COMMONWEALTH of VIRGINIA

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COMMISSIONER

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November 15, 2023

To: Governor Glenn Youngkin, Governor of Virginia
The Honorable Patrick A. Hope, Chair, House of 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
The Honorable R. Creigh Deeds, Chair, Behavioral Health Commission

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. DBHDS staff are available should you wish to discuss this request.

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

DBHDS
Virginia Department of Behavioral Health and Developmental Services

Marcus Alert and the Impact and Effectiveness of the Comprehensive Crisis System

(37.2-311.1 Code of Virginia)

November 13, 2023

DBHDS Vision: A Life of Possibilities for All Virginians

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Preface

§ 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 (DCJS) to include an update on the implementation of the Marcus Alert System in this report. The language reads:

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Executive Summary

Marcus-David Peters 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 law enforcement, 9-1-1, 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 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.

Implementation of the Marcus-David Peters Act has successfully followed the original schedule, with the first five sites launched December 1, 2021 and an additional five Marcus Alert programs beginning on July 1, 2023. The availability of crisis services has grown tremendously since the passing of this legislation. Not only is the 9-8-8 service available across the Commonwealth, but Virginia has maintained an average 92% in-state answer rate by the two regional crisis call centers answering Virginia calls. All ten Marcus Alert sites have worked closely with their regional crisis call centers to implement protocols for Marcus Alert. The 9-1-1 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. DBHDS is working to ensure Virginia continues to meet the deadline of July 1, 2028 to implement Marcus Alert programs statewide in all 40 locally operated community services boards (CSBs) catchment areas. Areas of focus for this reporting period include:

- **Regional Implementation** – Ten Marcus Alert programs have launched in the five DBHDS regions.
- **Launching Additional Five Regional Sites** – 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 Marcus Alert Programs** – Three local Marcus Alert protocols were required by initial areas on December 1, 2021. These three local protocols include: 1) diversion of appropriate 9-1-1 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 support for community coverage to be achieved statewide will be contingent on the amount of funding available, as well as the local planning processes.

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

Table of Contents

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 law enforcement, 9-1-1, and the comprehensive crisis system. The five initial areas implemented on 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.

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. The Department of Behavioral Health and Developmental Services (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. 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 (see Table 1) submitted detailed implementation plans on October 15, 2021. Each area has submitted their plans, and the plans were reviewed by DBHDS and DCJS. The three protocols were required statewide by July 1, 2022, and community coverage will be phased in over a number of years per the legislation. These five areas were granted Conditional Approval.

Table 1: Five Initial Areas Implementing Marcus Alert December 1, 2021

Community Services Board	Law Enforcement Agency	Public Safety Answering Points
Rappahannock Rapidan Community Services Board	• Culpeper Sheriff's Office • Culpeper PD • Fauquier Sheriff's Office • Madison Sheriff's Office • Orange Sheriff's Office • Rappahannock Sheriff's Office • Remington PD • Town of Orange PD • Warrenton PD	• Culpeper County • Fauquier County Sheriff's Office • Madison County ECC • Orange County ECC • Rappahannock County Sheriff's Office

	• Virginia State Police • Germanna Community College PD • Lord Fairfax Community College PD	
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	• Richmond
Virginia Beach Community Services	• Virginia Beach Police Department • Virginia Beach Sheriff's Office	• Virginia Beach

Table 2: Second Areas Implementing Marcus Alert 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 • IHEs	• 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	• Fairfax County Department of Public Safety Communications

	• George Mason University Police Department • Northern Virginia Community College Police Department	
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	• 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

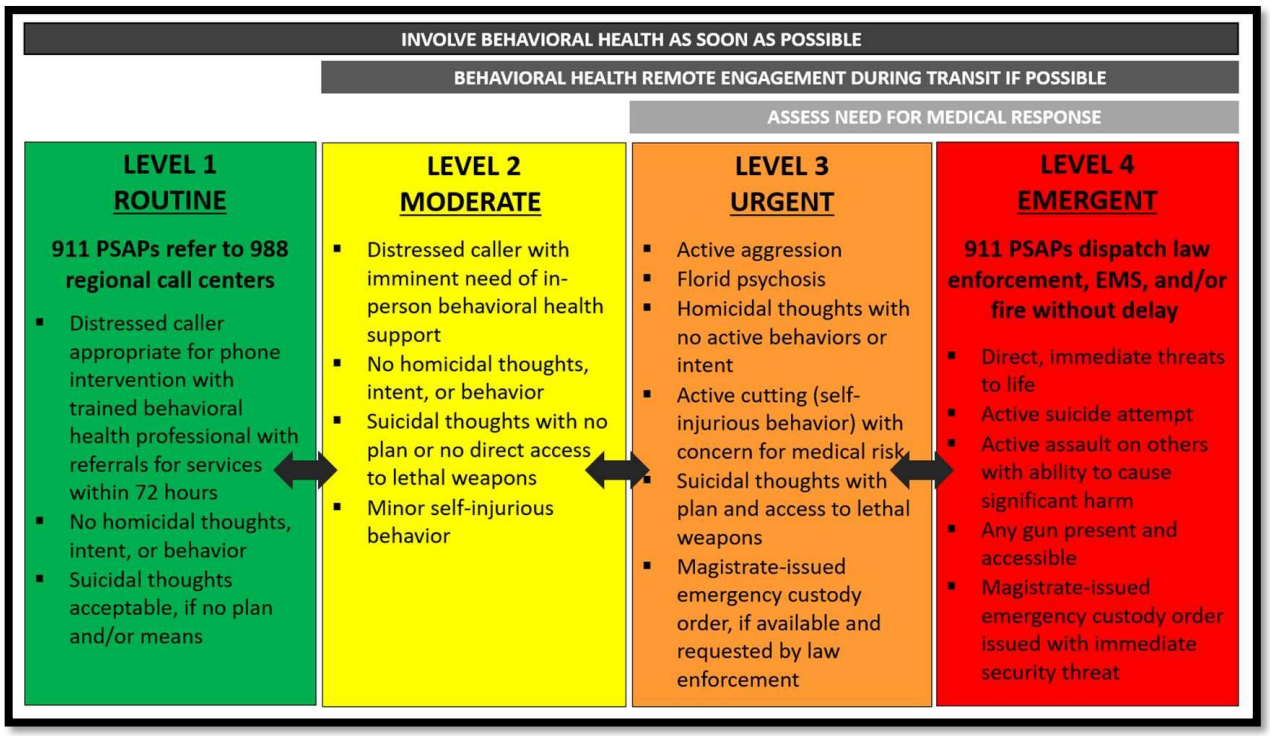
A complete Marcus Alert System implements three required protocols which are:

