COMMONWEALTH of VIRGINIA

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COMMISSIONER

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November 15, 2024

To: Governor Glenn A. Youngkin
The Honorable Patrick A. Hope, Chair, House Courts of Justice Committee
The Honorable Mark D. Sickles, Chair, House Health & Human Services Committee
The Honorable Scott A. Surovell, Chair, Senate Courts of Justice Committee
The Honorable Ghazala F. Hashmi, Chair, Senate Education & Health Committee

From: Nelson Smith, Commissioner, Department of Behavioral Health and Developmental Services

RE: § 37.2-311.1 of the Code of Virginia, Annual Report on Marcus Alert & the Comprehensive Crisis System

§ 37.2-311.1 of the Code of Virginia directs the Department of Behavioral Health and Developmental Services (DBHDS) to report on the impact and effectiveness of the comprehensive crisis system and to work in collaboration with the Department of Criminal Justice Services to include an update on the implementation of the Marcus Alert System in this report. The language reads:

D. The Department shall report annually by November 15 to the Governor and the Chairmen of the House Committees for Courts of Justice and on Health and Human Services, the Senate Committees for Courts of Justice and on Education and Health, and the Behavioral Health Commission regarding the comprehensive crisis system and the effectiveness of such system in meeting the goals set forth in this section. The report shall include, for the previous calendar year, (i) a description of approved local Marcus alert programs in the Commonwealth, including the number of such programs operating in the Commonwealth, the number of such programs added in the previous calendar year, and an analysis of how such programs work to connect the Commonwealth's comprehensive crisis system and mobile crisis response programs; (ii) the number of calls received by the crisis call center established pursuant to this section; (iii) the number of mobile crisis responses undertaken by community care teams and mobile crisis teams in the Commonwealth; (iv) the number of mobile crisis responses that involved law-enforcement backup; (v) the number of crisis incidents and injuries to any parties involved; (vi) an analysis of the overall operation of any local protocols adopted or programs established pursuant to § 9.1-193, 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; (vii) a description of the overall function of the Marcus alert program and the comprehensive crisis system, including a description of any successes and any challenges encountered; and (viii) recommendations for improvement of the Marcus alert system and approved local Marcus alert programs. The report shall also include (a) a description of barriers to establishment of a local Marcus alert program and community care or mobile crisis team to provide mobile crisis response in each geographical area served by a community services board or behavioral health authority in which such program and team has not been established and (b) a plan for addressing such barriers in order to increase the number of local Marcus alert programs and community care or mobile crisis teams. The Department of Criminal Justice Services shall assist the Department in the preparation of the report required by this subsection.

Please find enclosed the report in accordance with § 37.2-311.1. Staff are available should you wish to discuss this request.

cc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources Secretary Janet V. Kelly

DBHDS

Virginia Department of Behavioral Health and Developmental Services

Report on Marcus Alert and the Comprehensive Crisis System, FY 2024

(§ 37.2-311.1 of the Code of Virginia)

January 14, 2025

DBHDS Vision: A Life of Possibilities for All Virginians

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Preface

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§ 37.2-311.1 Report on Marcus Alert & Comprehensive Crisis System

Table of Contents

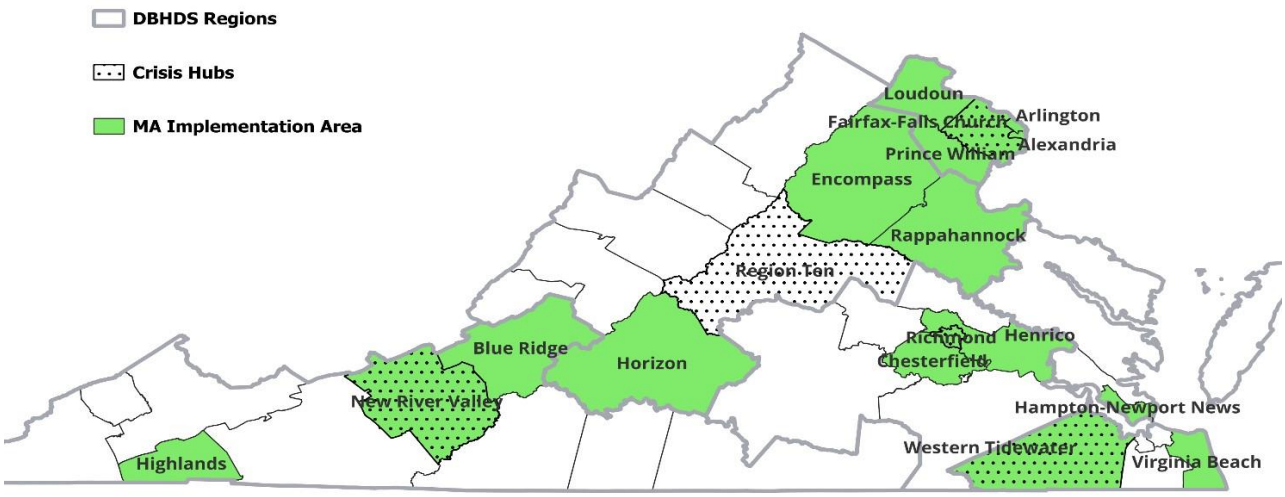
Executive Summary

During the 2020 Special Session I of the General Assembly, the Marcus-David Peters Act was written to support development of an interconnected statewide framework for behavioral health crisis response. The Act was created in memory of Marcus-David Peters, who tragically lost his life 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. This report provides an overview of the implementation process thus far and progress made towards the measurement of each indicator required in the act. The summary of the state plan for implementation including details of the planning process of the Marcus-David Peters Act can be found here: State Plan for the Implementation of the Marcus David Peters Act.[1]

Implementation of the Marcus-David Peters Act has followed the original schedule thus far, with the first five sites launched December 1, 2021, and an additional 12 Marcus Alert programs beginning on July 1, 2024. The availability of crisis services has grown tremendously since the passing of the legislation. All 17 Marcus Alert sites have worked closely with their regional crisis call centers to implement protocols for Marcus Alert. The 911 Centers/Public Safety Answering Points (PSAPs) have incorporated Marcus Alert data collections elements within their Computer Aided Dispatch (CAD) systems to capture metrics related to Marcus Alert instances. The Department of Behavioral Health and Developmental Services (DBHDS) is working to meet the statewide implementation of all 40 Marcus Alert programs by July 1, 2028, as required. At this time, funds have only been allocated to the established first 17 sites (Figure 1).

