generally, three to ten days). This can also be a step-down level of care for individuals being discharged from an inpatient psychiatric facility.

Hazard list: a list of information that may be relevant to first responders. For example, a note may be recorded indicating that there is an individual who uses a wheelchair living in a fourth-floor apartment. This may also be referenced to as a special needs list or a list of flagged residences.

Intercept 0: community based behavioral health services, including the crisis continuum. Intercept 0 was added to the Sequential Intercept Model to highlight that when community based behavioral health services are accessible in the community, they serve as the "ultimate intercept," because no intercept/diversion would be needed if individuals receive the care they need.

Intercept 1: the first diversion point in the Sequential Intercept Model. This intercept refers to the point at which individuals begin to interact with law enforcement (for example, by call 9-1-1). See: Sequential Intercept Model.

Law enforcement agency (LE): an umbrella term used here to refer to police departments, including college/university campus police departments, sheriff's offices, and divisions of the Virginia State Police.

Level 1 (Routine) Response – Crisis response to a non-urgent and non-emergent behavioral health need. Situations requiring a level 1 response will be diverted to 988, where the call center can (1) provide

information, (2) act as a warm-line for those already linked with services, and/or (3) offer the appropriate referral or resource, which can include offering an urgent appointment within 24 to 48 hours.

Level 2 (Urgent) Response – Crisis response to a situation where the absence of clinical intervention suggests the advancement of greater risks and a degree of urgency. A level 2 response does not include first responders (law enforcement, fire, or EMT), but it does include a possible response by a mobile crisis team, community care team, or call center intervention.

Level 3 (Urgent) Response – Crisis response that includes first responders, who will clear and secure the scene to allow for the mobile crisis team or community care team to provide the appropriate intervention. Situations requiring a level 3 response may include patient history of recent or active aggression, minor self-injury, and active psychosis.

Level 4 (Emergent) Response – Law enforcement is dispatched and leads the level 4 response, with the option to call for assistance from an EMT, Fire, mobile crisis, or a community care team. Situations requiring a level 4 response includes those that are too dangerous to deploy without law enforcement securing the scene.

Living Room Model: "The Living Room Model is a walk-in respite center for individuals in crisis. These home-like environments offer a courteous and calming surrounding for immediate relief of crisis symptoms and to avert psychiatric hospitalization…The Living Room Model is distinctly different from the 23-hour crisis stabilization units. The Living Room Model provides crisis resolution and treatment for those who need more than 24 hours to resolve the issues that brought them into crisis, are short term and provide intensive treatment (CITAC Expansion Plan, 2020)."

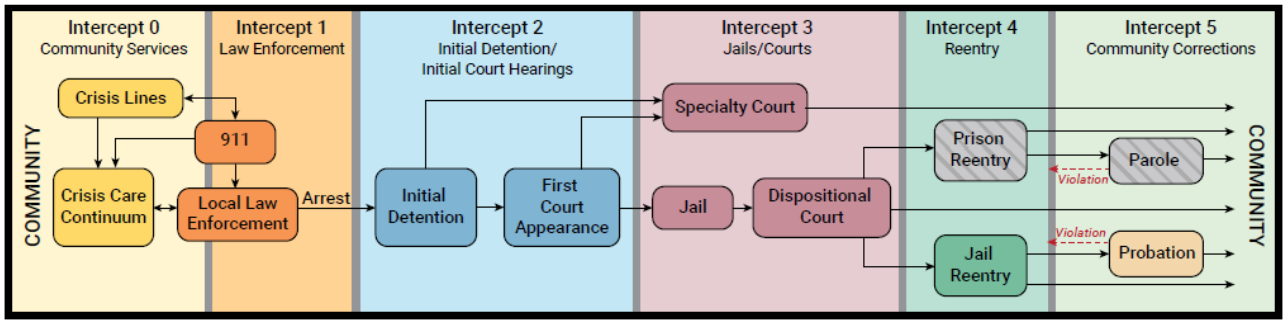
Mobile crisis team (MCT): a team of behavioral health professionals that deliver services to individuals wherever they are located. The behavioral health professionals could be peer recovery specialists, master's-level clinicians, etc.

Peer support professional: an umbrella term that includes peer recovery specialists and family support partners.

Public Safety Answering Point (PSAP): a call center where calls to 911 from mobile and landline subscribers are answered. It may also be referred to as a **department of emergency communications (DEC)** or a public safety access point.