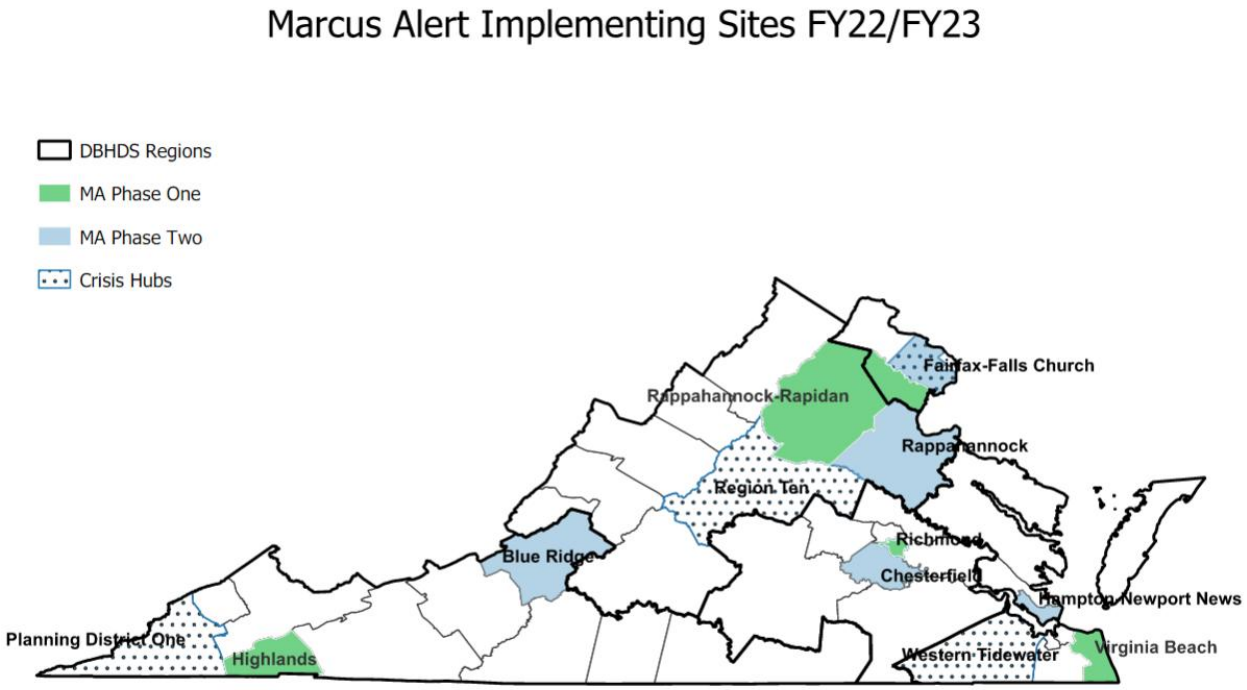
1. 9-1-1 call diversion
2. Mobile crisis back-up
3. Requires a specialized response by law enforcement in accordance with minimum standards and best practices published by DBHDS and DCJS.

Community coverage by mobile crisis teams and community care teams can be phased in over several years as those programs expand statewide.

The State Level Triage Framework (see Figure 2) is designed to assist 9-1-1 operators in diverting calls to the 9-8-8 system. 9-1-1 is required to divert Level 1 calls to 9-8-8. Level 2 calls are recommended to have a mobile crisis dispatch, however, as mobile crisis doesn't consistently exist across Virginia, other response options are allowed and utilized. Level 3 calls are recommended to utilize specialized teams such as Children's Mobile Crisis, or REACH for developmental disabilities, when relevant. Level 3 calls frequently involve law enforcement and require a law enforcement *specialized response* at the scene. Level 4 calls require a 9-1-1 dispatch due to a concern of imminent risk for the caller, however, 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





Crisis System Transformation (7)

Virginia is currently 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 be offered at every one of Virginia's 40 local CSBs. That means all Virginians will be able to access high quality behavioral health services aimed at managing symptoms before they become crisis-level, as well as avoiding expensive and 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 based on the four core elements: High Tech Crisis Call Centers, 24/7 Mobile Crisis, Crisis Stabilization Programs, Essential Principles & Practices. below:

The first element, crisis call centers, needed to be onboarded and integrated into Virginia's crisis infrastructure. Federal law required the 9-8-8 number be accessible no later than July 16, 2022 to the National Suicide Prevention Lifeline supports and services. The 9-8-8 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), Planning District One (Region 3), Richmond Behavioral Health Authority (RBHA; Region 4), and Western Tidewater (Region 5). Virginia was the first state to pass a 9-8-8 cell phone tax 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 began July 1, 2021. In addition, increased Medicaid reimbursement rates for comprehensive crisis services launched 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.

Comprehensive Crisis System Data (2-5)

- The number of calls received by the crisis call center established pursuant to this section.
- The number of mobile crisis responses undertaken by community care teams and mobile crisis teams in the Commonwealth.
- The number of mobile crisis responses that involved law-enforcement backup.
- The number of crisis incidents and injuries to any parties involved.

Progress toward Measurement – Comprehensive Crisis System

DBHDS is responsible for data collected from the crisis call center data platform, including behavioral health-only responses, behavioral health responses with law enforcement back up, and data on calls transferred from 9-1-1 to 9-8-8. It is the intent that data from 9-1-1 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 Crisis Call Center Data Platform went live on December 1, 2021. The Crisis Call Center Data Platform has built out functionality for receiving and triaging crisis calls and is currently utilized by all regions except Region 2. The mobile dispatch functionality has also been completed. Currently, Region 5, Western Tidewater Community Service Board, is actively utilizing the mobile dispatch within their region. While the Crisis Call Center Data Platform continues to progress in development, there have been some delays due to staffing changes with our subcontracted vendor and differences between the regions. 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 per region, which has become timelier than originally anticipated. Additional functionality within Crisis Call Center Data Platform in development includes:

- Bed Registry – this feature will offer ease of use and efficiency in identifying available beds within each region and statewide.
- Community Resources – this will enhance features for identifying and connecting individuals to community resources as a follow up to access crisis services.
- Messaging and Communication – this feature will allow call center agents, mobile dispatch, and mobile team members to communicate in real time to effectively and efficiently provide crisis services to Virginians.

Call Center Data for 2022

In calendar year 2022 (January 2022-December 31, 2022), a total of 64,684 Lifeline calls were routed to Virginia. These included Spanish-speaking calls and calls to the Veteran's crisis line. Looking exclusively at National Suicide Prevention Line (NSPL) calls, Virginia received a total of 50,001 calls with an average answer rate of 65%. With the expansion of call center staff and enhanced funding to call centers, Virginia now has an 85% answer rate. This is an increase of 30% from January 2021. In addition to the increased in-state answer rate, the number of calls has also doubled since 2021. Below, Figure 2 shows a monthly breakdown of calls provided by Vibrant.

Figure 2. Summary of In-State Call Metrics

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.

KPIs for Calls in VA													
	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023

Routed	4,130	3,761	4,289	3,966	4,671	4,606	7,469	7,221	6,679	5,791	5,383	5,716	6,017
Received	4,130	3,761	4,289	3,966	4,671	4,605	7,049	6,761	6,401	5,791	5,383	5,716	6,017
Answered In-State	3,555	3,160	3,553	3,320	3,951	3,841	5,885	5,766	5,804	5,310	4,913	5,110	5,045
In-State Answer Rate	86%	84%	83%	84%	85%	83%	83%	85%	91%	92%	91%	89%	84%

Youth Mobile Crisis Response Data

DBHDS began to collect mobile crisis utilization data regarding our youth services from our five regional hubs beginning July 1, 2021. With the anticipation of the Crisis Data Platform, adult mobile crisis utilization data did not get collected. The regional hubs are managed by a local community service board. Each of the managing regional hubs are listed below.

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

Based on the information received for FY 2022, there were a total of 814 mobile crisis calls with many calls being categorized as non-crisis (509). Non-crisis calls were classified as calls that could be resolved at the call center level. Examples of these would include requesting information and obtaining referrals. Most crisis calls resulted in individuals being able to retain their setting either with or without support.

Progress toward Measurement – Marcus Alert

Marcus Alert specific data points are gathered from DBHDS and DCJS records as well as PSAPs/9-1-1 centers. DBHDS and DCJS will be utilized to provide a summary of 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 ongoing stakeholder meetings each six months and feedback reviewed by the Crisis Coalition will also be reported in the yearly report.