Figure 1. Active Marcus Alert Sites and Crisis Hubs as of FY 2024

[1] https://www.dbhds.virginia.gov/assets/doc/hr/Health-Equity/mdpa/final-state-plan_july-1-2021_ma.pdf



Areas of focus for this reporting period include:

- **Regional Implementation** – 17 Marcus Alert programs have launched in the five DBHDS regions.
- **Launching Additional Regional Sites** – The six community services boards (CSBs) identified as FY 2025 planning sites are considering with their local partners if any planning activities can be started without funds, or if planning should be delayed.
- **Local Marcus Alert Programs** – Three local Marcus Alert protocols were required by initial areas on December 1, 2021. The level of additional local supports for community coverage to be achieved statewide will be contingent on the level of funding available and the local planning processes. These three local protocols include (1) diversion of appropriate 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.
- **Virginia's Comprehensive Crisis System** – Marcus Alert is one aspect of the ongoing infrastructure development of Virginia's Comprehensive Crisis System. This transformation began during the 2020 Session and is continuously supported by Governor Youngkin's *Right Help, Right Now* initiative. The purpose is to improve how individuals who are experiencing behavioral health crises receive services by providing someone to call, someone to respond, and somewhere to go. Marcus Alert connects these structural changes.
- **Progress Toward Measurement** – DBHDS continues to enhance the operating systems of Marcus Alert. Data collection has been incorporated in Virginia's Crisis Connect (VCC) platform in addition to the data collected by PSAPs. The incorporation of other functions such as dispatching Mobile Crisis Response, state hospital tracking capabilities, and community resource dictionaries were also launched in VCC. Further data collection of Community Care Teams to further evaluate progress towards measurement has also begun. DBHDS and the Department of Criminal Justice Services (DCJS) continue to utilize statewide stakeholder meetings and site visits with the implemented areas as sources of measurement.
- **Addressing Barriers and Recommendations for Improvement** – DBHDS continues to coordinate with the areas who have already implemented Marcus Alert to inquire about barriers

and collaborate on recommendations. This information is used to improve state lead implementation, policies, and procedures. 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 culpabilities.

Background

Marcus-David Peters was a young, Black public-school teacher who died in Richmond, Virginia 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 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 were implemented on December 1, 2021. This report provides a timeline and overview of the implementation process thus far and progress towards the measurement of each indicator.

Marcus Alert Systems
In addition to the crisis system components implemented at the state and regional level, Marcus Alert has components which are implemented at the local level per the legislation. DBHDS created the Marcus Alert Local Plan Guide in April 2022 to assist localities in the planning and development of a Local Marcus Alert program.[2] The local required components are as follows:

1. Local Agency Inventory
2. Stakeholder Member List
3. Marcus Alert Responses
4. Protocol 1
5. Protocol 2 (not required for those choosing to be exempt)
6. Protocol 3 (not required for those choosing to be exempt)
7. Budget
8. Contact Information

The initial five areas submitted detailed implementation plans on October 15, 2021 (Table 1), followed by additional areas on July 1, 2023 and July 1, 2024 (Tables 2 and 3). These areas were reviewed by DBHDS and the Department of Criminal Justice Services (DCJS). Presently, 16 of the sites have been granted conditional approval and one has been fully approved. For the other sites, DBHDS and DCJS continue to reevaluate policies and procedures to assist communities in obtaining full approval.

Each area has affiliated Law Enforcement Agencies and Public Safety Answering Points (PSAPs) that are participating in all three protocols listed below. Please see Appendix A for details. All PSAPs are required to participate in Protocol 1.

[2] https://dbhds.virginia.gov/wp-content/uploads/2022/05/Marcus-Alert-Local-Plan-Guide-4.22.pdf

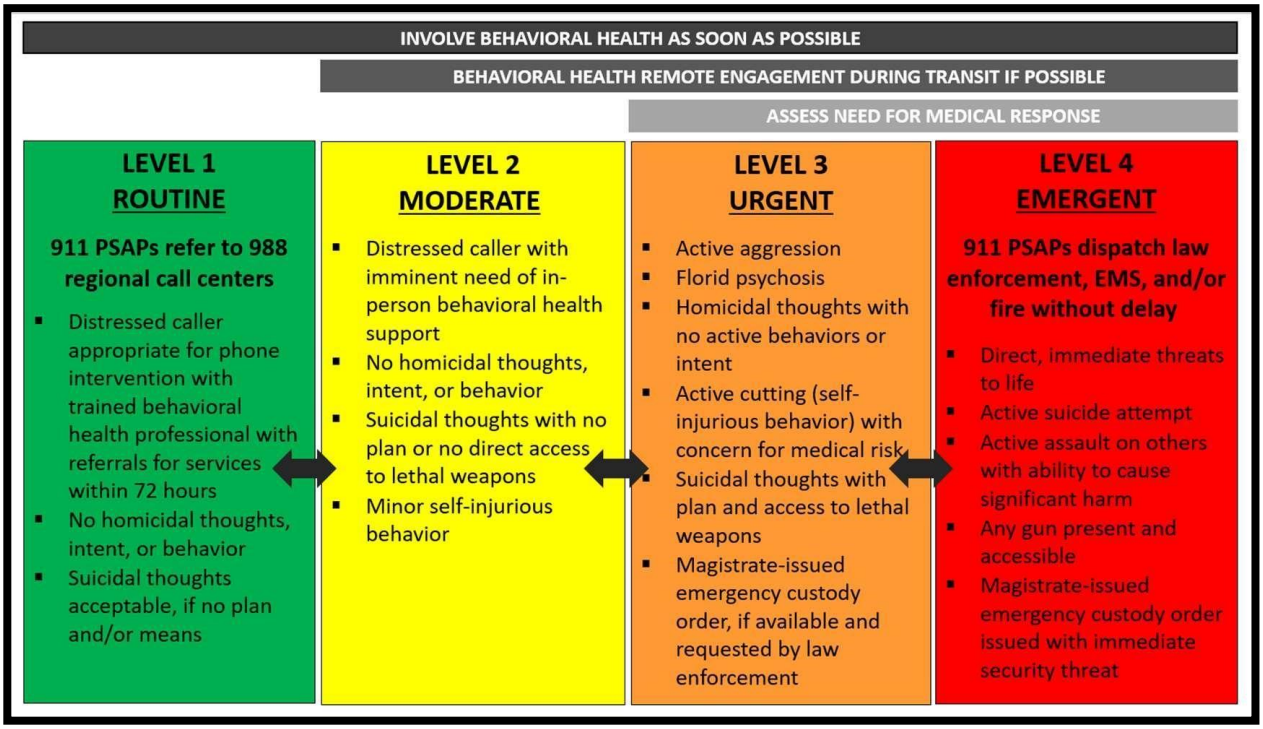
A complete Marcus Alert System implements three required protocols:

