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

November 15, 2021

The Honorable Patrick Hope, Chair
Joint Commission on Health Care
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Delegate Hope,

Chapter 41 of the 2020 Acts of Assembly directs the Department of Behavioral Health and Developmental Services (DBHDS) to report on the impact and effectiveness of the comprehensive crisis system in Virginia. The language states:

> *The Department 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, 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 C 3. 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.

In accordance with this item, please find enclosed the combined report. Staff are available should you wish to discuss this request.

Sincerely,

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

CC:
The Honorable Vanessa Walker Harris, MD
Members of the Joint Commission on Health Care
Susan Massart
Mike Tweedy
Department of Criminal Justice Services
The Honorable Brian Moran

Report on Chapter 41 of the 2020 Acts of Assembly (HB5043/SB5038)

Annual Report on the Implementation of Marcus Alert and the Impact and Effectiveness of the Comprehensive Crisis System

To the Joint Commission on Health Care

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

Preface

Chapter 41 of the 2020 Acts of Assembly requires the Department of Behavioral Health and Developmental Services (DBHDS), in collaboration with the Department of Criminal Justice Services, to report on the impact and effectiveness of the comprehensive crisis system in Virginia. The language states:

> *The Department 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, 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 C 3. 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.*

Table of Contents

Executive Summary

Marcus-David Peters, who was a young, Black biology teacher who was shot and killed in Richmond, Virginia by police during a mental health crisis. The Marcus-David Peters Act was signed into law following the 2020 Special Session of the General Assembly. The Act in its entirety includes the build-out of a comprehensive, statewide behavioral health response system, as well as a series of local protocols and supports to coordinate between law enforcement, 911, and the comprehensive crisis system. Elements of the comprehensive crisis system are explained below in more detail. This report provides an overview of the planning process thus far and progress made towards the measurement of each indicator required in the act. The details of the planning process and a summary of the state plan for implementation of the Marcus-David Peters Act can be found here: https://www.dbhds.virginia.gov/assets/doc/hr/Health-Equity/mdpa/final-state-plan_july-1-2021_ma.pdf

Implementation of the Marcus-David Peters Act is currently on schedule, with the comprehensive state plan completed by July 1, 2021 and Marcus Alert programs due to launch in each of Virginia's five regions (referred to as "initial areas") by December 1, 2021. Because of the interconnectedness of the different components of the crisis system, not all features will be fully operational on December 1, 2021. This is primarily due to the build out of the five regional call centers currently under development and will only have certain elements implemented on December 1, 2021. The five initial areas are working closely with their developing call centers and temporary processes are being stood up to ensure that initial implementation occurs on time. For example, a secondary law enforcement-only phone line will be utilized at the beginning of implementation to ensure that all law enforcement calls from Marcus Alert areas are prioritized by the call center as the broader infrastructure continues to develop.

DBHDS is working to ensure Virginia meets the requirement of July 1, 2026 to implement Marcus Alert programs statewide in all 40 locally-operated community services boards (CSBs). Areas of focus for this reporting period include:

- **State Plan** – Comprehensive state plan completed by DBHDS and the Department of Criminal Justice Services (DCJS) by July 1, 2021.
- **Regional Implementation** – Marcus Alert programs due to launch in each of Virginia's five regions (referred to as "initial areas") by December 1, 2021.
- **Launching More Programs** – The next five localities have been identified to launch Marcus Alert programs by July 1, 2023.
- **Mobile Crisis Coverage** – Statewide coverage by mobile crisis teams (one-hour response) continues to grow and is expected to be robust, statewide, and available 24/7 by July 1, 2024. Importantly, there are ongoing significant workforce challenges in the behavioral health system exacerbated by COVID-19 that will impact the speed at which 24/7 coverage is achieved.
- **Local Protocols** – Three local Marcus Alert protocols are required statewide by July 1, 2022. These three local protocols include: 1) diversion of certain 911 calls to crisis call centers, 2) agreements between mobile crisis regional hubs and law enforcement, and 3) policies for law enforcement participation in the Marcus Alert system. The level of additional local supports for community coverage to be achieved statewide will be

contingent on the level of funding available as well as the local planning processes currently underway.