Qualified mental health professional (QMHP): an individual with a degree in human services or a related field (e.g., social work, marriage and family counseling, art therapy, etc.) and upwards of 500 hours of direct, supervised experience working with individuals with mental illness within the last five years. A QMHP must be registered with the Board of Counseling. See the Board of Counseling's webpage for a full list of requirements.

Sequential Intercept Model (SIM). The Sequential Intercept Model demonstrates how individuals with mental health disorders and substance use can be diverted from the criminal justice system at different intercept points (e.g., arrest, initial court hearings, re-entry). The model was expanded to include **Intercept 0: Community Services** after previously beginning with **Intercept 1: Law Enforcement** to highlight the role of community services in diverting from law enforcement interactions.


Intercept 0
Community Services
Intercept 1
Law Enforcement
Intercept 2
Initial Detention/
Initial Court Hearings
Intercept 3
Jails/Courts
Intercept 4
Reentry
Intercept 5
Community Corrections
COMMUNITY
Crisis Lines
911
Crisis Care Continuum
Local Law Enforcement
Arrest
Initial Detention
First Court Appearance
Specialty Court
Jail
Dispositional Court
Prison Reentry
Jail Reentry
Parole
Probation
Violation
Violation
COMMUNITY

Appendix C. Current Landscape Analysis Additional Tables

Additional CSB Respondent Tables

Private Crisis Providers by CSB Respondent

CSB respondents were permitted to write in any known private crisis providers that operate within their respective catchment areas.

CSB Respondent	Private Crisis Providers
Arlington County Community Services Board	REACH AND CR2
Chesterfield Community Services Board	Many... National Counseling Group is the largest
Danville-Pittsylvania Community Services	EPIC - crisis stabilization
District 19 Community Services Board	Community based providers
Fairfax-Falls Church Community Services Board	PRS Crisis Link: Suicide prevention 988 2-text lines
Hanover County Community Services Board	National Counseling Group, Intercept and others
Henrico Area Mental Health and Developmental Services	National Counseling Group--mobile Crisis Stabilization WHOA Behavioral Health--mobile crisis stabilization
Highlands Community Services	Family Preservation: Crisis intervention and Crisis stabilization
New River Valley Community Services	EHS offers mobile crisis, National Counseling Group offers mobile crisis
Norfolk Community Services Board	Commonwealth ICT, National Counseling group
Prince William County Community Services Board	REACH, CR2
Rappahannock Area Community Services Board	National Counseling
Richmond Behavioral Health Authority	National Counseling Group, Intercept One, many others doing community based crisis stabilization.
Valley Community Services Board	Intercept (very limited)

FY 2022 Upcoming Crisis System Components by CSB Respondent

CSB Respondent	Upcoming Crisis System Component
Alleghany Highlands Community Services Board	23-hour observation center
	Adult mobile crisis team
	Co-response team with LE
	Crisis text line
	Other (please specify)
Arlington County Community Services Board	Adult mobile crisis team
	Child/youth mobile crisis team
	Co-response team with EMS
	Co-response team with fire and rescue
	Crisis text line
Chesterfield Community Services Board	Adult mobile crisis team
Cumberland Mountain Community Services	23-hour observation center
	Adult mobile crisis team
Danville-Pittsylvania Community Services	Adult mobile crisis team

	Other (please specify)
District 19 Community Services Board	Adult mobile crisis team
Henrico Area Mental Health and Developmental Services	Adult mobile crisis team
Highlands Community Services	23-hour observation center
	Adult mobile crisis team
	Co-response team with EMS
	Co-response team with fire and rescue
	Co-response team with LE
	CSU
Loudoun County Department of MH, SA and Developmental Services	Other (please specify)
Mount Rogers Community Services Board	23-hour observation center
	Adult mobile crisis team
	Other (please specify)
New River Valley Community Services	23-hour observation center
Norfolk Community Services Board	23-hour observation center
	Adult mobile crisis team
	Child/youth mobile crisis team
	CITAC
	Co-response team with EMS
	Co-response team with fire and rescue
	Co-response team with LE
Piedmont Community Services	Adult mobile crisis team
Prince William County Community Services Board	Adult mobile crisis team
	Other (please specify)
Rappahannock Area Community Services Board	Adult mobile crisis team
	Co-response team with LE
Richmond Behavioral Health Authority	Adult mobile crisis team
	Co-response team with LE
	Other (please specify)