1. 911 Call Diversion,
2. Memorandum of Understandings (MOU) between agencies that includes a requirement that participating Law Enforcement provide backup to Mobile Crisis Response, and
3. Specialized Response by Law Enforcement in accordance with minimum standards and best practices published by DBHDS and DCJS.

The three protocols were required statewide by July 1, 2022, and community coverage is being phased in over several years per the legislation.

The State Level Triage Framework (Figure 2) is designed to assist 911 Call Takers in diverting calls to the 988 system. 911 is required to divert Level 1 calls to 988. Level 2 calls are recommended to have a mobile crisis dispatch; however, as mobile crisis continues to develop across Virginia other response options are utilized. Level 3 calls are recommended to utilize specialized teams such as CSB-developed community care teams, Children's Mobile Crisis, or the Regional Education Assessment Crisis Services Habilitation (REACH) for developmental disabilities, when relevant. Level 3 calls also frequently involve law enforcement and thus require a law enforcement specialized response, such as behavioral lead Co-Response teams, at the scene. Level 4 calls require a 911 dispatch due to a concern of imminent risk with the caller, though some implementing areas choose to have mobile crisis teams respond to the individual after law enforcement declares the scene safe.

Figure 2. State Level Triage Framework



Community Care Teams

The Marcus Alert system encourages the development of community care teams. These are constructed by each CSB to meet the needs of the jurisdictions they serve. Development of these teams requires coordination and collaboration from various stakeholders to include law enforcement, fire/EMS, community organizations, and other behavioral health agencies. CSBs will spend most of their planning year coordinating with these named agencies to determine the needs of their communities. Typically, the goal of these teams is to increase access to the appropriate form of behavioral health services while reducing the burden of law enforcement.

All 17 implemented CSBs have partnered with area first responders construct teams to improve quality of treatment in their communities. First responders site several barriers to facilitate a united approach, including a lack of staffing and resources for calls dispatched for behavioral health crises. The development of behavioral lead co-response teams helps address this issue.

Teams can consist of law enforcement, fire/EMS, clinicians, and/or peer recovery specialists (Table 4, below). Each team varies in functionality and availability. Most are included as response options in the localities Marcus Alert Local Plan under community response to address intermediate Marcus Alert level calls. Some teams have the capability to be dispatched by the local PSAP. Reports given by CSBs demonstrates these community care teams have reduced the time law enforcement spends on Emergency Custody Orders (ECOs) and Temporary Detention Orders (TDOs). Additionally, they have high success rates of diverting individuals back into the community or connecting them with less restrictive services in Virginia's comprehensive crisis continuum such as Crisis Intervention Team Assessment Centers (CITACs), Crisis Receiving Centers (CRCs), and Crisis Stabilization Units (CSUs).

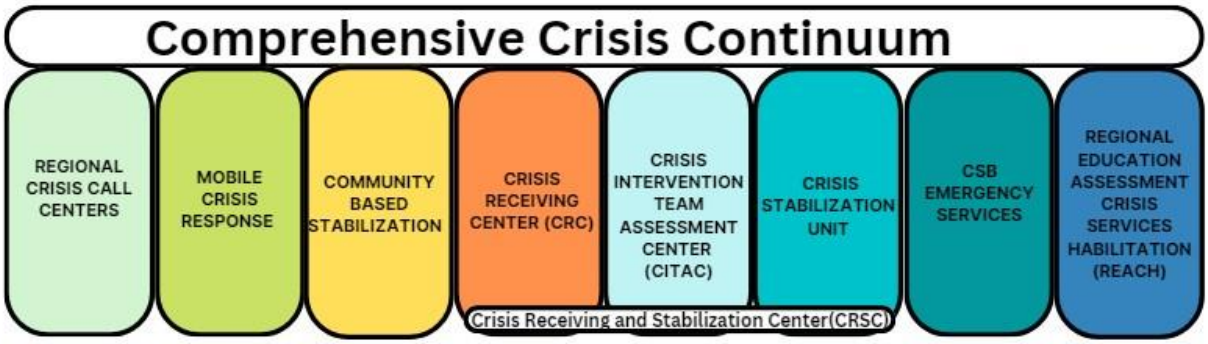
Table 4. Marcus Alert Co-Response Teams Implemented as of July 1, 2024