As progress is made on implementation of Marcus Alert programs across Virginia, DBHDS will continue working with state and local partners to capture more data and expanding reporting capabilities.

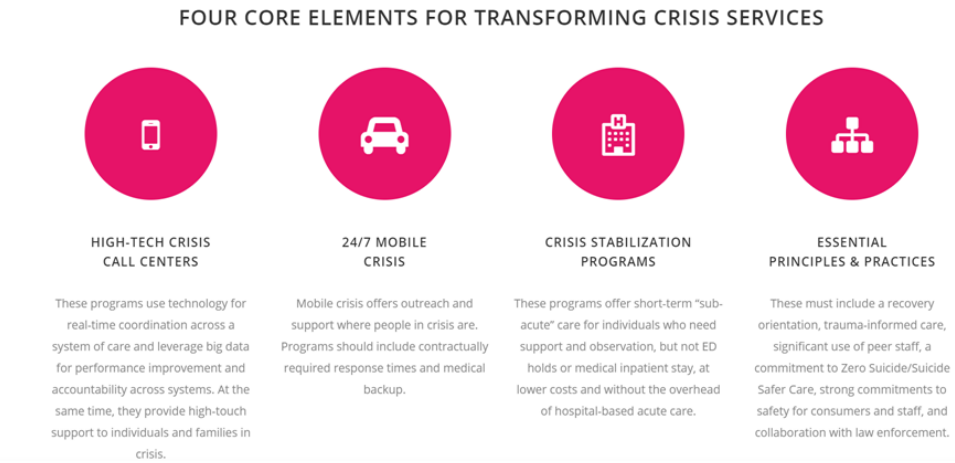
Background

In Special Session 2020, the Marcus-David Peters Act was signed into law, named after Marcus-David Peters, who was a young, Black, Biology teacher shot and killed by police during a mental health crisis. The Act in its entirety includes the build-out of a comprehensive, statewide behavioral health response system, as well as a series of local protocols and supports to coordinate between law enforcement, 911, and the comprehensive crisis system. The five initial areas are required to implement December 1, 2021. This report provides an overview of the planning process thus far and progress towards the measurement of each indicator. The timeline for implementation is included below. Additional details about the planning process and a summary of the state plan for implementation of the Marcus-David Peters Act can be found here: https://www.dbhds.virginia.gov/assets/doc/hr/Health-Equity/mdpa/final-state-plan_july-1-2021_ma.pdf.

Crisis System Transformation

Virginia is currently in the midst of transforming our public behavioral health services through an initiative called System Transformation, Excellence and Performance, or STEP-VA. STEP-VA is a set of critical core services that will soon all be offered at every one of Virginia's 40 local community services boards. That means all Virginians will be able to access high quality behavioral health services aimed at managing symptoms before they become crisis-level and avoiding expensive, restrictive in-patient services or possible incarceration.

STEP-VA calls for a stronger, crisis system that meets the needs of youth and adults in their communities, supporting them in the least restrictive environment where they can safely and successfully live. To accomplish these critical goals, Virginia is aligning existing and planned investments with the Crisis Now model. The Crisis Now model includes four core elements:



The first element is crisis call centers. Federal law requires 988 be accessible no later than July 16, 2022 to, at a minimum, the National Suicide Prevention Lifeline supports and services. Virginia awarded a contract to Netsmart for a crisis call center data platform, which is described in a section below. The 988 line will be managed by five regional call centers under the purview of five CSBs representing each DBHDS region: Region 10 CSB (Region 1), Fairfax-Falls Church (Region 2), New River Valley (Region 3), Richmond Behavioral Health Authority (RBHA; Region 4), and Western Tidewater (Region 5). Virginia was the first state to pass a 988 cell phone tax earlier in 2021 via Senate Bill 1302.