Currently, the five initial sites were implemented on December 1, 2021, however, data collection did not begin until July 1, 2022. This is in part due to the build out of the Crisis Call Center Data Platform as well as incorporating the data elements within each PSAPs unique CAD system. A PSAPs data collection template with minimum data elements required was developed in order to ensure standardization across all PSAPs systems, regardless of the software platform. PSAPs are submitting quarterly reports to DBHDS with required data elements with the first submission due by October 30, 2022. The initial findings were not available for this report.

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

Subsequent Marcus Alert reports will include expected summaries of metrics including response times, demographic information, and outcomes of Marcus Alert related instances.

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.

Identified Barriers for Implementation

Local plans for the implementation of Marcus Alert were submitted to DBHDS and DCJS on October 15, 2021. Each local plan submission included a barrier statement representative of each implementing area's community services board, law enforcement agencies, and 9-1-1 agencies. In addition, DBHDS along with DCJS administered a survey to all law enforcement agencies, 9-1-1 agencies (PSAPs), and community services boards requesting information on barriers to implementing Marcus Alert successfully. An overview of the survey results along with a report from the code-mandated workgroup will be presented to address such barriers to the Chairmen of the House Committees for Courts of Justice and on Health, Welfare, and Institutions, the Senate Committees on the Judiciary and Education and Health, the Behavioral Health Commission, and the Joint Commission on Health Care by December 1, 2022. This report is included in the Appendix.

DBHDS Region One: Rappahannock Rapidan Community Services Board

As a pilot representing five counties with more than nine law enforcement agencies and five PSAPs, coordinating a cohesive plan has been a challenge. The guidance from the State did not meet the level of detail needed for all our law enforcement agencies to confidently create protocols. Specifically, there remain too many holes in the service system for the law enforcement agencies to confidently plan to utilize those services at implementation. The programming and infrastructure that will support Marcus Alert protocols that is not in place includes:

1) State just contracted a data collection vendor in late September.
2) Region 1's crisis call center vendor has not yet been identified as it remains in the limbo of the state procurement process.
3) Region 1's Child Mobile Crisis is stood up for only 8 hrs./day, 5 days per week; Adult Mobile Crisis will be stood up for less than 8hrs per day until January 2022 which has been cited as the best-case scenario.
4) DCJS promises Advanced Marcus Alert training and PSAP training as well as other mental health and social justice trainings, but those trainings are not yet developed, nor have any roll outs been announced.

Therefore, our LEs and PSAPs have struggled to "imagine" protocols with entities that don't yet exist. Protocol #1 requires PSAPs to develop a plan for dispatching calls based on a triage that deviates from their current vendor-produced, evidence-based guide cards. The PSAP staff rely upon these evidence-based guide cards to direct calls; there is significant liability involved with deviating from the established guide cards. Protocol #1 also includes diverting some calls to the regional crisis call center, which does not exist. Protocol #2 requires creating an MOU with the nonexistent regional crisis call center, as well as establishing coordination with mobile crisis, which also does not yet exist.

Our law enforcement agencies, despite a deep desire to improve outcomes for mental health calls, cannot commit to sending officers to trainings when they do not know the specifics. How many trainings, how many hours these trainings will take, and how often trainings will occur are just a few of the specifics yet to be defined. There are too many unknown variables for our Law Enforcement Agencies to confidently move forward.

DBHDS Region Two: Prince William Community Services

One barrier to the warm handoff that was identified is PSAPs with limited staffing may need to exit a call with the Regional Crisis Call Center prior to a response being identified at level 2. This may be due to other calls coming into the PSAP that need to be answered and limited staffing to answer the incoming calls.

Another barrier that was identified pertains to the collection of dispositions and call types. The CAD systems are utilized across the entirety of the call. This means the call type or disposition can be changed at any time throughout the process. The PSAP may identify the call as type 3 and disposition as dispatched co-responder team. However, once the co-responder team responds, the call type and disposition could be updated as the call continues. Currently, there is no process to track changes during the call. Consideration should be given to whether the state wants to track the status of the call at the beginning or end of disposition. This would yield different results depending on when the state wants to categorize and report the call.

Callers whose primary language is not English also present a barrier, since PSAPS cannot conference more than 3 callers at a time. An interpreter would need to be available at the Regional Crisis Call Center to continue interpretation once the warm handoff occurs. Additionally, obtaining appropriate placement for people in crisis is a current barrier to treatment across Virginia. Outpatient stabilization options are minimal and require expansion for the crisis now model to be effective. The funding of outpatient community services and crisis receiving centers is imperative to the successful functioning of the Marcus Alert legislation.

DBHDS Region Three: Highlands Community Services

The Region Three implementing area chose not to submit the optional barriers statement.

DBHDS Region Four: Richmond Behavioral Health Authority

The Region Four implementing area chose not to submit the optional barriers statement; however, they provided the below statement via email to DBHDS.

"As you know, the challenges and barriers are steep. I am quite concerned about system credibility because of the late adoption of the call center data base, late stand up of the call centers, technical challenges with the PSAPs (ours is on the ball, but still having to work through complicated and expensive changes in CAD), limitations of the voluntary database concept, and workforce/recruiting barriers. I am sure we will be working through bugs throughout this first year."

DBHDS Region Five: Virginia Beach Community Services

The most significant concerns and potential barriers that we anticipate facing with the Marcus Alert implementation include the following:

- Workforce shortage and changing regulations for crisis services.
- System capacity, including the ability to provide a wide scope of services 24/7.
- Inadequate funding to support a robust continuum of crisis services 24/7/365.
- Ensuring that the RCCC has similar phone capabilities as 9-1-1 such as TTY and resources to assist individuals with Limited English Proficiency.
- Community awareness of Marcus Alert, options along the crisis continuum of care, and how to access services behavioral health services prior to a crisis arising.

To address these issues, we would need additional funding and state-level action to incentivize the community workforce, provide a robust call center platform, and develop a widespread media campaign.

Addressing Barriers

Addressing Marcus Alert Barriers

DBHDS, along with DCJS, administered a survey to all law enforcement agencies, 9-1-1 agencies (PSAPs), and community services boards requesting information on barriers to implementing Marcus Alert successfully. An overview of the survey results along with a report from the code mandated workgroup will be presented to address such barriers to the Chairmen of the House Committees for Courts of Justice and on Health, Welfare and Institutions, the Senate Committees on the Judiciary and Education and Health, the Behavioral Health Commission, and the Joint Commission on Health Care by December 1, 2022. This report is included in the Appendix.

Addressing Mobile Crisis and Community Care Team Barriers

DBHDS integrated each Health Planning Region into the Mobile Dispatch function of the Crisis Data Platform throughout 2022. This functionality allows for Air Traffic Control and connects individuals to services along the crisis continuum following a No Wrong Door approach.

DBHDS, along with the Health Planning Regions, will oversee the coordination of private provider integration into Mobile Crisis response to expand capacity across the Commonwealth.

The Health Planning Regions will identify means for allocated Mobile Crisis Response funding to enhance service provision.

Recommendations for Improvement

Additional funding

Legislative code amendments made during the 2022 General Assembly Session made 9-1-1 participation in Marcus Alert a statewide requirement, regardless of population size. Fortunately, many 9-1-1 centers are eager to implement it in advance of the 2028 deadline. Currently, funding is allocated on the schedule of one locality implementation per DBHDS region per year and does not fiscally support the "early adoption" of Marcus Alert by localities.

For 9-1-1 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 9-1-1 centers on triaging Marcus Alert calls or making the required technical changes to their CAD systems for Marcus Alert data collection.