Community Services Board	Co-Response Team Composition
Encompass Community Services	Clinician and Law Enforcement
Prince William Community Services	Clinician and Law Enforcement
Highlands Community Services	Clinician and Law Enforcement
Highlands Community Services	Clinician and Law Enforcement
Richmond Behavioral Health Authority	Clinician and Law Enforcement
Blue Ridge Behavioral Health	Clinician and Law Enforcement
Chesterfield Community Services Board	Clinician and Law Enforcement
Hampton-Newport News Community Services Board	Clinician Only Mobile Response and Fire/EMS/Clinician Co-Response
Horizon Behavioral Health	Clinician Only Mobile Response
Arlington Community Services Board	Clinician Only Mobile Response
Alexandria Community Services Board	Clinician and Law Enforcement
Loudoun Community Services Board	Clinician and Law Enforcement
New River Valley Community Services Board	Clinician, Law Enforcement, and Peer
Henrico Area Mental Health & Developmental Services	Various Teams with Law Enforcement, Fire/EMS, and Clinicians
Western Tidewater Community Services Board	Fire/EMS/Clinician Co-Response

Virginia's Comprehensive Crisis System

Virginia is currently transforming public behavioral health services to develop a comprehensive crisis system that will be available for the entire Commonwealth. This shift began during the development of the Marcus Alert legislation and has grown through Governor Youngkin's *Right Help, Right Now* initiative. That means all Virginians will be able to access high quality behavioral health services aimed at managing symptoms before they reach crisis-level and avoiding expensive, restrictive in-patient services or possible incarceration. Combining a series of components, Workstreams One and Two of *Right Help, Right Now* create opportunities for community members to have someone to call, someone to respond, and somewhere to go (Figure 3). This initiative 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. The graphic below highlights major components of Virginia's Comprehensive Crisis System.

Figure 3. Components of the Virginia Comprehensive Crisis System



In 2021, Virginia was the first state to pass a 988 cell phone tax, via Senate Bill 1302. The infrastructure changes that follow Marcus Alert implementation allow for increased utilization of Regional Crisis Call Centers and the three-digit 988 National Suicide Prevention Lifeline supports and services. The 988 line is managed by two regional crisis call centers under the purview of five CSBs representing each DBHDS region: Region Ten 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).

Marcus Alert plays a critical role in connecting the interoperability of law enforcement and behavioral health systems, as well as systems seen in the Comprehensive Crisis Continuum. This is shown by outlined roles and responsibilities within the MOUs for 911 call takers to transfer Level 1 calls to 988, relieving 911 call centers of non-emergency calls. While not required within the Marcus Alert legislation, the 17 implemented areas have also mutually agreed to transfer Level 2 calls to 988 with the intention of utilizing Mobile Crisis Response as appropriate.

Additionally, all the implemented sites have various compositions of co-response teams (Table 4). These teams increase behavioral health led responses while offering further relief for law enforcement agencies. In conjunction with the ability to divert individuals in crisis in the community, co-response teams also utilize the less restrictive community-based services such as CITACs, CRCs, and CSUs. Marcus Alert and *Right Help, Right Now* work in concert by addressing behavioral health crises within various levels of severity, providing a behavioral health led response to each incident that reduces the burden on law enforcement, and encourages the utilization of community-based services defined in the Comprehensive Crisis Continuum.

Progress Toward Measurement – Comprehensive Crisis System

DBHDS is responsible for data from VCC, which will include behavioral health only responses, behavioral health responses with law enforcement back up, and calls transferred from 911 to 988. It is the intention 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.

Virginia Crisis Connect

Most of the data required to assess the comprehensive crisis system is being developed for collection in the VCC Platform. VCC, previously referred to as the call center data platform, is built off the Behavioral Health Link platform operated for the state of Georgia. The platform provides tools for intake, mobile crisis dispatch, facility referral/bed registry (including CSUs, Crisis Therapeutic Homes, Private Psychiatric Hospitals, and State Hospitals), resource referral, and data analytics. These components will provide a base functionality with training being provided to users in ongoing format and as new modules are released.

VCC went live on December 1, 2021, and has rolled out new modules each subsequent year. It has built out functionality for receiving and triaging crisis calls and is currently utilized by all regions. The mobile dispatch functionality has also been completed. On December 15th, 2023 began statewide dispatch of both public and private providers of Mobile Crisis Response as the centralized dispatch platform for the service. While VCC continues to progress in development, there have been some delays due to contract and project changes as well as configurations for regional differences. These regional differences are critical considerations to ensure that each region can successfully meet the needs of their regions. These considerations include navigating the volume and training of private providers for each region.

In 2024, VCC completed two enhancement modules: 1) Community Resources – an integration of all national 211 resources enhances the ability of call center staff to identify and connect individuals to community resources as a follow up to access crisis services; and 2) Messaging and Communication – this allows call center agents, mobile dispatch, and mobile team members to communicate in real time to effectively and efficiency provides crisis services to Virginians.

VCC can both monitor the sending and acceptance of referrals by hospital and the ability to track bed inventory across systems. This module is fully actively receiving enhancements based on user-experience by CSB Emergency Services staff and admissions staff at both private and state facilities. DBHDS is in the midst of full implementation of the module, CSB Emergency Services is in a pilot phase of sending referrals to the state mental health hospitals, the state bed inventory is being prepared for automated update, and private hospital admission staff are participating in user trainings. Full implementation by all three user types is anticipated by the end of 2024. Private hospitals will have the ability and will be expected to manually update their bed inventory, which is functionality independent of receiving and accepting or rejecting referrals by CSB Emergency Services staff.

Call Center Data for Calendar Year 2023

In calendar year 2023, a total of 72,886 calls to 988 were routed to Virginia, with an average answer rate of 91 percent. Table 5 shows a monthly breakdown of calls provided Vibrant Emotional Health, the 988 Administrator.

Table 5. Summary of In-State Call Metrics: KPIs for Calls in Virginia

CY 2023	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Routed	6,017	5,331	5,692	5,671	6,017	5,679	6,057	6,075	5,941	6,428	6,236	7,742
Received	6,017	5,331	5,692	5,671	6,017	5,679	6,057	6,075	5,941	6,428	6,236	7,742
Answered In-State	5,261	4,747	5,223	5,239	5,553	5,223	5,557	5,540	5,343	5,853	5,601	6,841
In-State Answer Rate	87%	89%	92%	92%	92%	92%	92%	91%	90%	91%	90%	88%

Note. This is a monthly breakdown of calls routed to Virginia call centers. The in-state rate provides the total number of answered in-state calls over the total number of calls routed to the state.