STEP-VA mobile crisis funding was distributed to the five regions listed above in 2020 and 2021. The initial disbursements were targeted to develop specialized children's mobile crisis teams. Funding for adult teams recently began (July 1, 2021). In addition, increased Medicaid reimbursement rates for comprehensive crisis services are set to launch on December 1, 2021 through the Department of Medical Assistance Services' Project BRAVO . Additionally, one time ARPA funds will continue to support the build out of additional mobile crisis teams and the further development of Crisis Stabilization Units and Crisis Receiving Centers.

Local Marcus Alert Systems

In addition to the crisis system components being implemented at the state and regional level, Marcus Alert has components which are implemented at the local level per the legislation. The local components are as follows:

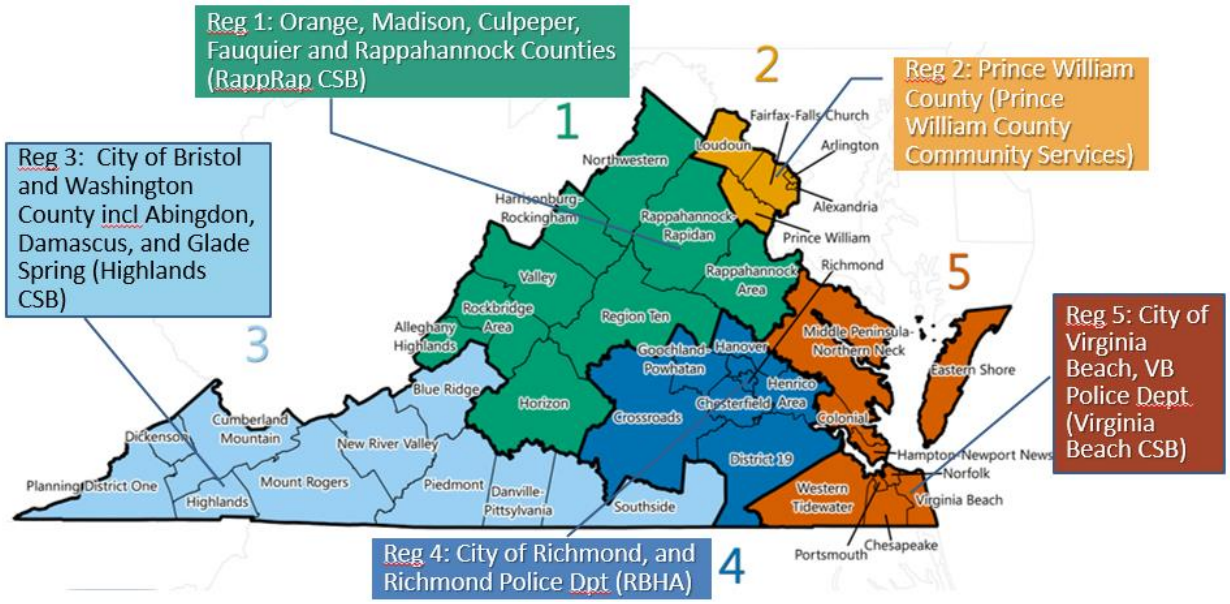
1) Required local planning process
2) Voluntary database
3) Protocol 1 – the ability to transfer calls from 911 to 988 call centers.
4) Protocol 2 – the agreement between the mobile crisis regional hub and any local law enforcement departments, which will be providing back-up.
5) Protocol 3 – the Law Enforcement-specific policies and procedures that provide a specialized response for individuals in behavioral health crisis.
6) Plan for Community Coverage. Plan for community coverage refers to the way that a local area will respond to situations at each of the Marcus Alert urgency levels.
7) Submission and Approval process

The initial five areas were required to submit detailed implementation plans October 15, 2021. Each area has submitted their plans and the plans are currently under review by DBHDS and DCJS. The three protocols are required statewide by July 1, 2022 and community coverage will be phased in over a number of years per the legislation.

The image below shows the activity and coordination necessary at every level of government to successfully implement and operate Marcus Alert programs in Virginia.

Plan to Phase in State Coverage

DBHDS is also required by legislative language phase in Marcus Alert and mobile crisis response throughout all 40 Virginia CSBs. The first five regional locations with a December 1, 2021 implementation date are displayed below:



The second areas to be supported for full implementation are as follows. Per the Act, the second five areas should be those CSB/BHA catchment areas that serve the highest population within each region (unless already implemented in the initial area).