"Other" FY 2022 Upcoming Crisis System Components by CSB Respondent

CSB Respondent	"Other" Upcoming Crisis System Component
Alleghany Highlands Community Services Board	Crisis Call Center
Danville-Pittsylvania Community Services	The local area are exploring the possibility of co-response teams with law enforcement or other professionals such as EMS/fire/rescue. Our agency is interested in the 23 hour observation center.
Loudoun County Department of MH, SA and Developmental Services	Rapid 911
Mount Rogers Community Services Board	Possible expansion of both youth and adult CSU, two crisis care centers will be 24/7, adult mobile crisis will be expanded, Marcus Alert Response team
Prince William County Community Services Board	Smart 911, expansion of Coresponder team, expansion of outreach and engagement team.

Richmond Behavioral Health Authority	23 Hour Observation is under consideration

Additional CITAC Respondent Tables

Law Enforcement Agencies Utilizing CITAC Respondents' Primary CITACs

CIT Respondent Associated with Primary CITAC	LE Agency Utilizing CITAC
Southside CIT	Colonial Heights City Sheriff's Office
	Colonial Heights Police Department
	Dinwiddie County Sheriff's Office
	Emporia City Sheriff's Office
	Emporia Police Department
	Greensville County Sheriff's Office
	Hopewell City Sheriff's Office
	Hopewell Police Department
	McKenney Police Department
	Petersburg City Sheriff's Office
	Petersburg Police Department
	Prince George County Police Department
	Prince George County Sheriff's Office
	Richard Bland College Police Department
	Surry County Sheriff's Office
	Sussex County Sheriff's Office
	Virginia State Police Area 1
	Virginia State Police Area 5
	Virginia Union University PD
	Waverly Police Department
Mount Rogers CIT	Chilhowie Police Department
	Galax Police Department
	Hillsville Police Department
	Marion Police Department
	Rural Retreat Police Department
	Saltville Police Department
	Smyth County Sheriff's Office
	Wythe County Sheriff's Office
	Wytheville Police Department
Alexandria CIT	Alexandria City Sheriff's Office
	Alexandria Police Department
Arlington County CIT	Arlington County Police Department
	Arlington County Sheriff's Office
	Falls Church Police Department
	Metro Washington Airport Authority PD
Blue Ridge CIT	Augusta County Sheriff's Office
	Blue Ridge Community College PD
	Highland County Sheriff's Office
	Staunton City Sheriff's Office
	Staunton Police Department
	Virginia State Police Area 17
	Waynesboro City Sheriff's Office

	Waynesboro Police Department
Danville-Pittsylvania CIT	Danville City Sheriff's Office
	Danville Police Department
	Gretna Police Department
	Hurt Police Department
	Pittsylvania County Sheriff's Office
Greater Prince William CIT	Haymarket Police Department
	Manassas City Police Department
	Prince William County Police Department
	Prince William County Sheriff's Office
Harrisonburg-Rockingham CIT	Bridgewater College Police Department
	Bridgewater Police Department
	Broadway Police Department
	Dayton Police Department
	Elkton Police Department
	Grottoes Police Department
	Harrisonburg Police Department
	Rockingham Co. Sheriff's Office
	Timberville Police Department
	Virginia State Police Area 16
Henrico CIT	Charles City County Sheriff's Office
	Henrico County Division Of Police
	Henrico County Sheriff's Office
	New Kent County Sheriff's Office
Highlands CIT	Abingdon Police Department
	Bristol City Sheriff's Office
	Bristol Police Department
	Damascus Police Department
	Glade Spring Police Department
	Virginia State Police Area 4
	Washington County Sheriff's Office
Loudoun County CIT	Leesburg Police Department
	Loudoun County Sheriff's Office
	Metro Washington Airport Authority PD
	Middleburg Police Department
	Purcellville Police Department
Lynchburg-Central Virginia CIT	Amherst County Sheriff's Office
	Amherst Police Department
	Appomattox County Sheriff's Office
	Bedford County Sheriff's Office
	Bedford Police Department
	Campbell County Sheriff's Office
	Central Virginia Community College PD
	Liberty University Police Department
	Lynchburg City Sheriff's Office
	Lynchburg Police Department
New River Valley CIT	Blacksburg Police Department
	Christiansburg Police Department