Mobile Crisis Response Data

DBHDS began to collect mobile crisis utilization regarding our youth services from our five regional hubs on July 1, 2021 (Figure 4). With the anticipation of the Crisis Data Platform, adult mobile crisis utilization was not collected. The regional hubs are managed by a local community service board, listed below, and, together, they served over 6,500 individuals in FY 2024:

Region 1: Region Ten Community Services Board

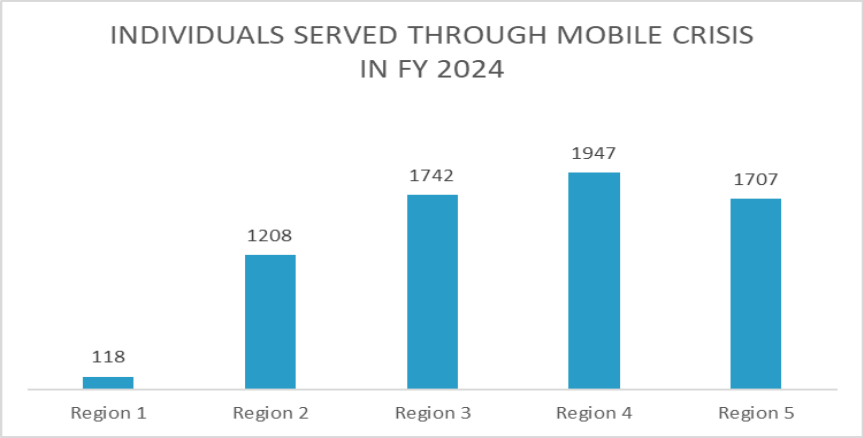
Region 2: Fairfax-Falls Church Community Services Board

Region 3: New River Valley Community Services Board

Region 4: Richmond Behavioral Health Authority

Region 5: Western Tidewater Community Services Board

Figure 4. Individuals Served Through Mobile Crisis, FY 2024



Progress Toward Measurement – Marcus Alert

The progress of Marcus Alert is measured by multiple quantitative and qualitative variables. Marcus Alert specific quantitative data points are currently only gathered from PSAPs/911 centers and reported to DBHDS. These data points provide insight into the progress of Marcus Alert and elicits areas of opportunities for improvement identified throughout this report. DBHDS and DCJS also provide qualitative summaries about approved local programs, including application materials (e.g., minimum standard checklists) and information gathered from ongoing technical assistance and/or site visits. Meanwhile, stakeholder input in the form of ongoing six-month stakeholder meetings is utilized as another evaluation source.

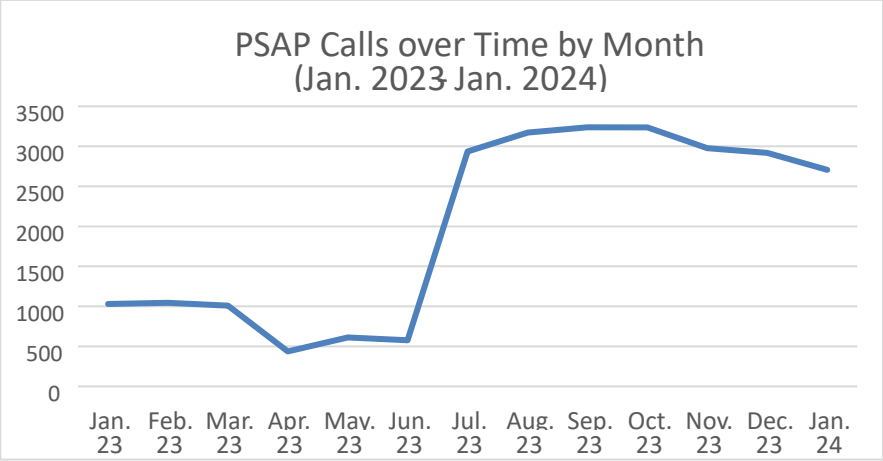
Virginia's 17 sites with fully operating Marcus Alert programs include primary PSAP centers collecting data regarding Marcus Alert level calls. This is done in tandem with the build out of the Crisis Call Center Data Platform. Additionally, PSAP centers are tasked with incorporating the data elements required within each unique CAD system. These data points are collected to identify response trends, call volumes, the various Marcus Alert levels encountered, and track the transferring of calls (Figure 5). Data points that are currently required from PSAPs/911 centers include date, time, PSAP or incident number, and dispatch outcomes. With the implementation of PSAPs each fiscal year, trends indicate that call volumes increase in July during the calendar year.

DBHDS is currently in the process of expanding data points to be collected from co-response and/or community care teams operating under the Marcus Alert framework. The inclusion of this data will increase the opportunities DBHDS will have to follow crisis incidents from beginning to end. Additionally, DBHDS will have the opportunity to share pertinent information such as time saved on behavioral health crises for law enforcement, racial and ethnic disparities related to response and disposition, injuries during behavioral health crises, and further identification of populations in need of resources during behavioral health crises such as neurodivergent and homeless groups. DBHDS projects the collection of this data to begin April 1, 2025.

In addition to data collection efforts at the PSAP level, data elements were also added to VCC to collect information regarding Marcus Alert instances. These elements include the Marcus Alert level identified, the outcome of the call as well as outcome of mobile crisis response, if applicable. Demographic information on each call is also captured such as gender identity, race, and location. Reports from the data collection in the Crisis Call Center Platform is also included in this report.

Subsequent Marcus Alert reports will include an expected summary of metrics, including response times, demographic information, and outcomes of Marcus Alert related instances. To do so, 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.

Figure 5. PSAP Calls over Time by Month



Note: Monthly breakdown of calls received by PSAPs, identifying a trend of consistency in volume over time. There were seven new sites implemented in July 2023, leading to the jump in number of reported PSAPs.

Identified Barriers for Implementation

Local plans for the implementation for all 17 Marcus Alert site were submitted to DBHDS and DCJS to review and determine approval status. Each local plan submission included a barrier statement which is representative of each implementing area's CSB, law enforcement agencies, and 911 agencies. While each area stated barriers specific to their community, common themes regarding implementation barriers are addressed below.