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

For these areas above, the implementation timeline will be as follows:

Component	Date available statewide
Marcus Alert Protocols #1-3	July 1, 2022
24/7 Coverage by one-hour response mobile crisis teams	July 1, 2023
Locally-defined additional community coverage	July 1, 2023*

**contingent upon additional funding*

After the first ten areas fully implement all required components (by July 1, 2023), protocols will have been in place for 12 months statewide, and 24/7 coverage by one-hour response mobile crisis teams will be continuing to expand statewide. It is expected that this coverage will be available statewide by July 1, 2024. The scheduled requirements of the law will be met by July 1, 2024, presuming no delays in the ongoing implementation of mobile crisis through STEP-VA, Project BRAVO, and that funding from the 988 fee continues to sustain the call centers. Each local area will be working with stakeholders to determine not only the required protocols and how to coordinate with the mobile crisis (one-hour response) teams, but also the local supports and teams needed to have a robust response for all Marcus Alert situations, including those that are too urgent to refer for a one-hour response. The majority of areas across the state should be ready to implement the full model by July 1, 2024, including local supports and teams, if state grants were available for all areas to fund these local aspects of the system.

Using the schedule below, the General Assembly would have the option of funding *all* local areas for July 1, 2024 (with funding beginning July 2023 or January 2024), or funding ten additional areas for 2024, ten additional areas for 2025, and ten additional areas for 2026. If areas are not funded at the local level, the system will be limited to the protocols and the one-hour response by the mobile crisis teams. Additionally, if additional areas are not funded, ancillary local costs such as computer-aided dispatch (CAD) changes, data collection, and reporting by public safety answering points (PSAPs) would have to be absorbed by the locality. Regarding costs of interoperability, the cost per PSAP for integrating software that allows communication between two applications (APIs) into their CADs (which is what they have done for Text-to-911) has come at a cost of approximately $20,000 - $45,000 per PSAP. More specific estimates of cost will be available once the Call Center Data Platform vendor's capabilities are fully understood (e.g., if they are able to host vendor-agnostic APIs).

Component	Date available
Locally-defined additional community coverage: areas 1-5	December 1, 2021
Marcus Alert Protocols #1-3 (statewide)	July 1, 2022
Locally-defined additional community coverage: areas 6-10	July 1, 2023*
24/7 Coverage by 1 hr response mobile crisis teams (statewide)	July 1, 2024
Locally-defined additional community coverage: areas 11-20	July 1, 2024*
Locally-defined additional community coverage: areas 21-30	July 1, 2025*
Locally-defined additional community coverage: areas 31-40	July 1, 2026*

**contingent on state grants for additional areas*

Progress towards Measurement – Comprehensive Crisis System

DBHDS is responsible for data from the crisis call center data platform, that will include behavioral health only responses and behavioral health responses with law enforcement back up, and data on calls transferred from 911 to 988. It is the intent that data from 911 centers be reported to the crisis call center data platform, although the technical details have not yet been completed. DCJS is ultimately responsible for data from law enforcement only encounters, although we are working together to create processes which work for all partners.

Crisis Call Center Data Platform

The majority of the data required to assess the comprehensive crisis system will be collected using the Crisis Call Center Data Platform. In summer 2021, a contract was awarded to Netsmart who serves as the primary vendor and has a subcontract with Behavioral Health Link. Behavioral Health Link is the platform operated for the state of Georgia. The tool provides off-the-shelf tools for intake, mobile crisis dispatch, bed registry (including Crisis Stabilization Units, Crisis Therapeutic Homes, Private Psychiatric Hospitals, and State Hospitals), appointment scheduling, and data analytics. These components will provide a base functionality that training will be provided for key system partners in November 2021. The go live data for the base functionality is December 1, 2021. Work on the crisis call center data platform will advance in two phases:

- Phase 1 implementation will start the process of better data visibility for crisis functions that will only improve as integrations increase.
- Phase 2 will focus on systems integrations that will provide broader functionality with system partners and will be an ongoing process with potential completion near July 2022.