	Dublin Police Department
	Floyd County Sheriff's Office
	Giles County Sheriff's Office
	Montgomery County Sheriff's Office
	Narrows Police Department
	Pearisburg Police Department
	Pembroke Police Department
	Pulaski County Sheriff's Office
	Pulaski Police Department
	Radford Police Department
	Radford University Police Department
	Virginia Tech PD
Norfolk CIT	Norfolk Police Department
	Norfolk State University Police Department
	Old Dominion University Police Dept.
Northwestern CIT	Berryville Police Department
	Clarke County Sheriff's Office
	Frederick County Sheriff's Office
	Front Royal Police Department
	Lord Fairfax Community College Police Department
	Luray Police Department
	Middletown Police Department
	Mount Jackson Police Department
	New Market Police Department
	Page County Sheriff's Office
	Shenandoah County Sheriff's Office
	Shenandoah Police Department
	Stanley Police Department
	Stephens City Police Department
	Strasburg Police Department
	Warren County Sheriff's Office
	Winchester City Sheriff's Office
	Winchester Police Department
	Woodstock Police Department
Planning District 1 CIT	Appalachia Police Department
	Big Stone Gap Police Department
	Coeburn Police Department
	Gate City Police Department
	Jonesville Police Department
	Lee County Sheriff's Office
	Mountain Empire Community College Campus PD
	Norton City Sheriff's Office
	Norton Police Department
	Pennington Gap Police Department
	Pound Police Department
	Saint Paul Police Department
	Scott County Sheriff's Office

	University of Virginia College at Wise PD
	Weber City Police Department
	Wise County Sheriff's Office
	Wise Police Department
Rockbridge-Bath CIT	Buena Vista Police Department
	Buena Vista Sheriff's Office
	Lexington Police Department
	Rockbridge County Sheriff's Office
	Virginia Military Institute Police Department
Virginia Beach CIT	Virginia Beach City Sheriff's Office
	Virginia Beach Police Department

Law Enforcement Agencies Utilizing CITAC Respondents' Secondary CITACs

CITAC Respondent Operating Secondary CITAC	LE Users
Southside CIT	Colonial Heights City Sheriff's Office
	Colonial Heights Police Department
	Dinwiddie County Sheriff's Office
	Emporia City Sheriff's Office
	Emporia Police Department
	Greensville County Sheriff's Office
	Hopewell City Sheriff's Office
	Hopewell Police Department
	McKenney Police Department
	Petersburg City Sheriff's Office
	Petersburg Police Department
	Prince George County Police Department
	Prince George County Sheriff's Office
	Richard Bland College Police Department
	Surry County Sheriff's Office
	Sussex County Sheriff's Office
	Virginia State Police Area 1
	Virginia State Police Area 5
	Virginia State University Police Dept
	Waverly Police Department
Arlington County CIT	Arlington County Police Department
	Arlington County Sheriff's Office
	Falls Church Police Department
	Metro Washington Airport Authority PD
Greater Prince William CIT	Haymarket Police Department
	Manassas City Police Department
	Prince William County Police Department
	Prince William County Sheriff's Office

Additional Law Enforcement Respondent Tables

Law Enforcement Respondents' CIT Participation

Law Enforcement Respondent	CIT-Coordinating CSB

Alexandria Police Department	Alexandria Community Services Board
Amelia County Sheriff's Office	Crossroads Community Services Board
Amherst County Sheriff's Office	Horizon Behavioral Health
Area 12	Rappahannock-Rapidan Community Services Board
Area 27	Highlands Community Services
Arlington County Police Department	Arlington County Community Services Board
Ashland Police Department	Hanover County Community Services Board
Augusta County Sheriff's Office	Valley Community Services Board
Bedford County Sheriff's Office	Horizon Behavioral Health
Bristol Police Department	Highlands Community Services
Buckingham County Sheriff's Office	Crossroads Community Services Board
Chincoteague Police Department	Eastern Shore Community Services Board
Christopher Newport University PD	Hampton-Newport News Community Services Board
Clarke County Sheriff's Office	Northwestern Community Services
Colonial Heights Police Department	District 19 Community Services Board
Culpeper Police Department	Rappahannock-Rapidan Community Services Board
Danville Police Department	Danville-Pittsylvania Community Services
Dublin Police Department	New River Valley Community Services
Essex County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board
Fairfax City Police Department	Fairfax-Falls Church Community Services Board
Fairfax County Sheriff's Office	Fairfax-Falls Church Community Services Board
Falls Church Police Department	Fairfax-Falls Church Community Services Board
Fauquier County Sheriff's Office	Rappahannock-Rapidan Community Services Board
Floyd County Sheriff's Office	New River Valley Community Services
Front Royal Police Department	Northwestern Community Services
Gloucester County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board
Goochland County Sheriff's Office	Region Ten Community Services Board
Hampton Police Department	Hampton-Newport News Community Services Board
Hanover County Sheriff's Office	Hanover County Community Services Board
Henrico County Division Of Police	Henrico Area Mental Health and Developmental Services
Herndon Police Department	Fairfax-Falls Church Community Services Board
Hopewell Police Department	District 19 Community Services Board
James City County Police Department	Colonial Behavioral Health
James Madison University Police Department	Blue Ridge Behavioral Healthcare
King William County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board
Lake Monticello Police Department	Region Ten Community Services Board
Loudoun County Sheriff's Office	Loudoun County Department of MH, SA and Developmental Services
Lynchburg City Sheriff's Office	Horizon Behavioral Health
Lynchburg Police Department	Horizon Behavioral Health
Madison County Sheriff's Office	Rappahannock Area Community Services Board
Manassas City Police Department	Prince William County Community Services Board
Manassas Park City Police Dept.	Prince William County Community Services Board
Mathews County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board