Some localities prefer the creation of local community care teams that include co-response teams, such as law enforcement and mental health professionals 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.

In order to achieve full 24/7 community coverage by Mobile Crisis and Community Care teams, additional funding is required for staffing, training, and programmatic costs.

Staffing

9-1-1 Centers currently face similar hiring shortages that Law Enforcement Agencies are struggling with, however, the 9-1-1 community was excluded from the enhanced benefits passed in recent General Assembly sessions. This shortfall in workforce makes implementing additional initiatives such as Marcus Alert much harder on 9-1-1 Centers, especially smaller agencies.

Law Enforcement Agencies also struggle with recruiting and retaining a workforce. Though Marcus Alert aims to remove law enforcement as 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 training when shifts are uncovered.

Behavioral health providers are also a rare commodity in Virginia due to their depleted workforce. Therefore, 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.

Interoperability between systems

Current workflows for calls received from 9-1-1 Centers to be transferred to crisis call centers require call agents to communicate caller demographic information to the receding agent. This is adding additional response time to each call. Additional information is also required to be shared during call transfers for data collection efforts as 9-1-1 operators need to provide a unique identifier in order to accurately capture the outcome and metrics of each call.

A PSAP data workgroup convened in August 2022 with the PSAP centers of the initial sites to explore opportunities for interoperability. Data requirements would need to be standardized across all CAD systems and implemented within the Crisis Call Center Data Platform.

Geolocation services are not currently enabled for 9-8-8 as they are for calls to 9-1-1. A caller's location information is not transmitted with a 9-8-8 call for possible dispatch of emergency services. The Lifeline automatically routes calls by area code to the nearest crisis center. For example, when a caller located in Virginia with a 703 area code calls 9-8-8, the Lifeline will route the call to a Virginia Lifeline call center regardless of the caller's location.

Call routing and geolocation are related location issues but involve different technical, legal, privacy, and cost considerations. As part of the 2020 Designation Act, the Federal Communications Commission (FCC) submitted a report examining the feasibility and cost of providing more precise location information than area code with a 9-8-8 call. Within that report, the FCC recommended that Congress require that a multi-stakeholder group be convened to further examine the key issues and collaborate on potential next steps. The FCC also held a 9-8-8 Geolocation Forum in May 2022, and the agency is actively analyzing the information gathered during that forum, including whether potential routing improvements could help callers to 9-8-8 connect to the regional call centers where they are located without sharing geolocation information.

This presents a specific problem in Virginia because of the connection of 9-8-8 Regional Crisis Call Centers as an entry point to Virginia's Crisis Continuum of Services. Virginia has a large transient population, whether short-term residents in the Washington DC metro area, military affiliated, or attending our colleges and universities, many residents do not have a Virginia-specific area code. If these residents with out of state area codes call 9-8-8, they will not reach Virginia services and will not get mobile crisis responses or care coordination that is offered in-state. Instead, they will be routed to a lifeline center close to their area code which may only offer a law enforcement response to someone needing more care than can be offered over the phone.

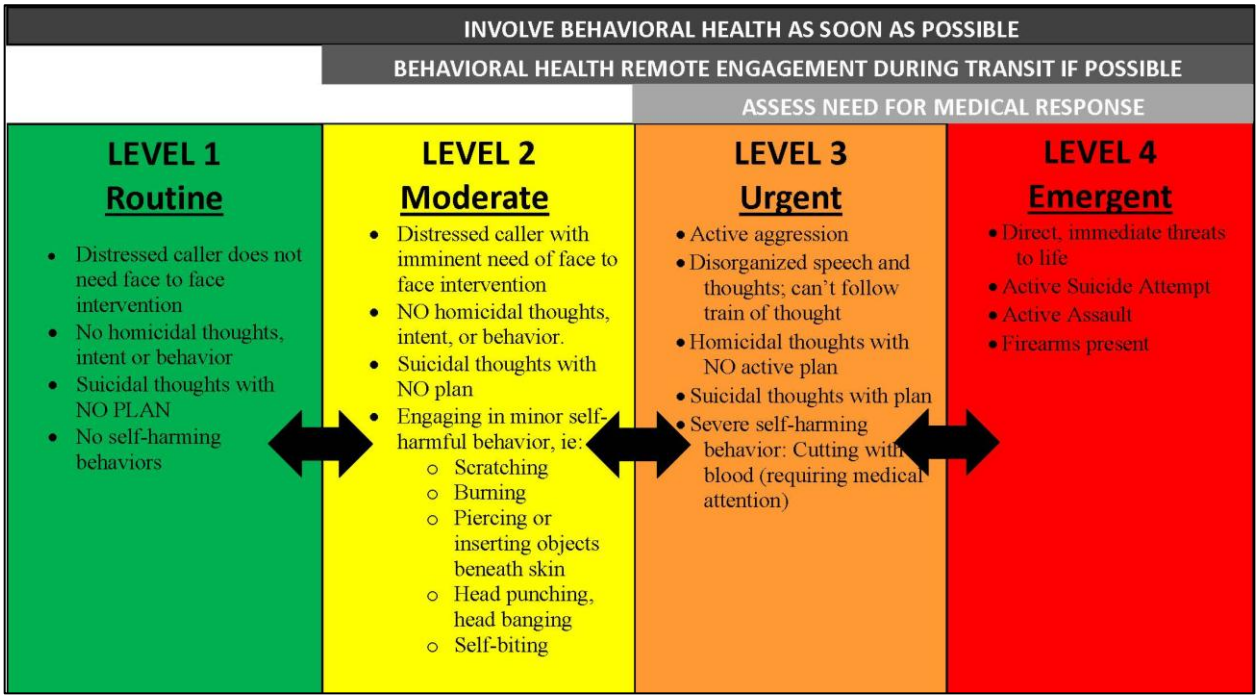
Standardization of Marcus Alert

Legislative code amendments made during the 2022 General Assembly Session now allow law enforcement agencies that serve smaller localities (<40,000) to not participate in Marcus Alert. Having only some localities participate is 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 to successfully implement Marcus Alert.

Appendix

Appendix A. DBHDS Region One: Rappahannock Rapidan CSB Geographical Catchment Area

Protocol 1. 9-1-1 Diversion to 9-8-8 Regional Crisis Call Centers



Marcus Alert Triage / Response Plan			
Symptom	If No	If Yes	Response
Immediate threat to life, active suicide attempt or homicidal thoughts with a plan?	↓	→	Dispatch Law Enforcement / Stage EMS (Code as Marcus 4) **Notify 988**
Active Assault?	↓	→	Dispatch Law Enforcement / Stage EMS (Code as Marcus 4) **Notify 988**
Firearms Present?	↓	→	Dispatch Law Enforcement / Stage EMS (Code as Marcus 4) **Notify 988**
Active Aggression?	↓	→	Dispatch Law Enforcement / Stage EMS (Code as Marcus 3) **Notify 988**
Disorganized Thought Process, inability to follow train of thought	↓	→	Dispatch Law Enforcement / Stage EMS (Code as Marcus 3) **Notify 988**
Homicidal Thoughts with no plan?	↓	→	Dispatch Law Enforcement / Stage EMS (Code as Marcus 3) **Notify 988**
Suicidal Thoughts with a plan or severe self harming (cutting with blood, requiring medical attention) ?	↓	→	Dispatch Law Enforcement / Stage EMS (Code as Marcus 3) **Notify 988**
Engaging in minor self harming (scratching, burning, peircing, head punching, self biting)?	↓	→	Connect the caller to 988; stay on the line to determine response. (Code as Marcus 2)
Suicidal thoughts with no plan?	↓	→	Transfer the caller to 988 for assistance. (Code as Marcus 1)
Dispatch for Call Type			

Protocol 2. Mobile Crisis Team Emergency Back-Up

The nine law enforcement agencies (Law Enforcement Agencies) and 5 PSAPs within the Rappahannock Rapidan Community Services catchment area are all committed to collaboration with regional adult and child mobile crisis teams as well as a Regional Crisis Call Center. Unfortunately, despite this commitment, the regional mobile crisis services are NOT yet fully stood up and thus creating an MOU with that entity is not yet possible. Additionally, our regional crisis call center vendor is not yet identified/available for collaborative planning and therefore, it is not yet possible to create an MOU with that entity either.