Summary of Comprehensive Crisis System Measures

It is expected that any crisis provider who is part of the overall crisis system will be integrated into the data platform, in which case this could be used as the data source. Supplementary

records to ensure that all crisis providers are known include DBHDS licensing records, budgets submitted for projects funded with funds managed by DBHDS, and records from monitoring visits and site reviews. The records from the data platform and these supplementary data sources (if needed) will be used to assess the overall build out of the comprehensive crisis system (e.g., number and location of providers/teams), coordination between the local systems and regional components, successes and problems encountered, and recommendations for improvement. For successes, problems encountered, and recommendations for improvement, stakeholder input in the form of the ongoing six-month stakeholder meetings and feedback and review by the Crisis Coalition will also be reported.

Below is a summary of the elements that will be gathered from DBHDS licensing, records, monitoring visits, and the Crisis Call Center Data Platform.

Comprehensive Crisis System and Growth

Overall the growth of the comprehensive crisis system will be measured using data from the call center platform (as providers will be under MOU), licensing and DBHDS records. This will include the number, address, location, and capacity. For DBHDS funded providers, this will also include geographical coverage, length of stay, service array, population served, referral source, hours of operation, physical space, and staff composition. Regardless of funding source, the definitions for Project BRAVO will be utilized to define any Medicaid reimbursable services and DBHDS definitions will be utilized for any which are not Medicaid services. Components included will be:

- Crisis stabilization units (CSU),
- Crisis Receiving Center (CRC),
- Crisis Intervention Team Assessment Center (CITAC), 23-hour observation,
- REACH Crisis Therapeutic Home,
- Peer Retreat (those funded by DBHDS, this is not a licensed service),
- STEP-VA Mobile Crisis Teams and specializations (e.g., child, adult, developmental disabilities),
- Other Mobile Crisis Teams (licensed providers and/or Medicaid providers of mobile crisis service), and
- Community Care Teams (those formed through the Marcus Alert implementation; this is not a specific licensed service).

Data Associated with Individual Encounters

In addition to measuring and reporting on growth in the structural components that comprise the comprehensive crisis system, the table below focuses on data needed from each individual encounter with the comprehensive crisis system. Note that standard call metrics that NSPL requires (e.g., length of call) are not included since they will already be incorporated.

Indicator	Associated Question(s)	Component of Crisis Continuum	Level of Detail Desired	Reliable Data Source
Origination	Is the C/MCT dispatched as a result of a direct call to 988 or a transferred call from 911?	STEP-VA Mobile Crisis Team Mobile Crisis Team Community Care Team	Individual Encounter	Crisis Call Center Data Platform[1]
Response Time	How long does it take for the C/MCT to arrive on site?	STEP-VA Mobile Crisis Team Mobile Crisis Team Community Care Team	Individual Encounter	Crisis Call Center Data Platform
Encounter Length	How long does the C/MCT remain on site with the individual?	STEP-VA Mobile Crisis Team Mobile Crisis Team Community Care Team	Individual Encounter	Crisis Call Center Data Platform
Backup	Did the encounter require law enforcement backup? Which LE agencies and/or LEO provided backup?	STEP-VA Mobile Crisis Team Mobile Crisis Team Community Care Team	Individual Encounter	Crisis Call Center Data Platform
Encounter Outcome	What was the result of the encounter? For example, was the individual transported to another location? If so, how and where? Were there any injuries?	STEP-VA Mobile Crisis Team Mobile Crisis Team Community Care Team	Individual Encounter	Crisis Call Center Data Platform
Individual in Crisis[6]	What is the self-identified race/ethnicity of the individual in crisis? Does the individual have a mental health and/or ID/DD diagnosis?	STEP-VA Mobile Crisis Team Mobile Crisis Team Community Care Team	Individual Encounter	Crisis Call Center Data Platform

Progress towards Measurement – Marcus Alert

Marcus Alert specific data points will be gathered from DBHDS and DCJS records as well as PSAPs/911 Centers. DBHDS and DCJS records will be utilized to provide summary information about approved local programs, including application materials (e.g., minimum standard checklists) and information gathered from ongoing technical assistance and/or site visits. For successes, problems encountered, and recommendations for improvement, in addition to utilizing information from the implementation sites, stakeholder input in the form of the ongoing six-month stakeholder meetings and feedback and review by the Crisis Coalition will also be reported in the yearly report.