Metro Washington Airport Authority PD[10]	Loudoun County Department of MH, SA and Developmental Services
Middleburg Police Department	Loudoun County Department of MH, SA and Developmental Services
Mountain Empire Community College Campus PD	Planning District One Behavioral Health Services
Nelson County Sheriff's Office	Region Ten Community Services Board
New Kent County Sheriff's Office	Henrico Area Mental Health and Developmental Services
Northern VA Community College PD	Fairfax-Falls Church Community Services Board
Northumberland County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board
Nottoway County Sheriff's Office	Crossroads Community Services Board
Old Dominion University Police Dept.	Norfolk Community Services Board
Orange Police Department	Rappahannock-Rapidan Community Services Board
Powhatan County Sheriff's Office	Chesterfield Community Services Board
Prince William County Police Department	Prince William County Community Services Board
Radford Police Department	New River Valley Community Services
Rappahannock County Sheriff's Office	Rappahannock-Rapidan Community Services Board
Richmond International Airport Police	Henrico Area Mental Health and Developmental Services
Roanoke County Police Department	Blue Ridge Behavioral Healthcare
Rockbridge County Sheriff's Office	Rockbridge Area Community Services
Russell County Sheriff's Office	Cumberland Mountain Community Services
Salem City Sheriff's Office	Blue Ridge Behavioral Healthcare
Salem Police Department	Blue Ridge Behavioral Healthcare
Scott County Sheriff's Office	Highlands Community Services
Shenandoah County Sheriff's Office	Northwestern Community Services
Suffolk City Sheriff's Office	Western Tidewater Community Services Board
Timberville Police Department	Harrisonburg-Rockingham Community Services Board
Vinton Police Department	Blue Ridge Behavioral Healthcare
Virginia Commonwealth University Police Dept.	Richmond Behavioral Health Authority
Virginia Tech PD	New River Valley Community Services
Virginia Western Community College PD	Blue Ridge Behavioral Healthcare
Warsaw Police Department	Middle Peninsula-Northern Neck Community Services Board
Waynesboro Police Department	Valley Community Services Board
West Point Police Department	Middle Peninsula-Northern Neck Community Services Board
Westmoreland County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board
Williamsburg Police Department	Colonial Behavioral Health
Wilson Workforce And Rehabilitation Center	Valley Community Services Board
Wintergreen Police Department	Region Ten Community Services Board
Wise County Sheriff's Office	Planning District One Behavioral Health Services
Wise Police Department	Planning District One Behavioral Health Services
York - Poquoson Sheriff's Office	Colonial Behavioral Health

Law Enforcement Respondents Receiving Transferred Calls from PSAPs

[10] Note that there is a discrepancy: Several CIT respondents noted having Metro PD participate in their respective programs.