Culture Shift

The Marcus Alert framework promotes a shift in how behavioral health crises are handled, encouraging the involvement of behavioral health professionals when appropriate. However, this change has faced some resistance, as many individuals remain reluctant to embrace the new approach and continue to anticipate a law enforcement response when they call 911. This reluctance reflects a broader cultural shift, requiring a redefinition of behavioral health emergencies for both the public and first responders. Feedback to DBHDS shows that some community

members still prefer to rely on traditional first responder services for non-emergent crises. Some 911 call centers have reported instances where callers refuse to be transferred to 988, even after the situation has been classified as a low-level behavioral health crisis. Additionally, frequent callers continue to specifically request law enforcement or Fire/EMS, highlighting their hesitation to fully adopt the behavioral health-focused response. Liability concerns have also emerged, particularly when transferring calls to 988 after someone expresses suicidal ideation or when behavioral health professionals respond without law enforcement present. Lastly, communities report a lack of commitment and overall awareness of the Marcus Alert, contributing to this reluctance.

Staffing

Staffing continues to remain a barrier for all agencies participating in Marcus Alert programs. CSBs report difficulties finding licensed clinicians to participate in co-response teams. Particularly ones with experiences working in crisis situations and collaborating with law enforcement. PSAP and law enforcement agencies also report difficulties with hiring and retaining staff. Law enforcement specifically addressed identifying applicates interested in co-response.

Interoperability between Systems

Many communities identified difficulties with the coordination between 911 and 988. As stated above, 911 call takers are concerned with transferring low-level suicidal calls and have expressed a desire to expand their knowledge of the processes which occur once the call has been transferred. An overall complaint regarding the training on Marcus Alert for PSAPs, or the absence of such training, was also mentioned. Additionally, lack of training that addresses triaging and transferring calls specific to the interoperability between 911 and 988 have been reported. PSAPs and CSB members have expressed difficulties in obtaining records of calls that were not transferred to 911 or the appropriate response agency. These mishandled call transfers caused exacerbated behavioral health crises and inappropriate or delayed dispatches from behavioral health and first responders. Further collaboration between 988 and 911 to develop additional training was suggested. Lastly, the CAD systems utilized by PSAPs vary across the state which created challenges in developing policies and procedures to adopt the Marcus Alert triage framework, collecting data, and continuing to build relationships with 988 call centers.

Additional Funding

Agencies such as PSAPs report challenges with implementation due to lack of funding. While it is encouraged that CSBs provide funds from their budget to offset the costs of CAD changes, it is not mandated. Additionally, CSBs report inadequate amount of funds to develop sufficient co-response or community care teams. Regulatory and payor regulations have also been identified as a challenge in supplementing revenue to sustain and/or expand Marcus Alert programs.

Training

All participating agencies report various challenges with training regarding Marcus Alert. Law enforcement agencies report difficulties with resources to send their officers to the increased mental health trainings required within the legislation. Additionally, CSBs and first responders report confusion with various aspects of the Marcus Alert protocols. Currently, CSBs are the responsible party tasked with educating their affiliated agencies on Marcus Alert policies and procedures which has created inconsistencies with implementation throughout the Commonwealth.

Community-Based Services Accessibility
The areas with co-response or community cares teams report increased diversion rates. However, reports of difficulties with the accessibility of additional community resources are still apparent. Mobile Crisis Response has been funded to operate 24/7 throughout the entire state but continues to experience staffing challenges. Call answering times and capacity issues with 988 have also been identified as challenges. While CRCs and CSUs continue to be developed, communities still report the need for these resources to avoid unnecessary arrests and involuntary hospitalizations.

Addressing Barriers

Addressing Marcus Alert Barriers
DBHDS and DCJS continue to accept feedback from the communities implementing Marcus Alert to develop internal processes adjustments. DBHDS will meet with communities regularly throughout their planning year to address questions, concerns, or barriers identified with implementing. This includes revising budgets, offering alternative suggestions, confirming training questions/ideas, and facilitating partnered relationships. DBHDS has also made a commitment to hold a statewide stakeholder meeting which calls for an evaluation of implementation processes to identify options towards improvement.

DBHDS has made increased commitments to engage with partnered agencies through site visits and/or virtual meetings for those implementing Marcus Alert to assist with training and cultural shift practices. These include thorough revision of training materials submitted by CSBs during their planning year to ensure consistent messaging to be disbursed throughout the Commonwealth. Lastly, DBHDS is currently in the final steps of developing a statewide training for all behavioral health professionals, law enforcement officers, and 911 call takers which will provide further education on roles and responsibilities. The training consists of health equity content, triage frameworks, legislative information, and role plays to apply course content in real time.

DBHDS has increased efforts to bring community awareness towards Marcus Alert and 988. This includes developing campaigns and improving marketing efforts. Regional coordinators as well as CSBs have utilized relevant social media platforms, awareness months, and community events to assist with education of 988 and increase utilization. DBHDS has also taken advantage of similar practices in conjunction with the public awareness campaign to reinforce cultural shifts. Lastly, DBHDS continues to provide support and education on the ongoing development of community-based services as part of the Comprehensive Crisis System.

Addressing Mobile Crisis and Community Care Team Barriers
Mobile Crisis Coverage – Cross-trained as responders to behavioral health and developmental disability crises, mobile teams are trained to ensure adequate statewide 24/7 coverage. DBHDS's

initial goal of 70 publicly funded cross-trained Mobile Crisis Response (MCR) teams in early 2023 was quickly accomplished and a new goal was set in late 2023 for 140 publicly funded cross trained MCR teams. Currently, the teams are 70.5% staffed, with 102 fully operational publicly funded teams. The build out of the implementation of the Virginia Crisis Connect portal for MCR dispatch function and access to authorization codes for billing is fully operational with two call centers. DBHDS dispersed $1,597,000 to each of the five regional HUBs in February 2024 for use in recruiting and retention of funded and cross-trained MCR team members.