Protocol 3. Law Enforcement Specialized Response

Rappahannock Rapidan Community Services has nine law enforcement agencies within its 5-county catchment area who have members participating in the Marcus Alert Planning Team and have been meeting since March. Those Law Enforcement Agencies include Culpeper Sheriff's Office, Town of Culpeper Police Department, Germanna Community College Police Department, Fauquier Sheriff's Office, Warrenton Police Department, Madison Sheriff's Office, Orange Sheriff's Office, Town of Orange Police Department, and Rappahannock Sheriff's Office. Many of our Law Enforcement Agencies remain concerned about creating and submitting protocols when many of the coordinating service providers and vendors (Regional Adult Mobile Crisis and the Regional Crisis Call Center), as well as training opportunities and curriculum, remain unknown. Below are the three Law Enforcement Agencies who were able to "imagine" Protocol 3 without those essential pieces in place.

Fauquier County Sheriff's Office

List any components of your specialized response (protocol #3) that fall at the leadership level (organization-wide

policies, procedures, training, culture).

Directives addressing the following: 1) Use of Force; 2) Mentally Ill Persons; and 3) Nonbiased Based Policing.

List any components of your specialized response (protocol #3) that relate to the training that all officers receive.

All deputies who attend the basic L.E. Academy receive training in responding to individuals experiencing a behavioral health crisis.

List any components of your specialized response (protocol #3) that relate to intermediate, voluntary training (e.g., CIT training or CIT enhancement).

The Fauquier County Sheriff's Office has a goal for 100% of deputies and dispatchers to be trained in CIT.

List any components of your specialized response (protocol #3) that relate to specialized units or advanced training (e.g., advanced Marcus Alert training, Suicide by Cop training, advanced CIT training).
N/A

Madison County Sheriff's Office

List any components of your specialized response (protocol #3) that fall at the leadership level (organization-wide policies, procedures, training, culture).

- Creation of new policies/procedures when dealing with mental health crisis and how a co-response will affect response time as well as who is lead.
- Madison County currently has no mental health services available within the county.
- We conduct training on Use of Force, De-escalation, and Implicit Bias Training. We currently conduct all the above training yearly. Community policing would fall under our implicit bias training. Officer wellness is touched on in our De-escalation training - you cannot de-escalate someone else if you cannot de-escalate yourself.
- We have changed our uniforms to be softer but still identify who we are.
- Our new policies and procedures would be based on co-response and CIT due to not knowing when Mobile Crisis Team will operational.
- Level 3 would require a co-responder go to the scene with CIT trained law enforcement (when available) and when safe, lead the conversation with the person in a mental health crisis. Co-response will be expanded to our county in the near future. Currently we can access Culpeper PD's co-responder if necessary.
- We have approximately 80% of our deputies CIT trained with more coming in the future. Madison County Sheriff's office has never taught the warrior mentality nor is it taught in the academy.

List any components of your specialized response (protocol #3) that relate to the training that all officers receive.

- All officers receive Use of Force, De-escalation, Implicit Bias Training, and eventually all officers will be CIT certified.
- Officer Wellness is a new curriculum offered by the state. New officers will receive this training in the Academy. Currently looking for a credible Officer Wellness program.

List any components of your specialized response (protocol #3) that relate to intermediate, voluntary training (e.g., CIT training or CIT enhancement).

- All Deputies will receive CIT training as available when manpower allows.
- Our goal is to have 100% CIT trained officers.
- Our goal is to send CIT trained deputies to all persons in crisis calls.
- Madison County Sheriff's Office has one CIT instructor.
- When advanced CIT Training is available, we will attend.
- We have 2 deputies that are certified hostage negotiators.

List any components of your specialized response (protocol #3) that relate to specialized units or advanced training (e.g., advanced Marcus Alert training, Suicide by Cop training, advanced CIT training).

- When the curriculum is published for advance Marcus Alert Training, Suicide by Cop and Advanced CIT Training, we will send deputies to attend.
- We do not have the manpower or capability of sending every deputy to advanced training.
- Deputies will be selected to attend advanced training.

Warrenton Police Department

List any components of your specialized response (protocol #3) that fall at the leadership level (organization-wide policies, procedures, training, culture).

General Order for Mental Health, Use of Force (de-escalation, CIT etc.)

List any components of your specialized response (protocol #3) that relate to the training that all officers receive.

WPD officers receive basic training and must pass practical exercises based on role-players in a mental health crisis. CIT training and adult and youth mental health first aid classes are also mandatory for all sworn officers.

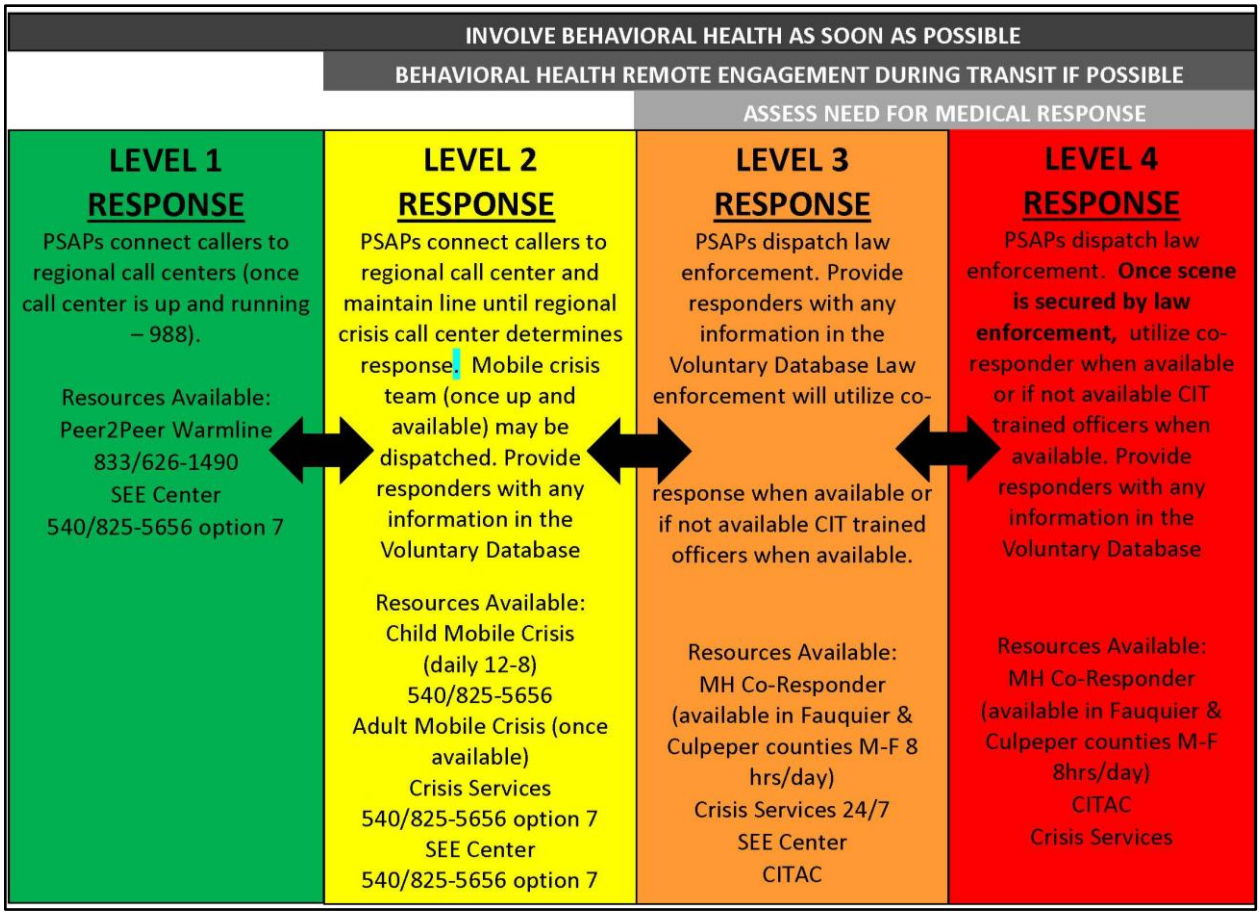
List any components of your specialized response (protocol #3) that relate to intermediate, voluntary training (e.g., CIT training or CIT enhancement).