Law Enforcement Respondent	Transferring PSAP
Area 12	Fauquier (FCC ID: 7126 / 7221)
	Rappahannock (FCC ID: 7189)
Area 27	Bristol (FCC ID: 7091)
	Scott (FCC ID: 7197)
	Washington (FCC ID: 7222)
Ashland Police Department	Hanover (FCC ID: 7143)
Augusta County Sheriff's Office	Augusta (FCC ID: 7085)
Bristol Police Department	Bristol (FCC ID: 7091)
Buckingham County Sheriff's Office	Buckingham (FCC ID: 7094)
Chincoteague Police Department	Eastern Shore (FCC ID: 7119)
Culpeper Police Department	Culpeper (FCC ID: 7114)
Danville Police Department	Danville (FCC ID: 7116)
Division of Capitol Police	Richmond City (FCC ID: 7191)
Dublin Police Department	Pulaski (FCC ID: 7187)
Fairfax City Police Department	Fairfax (FCC ID: 7123)
Falls Church Police Department	Arlington (FCC ID: 7084)
Floyd County Sheriff's Office	Floyd (FCC ID: 7127)
Front Royal Police Department	Warren (FCC ID: 7220)
Hanover County Sheriff's Office	Hanover (FCC ID: 7143)
Herndon Police Department	Fairfax (FCC ID: 7123)
Hopewell Police Department	Hopewell (FCC ID: 7147)
Lake Monticello Police Department	Buckingham (FCC ID: 7094)
	Charlottesville-UVA-Albemarle (FCC ID: 7101)
	Cumberland (FCC ID: 7115)
	Fluvanna (FCC ID: 7128)
	Goochland (FCC ID: 7136)
	Louisa (FCC ID: 7158)
Loudoun County Sheriff's Office	Loudoun (FCC ID: 7157)
Manassas City Police Department	Manassas (FCC ID: 7162)
	Prince William (FCC ID: 7186)
Mathews County Sheriff's Office	Mathews (FCC ID: 7165)
Middleburg Police Department	Loudoun (FCC ID: 7157)
Nelson County Sheriff's Office	Amherst (FCC ID: 7082)
	Appomattox (FCC ID: 7083)
	Augusta (FCC ID: 7085)
	Buckingham (FCC ID: 7094)
	Charlottesville-UVA-Albemarle (FCC ID: 7101)
New Kent County Sheriff's Office	New Kent (FCC ID: 7170)
Northern VA Community College PD	Alexandria (FCC ID: 7079)
	Arlington (FCC ID: 7084)
	Fairfax (FCC ID: 7123)
	Loudoun (FCC ID: 7157)
	Manassas (FCC ID: 7162)
	Manassas Park (FCC ID: 7163)
	MWAA (FCC ID: 8567)
	Prince William (FCC ID: 7186)
Northumberland County Sheriff's Office	Lancaster (FCC ID: 7154)

	Richmond County (FCC ID: 7190)
	Westmoreland (FCC ID: 7225)
Northumberland County Sheriff's Office	Other: St. Mary’s Co. Maryland
Norton Police Department	Dickenson (FCC ID: 8222)
	Lee (FCC ID: 7156)
	Norton (FCC ID: 7174)
	Russell (FCC ID: 7195)
	Scott (FCC ID: 7197)
	Wise (FCC ID: 7229)
Old Dominion University Police Dept.	Norfolk (FCC ID: 7172)
Powhatan County Sheriff's Office	Powhatan (FCC ID: 7184)
Roanoke County Police Department	Roanoke County (FCC ID: 7193)
Rockbridge County Sheriff's Office	Rockbridge (FCC ID: 7194)
Russell County Sheriff's Office	Buchanan (FCC ID: 7093)
	Dickenson (FCC ID: 8222)
	Scott (FCC ID: 7197)
	Tazewell (FCC ID: 7214)
	Washington (FCC ID: 7222)
	Wise (FCC ID: 7229)
Shenandoah County Sheriff's Office	Shenandoah (FCC ID: 7198)
Virginia Commonwealth University Police Dept.	Richmond City (FCC ID: 7191)
Virginia Tech PD	New River Valley (FCC ID: 8501)
Warsaw Police Department	Richmond County (FCC ID: 7190)
Washington Metro Area Transit PD	Alexandria (FCC ID: 7079)
	Arlington (FCC ID: 7084)
	Fairfax (FCC ID: 7123)
	Falls Church (FCC ID: 7124)
	Loudoun (FCC ID: 7157)
Waynesboro Police Department	Waynesboro (FCC ID: 7223)
Williamsburg Police Department	York-Poquoson-Williamsburg (FCC ID: 7232)
Wintergreen Police Department	Nelson (FCC ID: 7169)
Wise County Sheriff's Office	Dickenson (FCC ID: 8222)
	Lee (FCC ID: 7156)
	Norton (FCC ID: 7174)
	Russell (FCC ID: 7195)
	Scott (FCC ID: 7197)
Wise Police Department	Wise (FCC ID: 7229)