Currently, there are no areas in Virginia with approved Marcus Alert protocols. The five initial areas have all submitted their materials and they are now under review.

[1] These data points are under development with the vendor for the crisis call center data platform. At this time, it appears feasible for all responding behavioral health teams to be able to report using the Crisis Call Center Data Platform. Details about how they will access a data portal, etc., are not available at this time.

Marcus Alert Measures in Development

Of the required measures for this report, three key measures remain in development. In general, these are the measures that require data integration between multiple agencies, and where variability within agency types exists (e.g., differences in CAD functionality between different PSAPs). Interoperability and data integration between 911 centers, law enforcement, and other governmental entities, such as behavioral health providers or authorities are areas being developed nationally, with known challenges.

All events which are captured by the data call center platform (i.e., when a call comes directly to 988, a call is transferred from 911 to 988, a mobile crisis team is dispatched, or law enforcement brings an individual to a CITAC or Crisis Receiving Center) will have the required data points for individual encounters, to include the required elements (injuries, race/ethnicity, disposition) to evaluate the three measures in development.

Yet, per Protocol #3, there will be situations where behavioral health responders are not part of the response, including situations where it is not known to be a behavioral health emergency at the time of call or response, circumstances where law enforcement must respond urgently, or other factors (including areas who will not be implementing teams for a number of years; they will be relying on Protocol #3 until such teams become available 24/7). These situations are some of the most important situations to capture to understand the functionality of the system as a whole and to capture to reliably measure any racial disparities.

General conversations were held during the stakeholder planning group about desired data points regarding 911 center and law enforcement responses to Marcus Alert situations, but the vendor for the call center data platform had not yet been selected. A small group of the PSAPs from the initial areas and the DCJS and DBHDS Marcus Alert staff have begun meeting to work through these issues and determine how the call center vendor can design the system to be able to capture this additional data. Although technical details remain incomplete regarding the process, there is a general understanding across local areas and regional call centers that quarterly data from each PSAP (or for the entire area covered by multiple PSAPs) regarding the number of Marcus Alert 1, 2, 3, and 4 calls will be required beginning in FY 2023. This base data will allow for a statewide view of call classifications and any geographical differences in number of calls classified at each level. However, there are limitations to using only base data, including an inability to track some racial disparities, and an inability to measure injuries during all crisis events. DBHDS is considering contingencies should base data need to be relied on.

Because interoperability between the call center data platform and the various CAD systems used across the state is not yet fully understood, additional PSAP and law enforcement data points remain in development. As described, in addition to the data captured from the Call Center Data Platform which focuses on the comprehensive crisis system, the first priority will be the base PSAP data regarding calls at each level as described above. The second key priority will be information on dispatches in response to calls classified as Marcus Alert 1, 2, 3, and 4 calls. The third key priority will be information on disposition of calls in response to calls classified as Marcus Alert 1, 2, 3, and 4 at the time of the call or at the time of the response (e.g., law enforcement, EMS). Depending on modes of data transfer that are possible across the state, the disposition data would be where information regarding individual encounters for law enforcement only interactions would be captured.