Community Care Teams – As mentioned above, funding and staff are also barriers impacting the availability of Community Care Teams throughout the Commonwealth. Specific to Co-Response Teams, availability of resources such as vehicles and safety equipment were also identified. DBHDS and DCJS continue to collaborate on areas for additional funding sources to assist. Additional training for Marcus Alert and community efforts for recruitment and retention are also being supported by both state agencies.

Recommendations for Improvement

Additional Funding

Legislative code amendments made during the 2022 General Assembly Session made 911's participation in Marcus Alert a statewide requirement, regardless of the county's population size. Fortunately, many 911 centers are eager to implement in advance of the 2028 deadline. However, funding is currently being allocated to the 17 established sites and does not fiscally support the "early adoption" of Marcus Alert by localities.

For 911 Centers, Marcus Alert requires significant changes to current workflows and operations. Currently, there is no identified funding source that could support the state level infrastructure needed to guide 911 Centers on triaging Marcus Alert calls or making the required technical changes into their CAD systems for Marcus Alert data collection.

Some localities prefer the creation of local community care teams that include co-response teams, law enforcement and mental health riding together or co-responding to calls. These teams can incur significant costs to cover both law enforcement and behavioral health staffing, training, unmarked vehicles, plain clothes uniforms, and other expenses.

Staffing

911 Centers currently face similar hiring shortages that Law Enforcement Agencies are struggling with. This shortfall in a workforce makes implementing additional initiatives such as Marcus Alert much harder on 911 Centers especially smaller agencies (Table 6; Table 7)

Law Enforcement Agencies also struggle with recruiting and retaining a workforce. Though Marcus Alert aims to relieve law enforcement from being the responding agency to behavioral health crisis, some situations still require their presence. Being short staffed, many agencies have expressed obstacles with meeting training requirements because they are unable to send officers to trainings when shifts are uncovered.

Behavioral Health providers are also an increasing constrained resource in Virginia. With a depleted workforce, standing up 24/7 Regional Mobile Crisis teams is a multi-year initiative. Individual CSBs, Health planning Regions, and DBHDS are all working on initiatives to recruit and retain more providers statewide. Collaboration between Equity at Intercept 0 projects and co-response teams have also assisted in the ability to hire qualified clinicians.

Thus far, DBHDS has coordinated and established partnerships between public and private mobile crisis providers with referrals from 988 sent to both public and private providers for MCR dispatch. Those providers with access to VCC provide coordinated communication across the MCR network and teams are dispatched if they are the closest and/or most appropriate (specialty) team for response within the required time.

Table 6. MCR Staffing as of FY 2024

State		Funded FTEs	Filled FTEs	% filled teams
	REACH	159	115	72.3%
	BH	204	141	69.1%
Total Funded MCR		363	256	70.5%

Note. FTE = Full Time Employee

Table 7. MCR Staffing Goal

State	GOAL	Current	% met
	140 teams	102 teams	72.9%

Interoperability between Systems

Current workflows for calls received from 911 centers transferred to crisis call centers require call agents to communicate pertinent caller information, a unique identifier, and current address to the receiving crisis worker. Calls sent to 911 from the crisis call centers have no formalized requirements of information that must be shared. However, it is encouraged that crisis call centers provide relevant client demographics and Marcus Alert level. Exchanging this data, unfortunately, adds additional response time to each call; however, this extra information supports data collection efforts to capture each call's outcome and metrics. While the crisis call centers answering 988 all use VCC, Virginia PSAPs utilize several different CAD systems, and determining the interoperability capabilities of each CAD system is a challenge. Standardization of data points is in development for all PSAP CAD systems and the Virginia Crisis Connect system. It is anticipated that these will be finalized April 1, 2025.

988 did not receive the federal designation of an "emergency line," which prevents the transmission of detailed location information for 988 and crisis line calls. Instead, geo-routing was approved by the FCC for 988 calls. Geo-routing triangulates the caller's location based on the nearest cell tower, a major change from the current 988 area code routing method. This was begun with approximately half of cell towers in October 2024 and the remaining cell towers are planned to begin geo-routing in 2025. Without geo-routing, when a caller located in Virginia with a 703 area code calls 988, the

Lifeline will route the call to a Virginia Lifeline call center regardless of the caller's location exact location. Geo-routing will connect a caller with the closest center based on the wireless phone's current location, and in the rare case an emergency rescue is needed, the caller's general area is known.

Geo-routing is a significant change for Virginia due to the large transient population (e.g., short-term residents in the Washington DC metro area, military-affiliated individuals, and students attending our colleges and universities) needing a Virginia-specific area code. Once this process is complete, residents with out-of-state area codes who call 988 will reach Virginia services and have access to mobile crisis responses or care coordination offered in-state.

Standardization of Marcus Alert
Legislative Code amendments made during the 2022 General Assembly Session now allow law enforcement agencies that serve smaller localities (population < 40,000 individuals) to not participate in Marcus Alert. Having only some localities participate may be confusing for individuals attempting to navigate the behavioral health crisis system. Advocates have expressed concern with individuals crossing from city lines into a neighboring county where there is not a requirement for law enforcement agencies to respond with the state-expected best practices for behavioral health incidents. DBHDS and DCJS are working to gain an understanding of the barriers of law enforcement that must successfully implement Marcus Alert.

Other forms of standardization that include the statewide Marcus Alert training currently being developed. Implementing sites have reported confusion with the information currently available that describes policies and procedures related to Marcus Alert. Clarification and consistent messaging about these items across the Commonwealth will increase standardization. Lastly, availability of co-response teams across all of Virginia will increase access to all Virginians.

Conclusion

Thus far, the implementation of the Marcus-David Peters Act has been achieved for 17 sites. There have been improvements made to various aspects of the legislation since the original date of December 21, 2021. This includes the development and expansion of the VCC platform, community resource dictionaries, and the inclusion of data collection. The interoperability between 911 and 988 allows for collaboration between behavioral health professionals and law enforcement. Statewide training for Marcus Alert policies and procedures is currently being developed to identify barriers and tools required for seamless coordination.