The WPD has a goal that 100% of its sworn officers will receive CIT training and adult and youth mental health first aid classes.

List any components of your specialized response (protocol #3) that relate to specialized units or advanced training (e.g., advanced Marcus Alert training, Suicide by Cop training, advanced CIT training).

No WPD officers have taken the advanced classes mentioned above.

Community Coverage



Fauquier County

State Description	*Local Description of Response/Coverage*
General Information These are cross-level triage components. Please describe any general elements of your response type plan. For example, does each level include multiple options that are dispatched based on availability? Or does each level include multiple options that are determined appropriate based on triage/dispatcher decision making?	***When available, the co-responder and a CIT trained deputy are dispatched to all calls related to mental health.***
Level 1 STATE MINIMUM STANDARD: Level 1 calls must be transferred to the 9-8-8 call center BEST PRACTICE CONSIDERATION: Level 1 calls are fully diverted to 9-8-8	***We plan to divert all Level 1 calls to 9-8-8 once that call center becomes available and response protocols have been established. Until then, the co-responder and a CIT trained deputy will respond to these calls when available.***

Level 2 STATE MINIMUM STANDARD: Level 2 calls are coordinated with 9-8-8 BEST PRACTICE CONSIDERATION: Level 2 calls follow a poison-control model with 9-8-8	***Level 2 calls will be triaged by our communications center staff. If they identify the call as being appropriate to divert to 9-8-8, they will do so. If it is determined to not be appropriate for diversion, the co-responder and a CIT trained deputy will respond to these calls when available.***
Level 3 STATE MINIMUM STANDARD: Level 3 calls include multiple response options across agencies/entities, and includes a behavioral health-only response option Developmental status (i.e., age, developmental disabilities) is taken into consideration when making dispatch decisions at Level 3 BEST PRACTICE CONSIDERATION: Level 3 calls involving youth are coordinated with 9-8-8 and specialized children's mobile crisis teams Level 3 calls involving individuals with ID/DD are coordinated with 9-8-8 and specialized developmental disability mobile crisis teams/REACH program training	***Level 3 calls will be handled by the co-responder and a CIT trained deputy when available.*** ***In cases involving children, the deputies will leave resources for the Children's Mobile Crisis Unit for potential future use.***
Level 4 STATE MINIMUM STANDARD: Level 4 calls include law enforcement or EMS (Best practice elements for Level 4 include the systems approach for Protocol #3. All elements do not have to be described here. Here, describes what type of response will be sent to Level 4 calls and how behavioral health is taken into consideration.)	***Response protocol will be the same as Level 3.*** ***When the co-responder and/or a CIT trained deputy respond they will utilize the principles taught in CIT.***

Madison County

State Description	*Local Description of Response/Coverage*
General Information These are cross-level triage components. Please describe any general elements of your response type plan. For example, does each level include multiple options that are dispatched based on availability? Or, does each level include multiple options that are determined appropriate based on triage/dispatcher decision making?	**Our response options will be based on the triage/dispatcher decision-making. If dispatcher determines that level 1 is appropriate then law enforcement will not know about the call. If level 2 is determined then law enforcement may not know about call, unless 9-8-8 requests assistance or call elevates and it becomes a level 3. Co-response with mental health at level 3 with a CIT trained officer if available.**
Level 1 STATE MINIMUM STANDARD: Level 1 calls must be transferred to the 9-8-8-call center BEST PRACTICE CONSIDERATION: Level 1 calls are fully diverted to 9-8-8	**If dispatch determines level 1, call will then dispatch to 9-8-8 call center if and when the call center becomes available.**
Level 2 STATE MINIMUM STANDARD: Level 2 calls are coordinated with 9-8-8 BEST PRACTICE CONSIDERATION: Level 2 calls follow a poison-control model with 9-8-8	**All level 2 calls determined by dispatcher will be coordinated with 9-8-8 call center.**
Level 3 STATE MINIMUM STANDARD: Level 3 calls include multiple response options across agencies/entities, and includes a behavioral health-only response option Developmental status (i.e., age, developmental disabilities) is taken into consideration when making dispatch decisions at Level 3 BEST PRACTICE CONSIDERATION: Level 3 calls involving youth are coordinated with 9-8-8 and specialized children's mobile crisis teams Level 3 calls involving individuals with ID/DD are coordinated with 9-8-8 and specialized developmental disability mobile crisis teams/REACH program training.	**Dispatch will dispatch CIT trained law enforcement along with co-responder. Law enforcement will not wait for response from co-responder but will arrive on scene and wait for co-responder to arrive. If scene is safe and co-responder feels secure, then law enforcement will take a secondary role.** **Law enforcement, once on scene, will determine what other resources are needed, whether it is the Mobile Crisis** **Team for adults or for children. Communication between Dispatch, on-scene response, and 9-8-8 will continue to be in operation.**

Level 4 STATE MINIMUM STANDARD: Level 4 calls include law enforcement or EMS (Best practice elements for Level 4 include the systems approach for Protocol #3. All elements do not have to be described here. Here, describe what type of response will be sent to Level 4 calls and how behavioral health is taken into consideration.)	**CIT trained law enforcement, if available, EMS, and co-responder will be dispatched at same time, EMS and co-responder will stage at safe location determined by law enforcement. Once scene is determined safe or co-responder can communicate with person in crisis, law enforcement will become secondary for scene safety only.**

Warrenton Police Department

State Description	*Local Description of Response/Coverage*
General Information These are cross-level triage components. Please describe any general elements of your response type plan. For example, does each level include multiple options that are dispatched based on availability? Or, does each level include multiple options that are determined appropriate based on triage/dispatcher decision making?	***When available, the co-responder and a CIT trained officer/deputy are dispatched to all calls related to mental health.***
Level 1 STATE MINIMUM STANDARD: Level 1 calls must be transferred to the 9-8-8 call center BEST PRACTICE CONSIDERATION: Level 1 calls are fully diverted to 9-8-8	***We plan to divert all Level 1 calls to 9-8-8 once that call center becomes available and response protocols have been established. Until then, the co-responder and a CIT trained officer/deputy will respond to these calls when available.***
Level 2 STATE MINIMUM STANDARD: Level 2 calls are coordinated with 9-8-8 BEST PRACTICE CONSIDERATION: Level 2 calls follow a poison-control model with 9-8-8	***Level 2 calls will be triaged by our communications center staff. If they identify the call as being appropriate to divert to 9-8-8, they will do so. If it is determined to not be appropriate for diversion, the co-responder and a CIT trained officer/deputy will respond to these calls when available.***