Progress and Challenges in Building Additional Data Points

Required Indicator	Existing Sources	Issues/Unknowns with Interoperability and ability to collect
Number of crisis incidents and injuries to any parties involved	Number of incidents and whether any injuries occurred in all incidents that are ultimately connected to the call center data platform will be captured. PSAP data and law enforcement disposition data (potentially through PSAP reporting) for situations which are not ultimately connected to the crisis system is still needed	CADs are highly variable in the information they collect and retain (e.g., some CADs write over original call classifications when a class classification changes in the field; others retain the original classification and changes to classification are not recorded). It is unclear to what extent disposition information such as injuries incurred can be sent back to the CAD and then transferred to the call center.
Overall operation of local protocols or programs	Transfers to 988 will be captured in the call center data platform. PSAP data on dispatch and PSAP/law enforcement disposition will be required to assess all situations including those which are not ultimately connected to the crisis system.	Volume of all calls classified as Marcus Alert situations (1,2,3, and 4) is the first priority and is being worked on collaboratively between initial area PSAPs, DBHDS, and DCJS As described above, dispatch and disposition data for law enforcement situations not connected to the comprehensive crisis system remain in development by DCJS
Disparities in response and outcome by race and ethnicity	Demographic information will be collected for all encounters that come through 988 or reach the comprehensive crisis system (and thus, the data platform). Demographic information for encounters which do not reach the comprehensive crisis system would need to be collected and reported by the PSAP and/or law enforcement. Could be captured at time of call classification or disposition.	As described above, dispatch and disposition data for law enforcement situations which are not connected to the comprehensive crisis system remain in development by DCJS.

By July 2022, DBHDS will continue to work to make sure that these indicators are available for all Marcus Alert situations which ultimately addressed by the comprehensive crisis system (and thus are reported through the Crisis Call Center Data Platform). DCJS will continue to work to identify ways for these indicators to be made available through PSAP data, expanded CIT data

collection, or another form of data collection for law enforcement-only encounters.

Summary of Reporting and Evaluation Progress and Sources

Below is a summary of measures and current status.

Required Indicator	Progress and Source
Comprehensive Crisis System	
Number of calls to the crisis call center	Crisis Call Center Data Platform
Number of mobile crisis responses	Crisis Call Center Data Platform
Number of crisis responses that involved law-enforcement back-up	Crisis Call Center Data Platform
Overall function of the crisis system	DBHDS records for: • Scope and build out; active licenses; active MOUs and users of data platform • Crisis Call Center Data Platform for: • Response time, referral source, disposition (retained in setting)
Local Marcus Alert Systems	
Number and description of approved local programs	DBHDS and DCJS records
Interface between local programs and comprehensive crisis system	DBHDS and DCJS records
Number of crisis incidents and injuries to any parties involved	**Development in process** *(currently possible for incidents that connect to the comprehensive crisis system, but not all events to include law enforcement only events)*
Successes and problems encountered	DBHDS and DCJS records from site visits, survey, interviews
Overall operation of local protocols or programs	**Development in process** *(summary of attestation to minimum requirements and best practices will be available; additional measures capturing performance across the system require additional development)*
Disparities in response and outcome by race and ethnicity	**Development in process** *(currently possible for incidents that connect to the comprehensive crisis system, but not all events to include law enforcement only events)*
Recommendations for improvement	DBHDS and DCJS records from site visits, survey, informal interviews, technical assistance provided throughout the year, stakeholder meetings and coalition report

As Marcus Alert implementation continues, DBHDS will work with state and local partners to expand on data reporting capabilities.

Summary

Thus far, the implementation of the Marcus-David Peters Act is on schedule, with the comprehensive state plan completed by July 1, 2021 and initial areas due to reach a preliminary implementation by December 1, 2021. Because of the interconnectedness of the different components of the crisis system, not all features will be fully operational on December 1, 2021. This is primarily due to the build out of five regional call centers which are currently under development. Initial areas are working closely with their call centers under development and temporary processes are being stood up to ensure that initial implementation occurs on time. For example, a secondary law enforcement only phone line will be utilized at the beginning of implementation to ensure that all law enforcement calls from Marcus Alert areas are prioritized by the call center as the broader call center infrastructure continues to develop.

In addition, statewide coverage by mobile crisis teams (one-hour response) continues to grow and is expected to be robust, statewide, and available 24/7 by July 1, 2024. The local protocols are required statewide by July 1, 2022. The level of additional local supports for community coverage to be achieved statewide will be contingent on the level of funding available as well as the local planning processes that are currently underway.

Building Virginia's comprehensive crisis system and incorporating Marcus Alert programs statewide will require significant planning and coordination on the state, regional and local levels. Overall, through Marcus Alert implementation, Virginia's is well underway to improve the intersection of behavioral health and law enforcement and divert people in crisis to the best community service that meets their needs.