Of the required data elements of this annual report, data sources and reporting mechanisms have been identified for MCR and 911 Call Centers. DHBDS has identified a difficulty in obtaining reliable and valid data from community cares teams and is working with CSB's regarding the appropriate manner to obtain this information in the near future. The inclusion of data reporting from multidisciplinary agencies will allow a holistic evaluation of Marcus Alert.

The 17 areas that have implemented Marcus Alert report positive outcomes, including a reduction in unnecessary law enforcement involvement, increased behavioral health lead responses, and an

increase in least restrictive services available to the public. Increases in community resources and MCR have improved the treatment experience individuals have during a behavioral health crisis. The policies and procedures outlined in the legislation and state plan allow for partnerships between first responders and behavioral health professionals which connects these systems. The level of additional implementation will be contingent on the funding availability.

Appendices

Appendix A

Table 1. Initial Areas Implementing Marcus Alert as of December 1, 2021

Community Services Boards	Law Enforcement Agencies	Public Safety Answering Points
Encompass Community Services	• Culpeper Sheriff's Office • Culpeper Police Department • Fauquier Sheriff's Office • Madison Sheriff's Office • Orange Sheriff's Office • Rappahannock Sheriff's Office • Remington Police Department • Town of Orange Police Department • Warrenton Police Department • Virginia State Police • Germanna Community College Police Department • Lord Fairfax Community College Police Department	• Culpeper County • Fauquier County Sheriff's Office • Madison County Emergency Communication Center • Orange County Emergency Communication Center • Rappahannock County Sheriff's Office
Prince William Community Services	• Prince William PD • Manassas City • Manassas Park	• Prince William • Manassas City • Manassas Park
Highlands Community Services	• Washington County Sheriff's Office • Bristol Police Department • Bristol Virginia Sheriff's Office • Abingdon Police Department • Damascus Police Department • Glade Spring Police Department • Emory & Henry College Police Department • Virginia Highlands Community College Police Department • Virginia State Police Division 4	• Bristol • Washington County • Virginia State Police District 4
Richmond Behavioral Health Authority	• Richmond Police Department • Virginia Commonwealth University Police Department • Virginia Union University Police Department	• Richmond
Virginia Beach Community Services	• Virginia Beach Police Department • Virginia Beach Sheriff's Office	• Virginia Beach

Table 2. Secondary Areas Implementing Marcus Alert as of July 1, 2023

Community Services Board	Law Enforcement Agency	Public Safety Answering Points
Rappahannock Area Community Services Board	• Fredericksburg Police Department • Spotsylvania County Sheriff's Office • Stafford County Sheriff's Office • Caroline County Sheriff's Office • King George County Sheriff's Office • University Of Mary Washington Police Department	• Fredericksburg Police Department • Spotsylvania County Sheriff's Office • Stafford County Sheriff's Office • Caroline County Sheriff's Office • King George County Sheriff's Office
Fairfax Falls Church Community Services Board	• Fairfax County Police Department • City of Fairfax Police Department • City of Falls Church Police Department • Town of Herndon Police Department • Town of Vienna Police Department • George Mason University Police Department • Northern Virginia Community College Police Department	• Fairfax County Department of Public Safety Communications
Blue Ridge Behavioral Health	• Botetourt County Sheriff's Office • Roanoke Police Department • Roanoke City Sheriff's Office • Roanoke County Police Department • Roanoke County Sheriff's Office • Salem Police Department • Salem Sheriff's Office • Vinton Police Department • Virginia Western Community College Police Department	• Botetourt County Sheriff's Office • Craig County Sheriff's Office • Roanoke City • Roanoke County • City of Salem • Town of Vinton
Chesterfield Community Services Board	• Chesterfield County	• Chesterfield Emergency Communications
Hampton-Newport News Community Services Board	• Hampton Police Department • Newport News Police Department • Hampton University Police Department • Virginia Peninsula Community • College Police Department Christopher Newport University Police Department	• Hampton Emergency Communications Center • Newport News Emergency Communications Center

Table 3. Tertiary Areas Implementing Marcus Alert as of July 1, 2024

Community Services Board	Law Enforcement Agency	Public Safety Answering Points
Horizon Behavioral Health	• Lynchburg City Police Department • Liberty University Police Department • Central Virginia Community • College Police Department • Bedford County Sheriff Office • Town of Bedford Police Department • Campbell County Sheriff Office	• Amherst County Public Safety Communications • Appomattox County Public Safety • Bedford Emergency Communications Center • Campbell County Public Safety • Lynchburg Department of Emergency Services
Loudoun Community Services Board	• Loudoun County Sheriff Office • Leesburg Police Department	• Loudoun County Fire and Rescue • Loudoun County Sheriff Office • Leesburg Police Department
Arlington Community Services Board	• Arlington County Police Department • Arlington County Sheriff's Department	• Arlington County Emergency Communication Center
Alexandria Community Services Board	• Alexandria Police Department	• City of Alexandria Department of Emergency and Customer Communications
New River Valley Community Services Board	• Montgomery County Sheriff Office • Blacksburg Police Department • Christiansburg Police Department • Virginia Tech Police Department • Radford University Police Department	• New River Valley 911 Authority • Pulaski 911 Communications Center • Giles County Sheriff Office 911 • Floyd County Sheriff Office 911 • Radford City Emergency Communication Center • Radford University Police Department
Henrico Area Mental Health & Developmental Services	• Henrico County Police Department • New Kent County Sheriff's Office • Charles City County Sheriff's Office • J. Sargent Reynolds Community College Police Department • University of Richmond Police Department • Richmond Airport Police Department	• Henrico County Department of Emergency Communications • New Kent County • Charles City County
Western Tidewater Community Services Board	• Suffolk Police Department • Southampton County Sheriff • Courtland Police Department • Franklin Police Department • Isle of Wight County Sheriff • Smithfield Police Department • Windsor Police Department	• Suffolk Emergency Communications Center • Isle of Wight Emergency Communications Center • Southampton Emergency Communications Center • Franklin Emergency Communications Center