Level 3 STATE MINIMUM STANDARD: Level 3 calls include multiple response options across agencies/entities, and includes a behavioral health-only response option Developmental status (i.e., age, developmental disabilities) is taken into consideration when making dispatch decisions at Level 3 BEST PRACTICE CONSIDERATION: Level 3 calls involving youth are coordinated with 9-8-8 and specialized children's mobile crisis teams Level 3 calls involving individuals with ID/DD are coordinated with 9-8-8 and specialized developmental disability mobile crisis teams/REACH program training.	***Level 3 calls will be handled by the co-responder and a CIT trained officer/deputy when available.*** ***In cases involving children, the officers/deputies will leave resources for the Children's Mobile Crisis Unit for potential future use.***
Level 4 STATE MINIMUM STANDARD: Level 4 calls include law enforcement or EMS (Best practice elements for Level 4 include the systems approach for Protocol #3. All elements do not have to be described here. Here, describe what type of response will be sent to Level 4 calls and how behavioral health is taken into consideration.)	***Response protocol will be the same as Level 3.*** ***When the co-responder and/or a CIT trained officer/deputy respond, they will utilize the principles taught in CIT.***

Appendix B. DBHDS Region Two: Prince William Community Services
Protocol 1. 9-1-1 Diversion to 9-8-8 Regional Crisis Call Centers

Greater Prince William County has three PSAP providers. The three providers are Manassas City, Manassas Park, and Prince William County (PWC). Each PSAP is in the process of working with their CAD technical support to incorporate the call types (Level 1-4) and the call dispositions. All three PSAPS are committed to having these changes in place and functional by December 1, 2021.

State Description	***Local Description***
General Information These are cross-level triage components. Please describe any general triage elements used to identify Marcus Alert situations. For example, does your agency plan to begin calls with, "Police, Fire, Ambulance, or Mental Health?" Or, that all calls that come in through non-emergency line and are answered by 9-1-1 will be screened for appropriateness of a behavioral health response. Please describe any elements used to address implicit bias in the determination of level 3 vs. 4 calls.	All calls that come into local PSAPs will be screened for appropriateness of behavioral health response. All PSAP staff receive racial equity, cultural diversity, and implicit bias training annually or bi-annually.
Level 1 Level 1 is the lowest urgency level. Callers are distressed, but there is no immediate threat. Non-life-threatening situations include passive desires not to be alive with no plan or active suicidal intent, requests for referrals and information, general feelings of overwhelm, stress, loneliness, and fatigue. Level 1 calls are likely to be able to be resolved with time spent on the phone with a trained 9-8-8 call taker, including call takers with lived and family experience themselves, who can provide listening, empathy, support, resources, connection to services, and follow up.	For all calls triaged to meet the state criteria for Level 1, a transfer and warm handoff will be conducted to the Regional Crisis Call Center (RCCC). To do this, the PSAP call-taker will connect with the call center and provide them with the relevant and pertinent information that has been obtained from the caller at that point in time (problem summary). Once the caller has been informed and has begun conversing with the RCCC, the PSAP call taker will disconnect. The call will be documented in CAD using call type and disposition.

Level 2 Level 2 situations include situations where clinical intervention is needed to reduce the advancement of greater risk. Individuals with suicidal thoughts but no intent, plan, means, capability or weapons would be considered Level 2. Minor self-injurious behavior that would not require medical attention beyond basic first aid, such as scratching into the skin with a paperclip or pin, would also be considered Level 2. Individuals experiencing withdrawal from non-life-threatening substances or dependence on alcohol, benzodiazepines or barbiturates, but not in active withdrawal with no history of withdrawal seizures or detox symptoms may fit the recommended response for Level 2 from a behavioral health crisis response, and EMS dispatch is needed to evaluate withdrawal symptoms.	For calls that meet state criteria for Level 2, a warm handoff call will be conducted with the Regional Crisis Call Center. These instances may require dispatch of 9-1-1 resources in addition to the resources dispatched by the Regional Crisis Call Center. The handoff will occur the same as with Level 1; however, the PSAP call taker will remain on the line until the RCCC call taker determines if additional resources will be necessary. The PSAP call taker will enter the encounter into CAD, using the call type and disposition.
Level 3 Situations involving active aggression would be classified as Level 3. Individuals with active psychosis disconnected from reality would be considered Level 3, as well as individuals with homicidal thoughts with no active intent or access to means. Individuals with suicidal thoughts and a specified plan, but no lethal weapons present, are classified as a Level 3 situation. Individuals engaging in self-injurious behavior that could cause life-threatening bodily injury (e.g., using a sharp knife) would be a Level 3 situation. Third-party calls for service, if missing important details on the scene safety would likely be considered Level 3.	For calls triaged to meet the state criteria for Level 3, the PSAP call taker will dispatch local mobile behavioral health teams, emergency medical personnel and law enforcement as available. The PSAP call taker will keep the caller on the phone to monitor and provide updates to responders. If a regional behavioral health response is needed, law enforcement units will request contact be made with the Regional Crisis Call Center. The PSAP call taker will then contact the Regional Crisis Call Center and relay both the pertinent information of the call and the requesting unit's contact information. The PSAP call taker will document the call into CAD, using the call type and the disposition.
Level 4 Level 4, or Emergent, situations are situations too unpredictable and potentially life threatening to have any delay in dispatch, and law enforcement (and EMS if needed) should be dispatched. These situations include direct threats to life, individuals who are actively assaultive and possess the means to cause life threatening harm to others or themselves. Individual who has made active suicide attempts where injuries have already occurred or a situation where suicide is imminent would be considered Level 4. Those situations may include a gun in the hand, pills ingested, a hanging scenario in place, a knife in hand with an unwillingness to secure the knife, all along with expressed homicidal or suicidal intent and without expressed ambiguity or significant barriers to acting on the intent or plan.	For all calls that meet state criteria for Level 4, law enforcement, emergency medical personnel and local mobile behavioral health teams will be dispatched as available. Like level 3, PSAP call taker will keep caller on the line. Rescue personnel and mobile behavioral health teams are dispatched to stage at a safe location in the vicinity until scene deemed safe. Law enforcement units on scene are to make the determination regarding scene safety. If regional behavioral health response is needed, law enforcement units will request contact be made with the Regional Crisis Call Center. They will then be telephoned and relayed the pertinent information of the call. The PSAP call taker should document call into CAD, using the call type and disposition.

Protocol 2. Mobile Crisis Team Emergency Back-Up

Region 2 is currently in the RFP process and has not identified a vendor for the Regional Crisis Call Center. Agreements will be created within 12 months of vendor identification. The PWCPD and PWC CSB have an MOU and standard of operation guidelines for the operations of the co-responder team. The PWCPD, MCPD and MPPD all agree to preferentially dispatch CIT trained officers when available.

Protocol 3. Law Enforcement Specialized Response

List any components of your specialized response (protocol #3) that fall at the leadership level (organization-wide policies, procedures, training, culture).

Prince William County PD

Community Policing

PWCPD incorporates community policing practices and principles into several General Orders and Standard Operating Procedures. In addition, there is training on this topic at the academy and during refresher training. These principles are put into practice within every unit on the Department while several have a focus on community policing practices. The PWCPD believes in community involvement and a shared focus in this area.

Use of Force Continuum

PWCPD Use of Force continuum is listed in our Use of Force General Order. PWCPD Use of Force Model and policy addresses the ability to escalate and de-escalate actions based on the threat or compliance being presented at the time. All uses of force are investigated by a supervisor and subsequently reviewed by additional members in the individual's chain of command up to the Chief of Police and Office of Professional Standards. The Department also uses a Critical Decision-Making Model. This structure helps to ensure each critical step is considered and that key questions are answered when going through a use of force decision-making process. See attached use of force continuum.

De-Escalation Required

De-escalation is in the training standards at the Prince William County Criminal Justice Academy and the PWC General Orders. De-escalation is discussed specifically in the Department's Use of Force General Order. In addition, there is refresher and control tactics training that stress the importance of de-escalation techniques. De-escalation is also taught during the Crisis Intervention Team Training. Every use of force is reviewed to ensure the minimum necessary amount of force was utilized and if appropriate, de-escalation techniques were utilized.

Implicit Bias Training

Everyone in the Department participates in mandated bias-based trainings and cultural diversity training. This is accomplished starting in the academy with subsequent mandatory refresher trainings on a yearly basis. General Orders are in place that specifically address implicit bias.

Officer Wellness

The Prince William County Police Department has a Wellness & Resiliency Unit. This unit focuses on the overall wellness of the members of the Police Department, including both physical and mental wellness. Part of that Unit includes the Peer Fitness Advisors. In addition, the Department has a Peer Support Team that will respond to the scene of any serious incidents and they are available 24/7 on a confidential basis if an officer needs to speak with them. The Department also has a Public Safety Resiliency Center comprised of licensed mental health clinicians who are available to Department members on a confidential basis. In addition to the above, the Department has an Employee Assistance Program (EAP) which is also available 24/7 on a confidential basis.

Manassas City PD

Community Policing:

MCPD currently incorporates community policing practices into several General Orders, including, but not limited to: 7-15 Community involvement, Patrol Procedures 6-2 and 6-15 Domestic Violence. It is also a major component of the Police Department and the City Goals and Objectives and strategic plan.

Use of Force Continuum:

The use of force continuum is listed under General Order 2-4 and there is detailed verbiage regarding the ability to respond based on a threat and not only move up but back down the continuum. There is clear direction in this policy. Use of force is also mentioned in regard to the department strategic plan.

De-Escalation Required:

De-escalation has been built the training standards due to today's demands on policing and is found in the Manassas City Police departmental general orders.

De-escalation techniques are taught during the annual Control Tactics/Use of Force training which is mandatory for all patrol officers. Based on updated training certifications, de-escalation training principles will be expanded and will involve additional annual training that will be mandatory for all patrol officers.

Implicit Bias Training:

Implicit bias is mandatory with all officers during their training at the Northern VA. Criminal Justice Academy and again here at our headquarters annually. The City Police Department will additionally be revising its general order, GO.201-Rules of Conduct, to directly address, deject and educate personnel against implicit bias.

Officer Wellness:

Officer Wellness has been built into training via the Virginia Department of Criminal Justice Services (DCJS) and Northern Virginia criminal justice academy. All employees at MCPD have been provided information on Peer Support are automatically eligible. the City Employee Assistance Program (EAP) through Anthem BlueCross BlueShield is another program where they are provided 24/7 secure and confidential psychiatric or psychological debriefing and counseling when necessary. Manassas City Police has started a Peer Support group, spousal support and has a contracted in-house counselor.

Manassas Park PD

Community Policing:

Manassas Park has built community policing practices into numerous General Orders, including, but not limited to: GO.104 - Police Ethics, GO.601 – Patrol Procedures, GO.626 – Bicycle Patrol and GO.614 – Domestic Relations

Guardian vs. Warrior:

Our agency has conveyed our movement from the warrior mindset to that of the guardian mindset in the policy section of departmental general order, GO.204 – Use of Force. This model utilizes communication and restraint to create cooperation and compliance. In this way, it seeks to protect civilians from indignity and humiliation.

Use of Force Continuum:

The Manassas Park Use of Force Continuum is articulated under departmental general order, GO.204 – Use of Force. The attachment to this policy, 204 – Force Continuum, is outlined under procedure and details clear and explicit departmental rules of engagement.

De-Escalation Required:

De-escalation has been built into both the minimum training standards of the Virginia Department of Criminal Justice Services (DCJS) law enforcement academy and the Manassas Park departmental general order, GO.204 – Use of Force. This topic is outlined at length in the departmental guideline, under the procedure section VI, and includes specifications regarding ID/DD and other vulnerable persons.

Implicit Bias Training:

Implicit bias is addressed with all officers during their training at the Virginia Department of Criminal Justice Services (DCJS) law enforcement academy. The Manassas Park Police Department will additionally be revising its general order, GO.201-Rules of Conduct, to directly address, deject and educate personnel against implicit bias.

Officer Wellness:

Officer Wellness has been built into the minimum training standards of the Virginia Department of Criminal Justice Services (DCJS) law enforcement academy. All employees are automatically provided membership into the City of Manassas Park Employee Assistance Program (EAP) through Anthem BlueCross BlueShield where they are provided 24/7 secure and confidential psychiatric or psychological debriefing and counseling when necessary. Critical incident debriefs may also be held for all involved personnel, as deemed necessary.

List any components of your specialized response (protocol #3) that relate to the training that all officers receive.

Prince William County PD

De-escalation and response to Persons in Crisis are in the training standards of the Prince William County Criminal Justice Academy. There is also yearly refresher training in this area. De-escalation is addressed above and is always a primary focus during refresher control tactics training. During the basic academy, the recruits get an 8-hour introduction to CIT to start introducing them to Crisis Intervention Tools and further stress the importance of de-escalation.

Some members have taken Mental Health First Aid, but it is not currently a required course by the Department. We are currently evaluating the possibility of adding it to the training schedule.

Manassas City PD

De-Escalation and Response to Persons in Crisis have been re-enforced in our training by way of the academy and our own in-house defensive tactics training. These topics are also discussed during the field training program with new officers. The concept of De-Escalation is in the Use of Force general order, where consideration towards, medical conditions, physical limitations, language barriers and other factors may come into play.

Mental Health First Aid 8-hour training is being considered as an additional training for all officers. Manassas City PD will incorporate all requirements put forth by DCJS.

Manassas Park PD

De-Escalation and Response to Persons in Crisis have been added into the minimum training standards of the Virginia Department of Criminal Justice Services (DCJS) law enforcement academy. These topics are also discussed during in-house post-academy training, prior to the beginning of new officer field training. De-Escalation is a policy maintained in the Use of Force general order, where consideration is expressed toward ID/DD, medical conditions, physical limitations, language barriers and drug/alcohol use.

Mental Health First Aid 8-hour training is being considered as an additional training for all officers. Manassas Park PD will incorporate all requirements put forth by DCJS.

List any components of your specialized response (protocol #3) that relate to intermediate, voluntary training (e.g., CIT training or CIT enhancement).

Prince William County PD

PWCPD currently has 41% of their 670 sworn officers trained in CIT. The goal is to train as many officers in CIT as we can at our current rate of 5 CIT classes per year. The eventual, long-term goal is 100% participation, but we recognize this will not be achieved quickly. Because of the current set-up, we can continue to fill the classes with primarily voluntary participants. We recognize the importance of having CIT officers spread across the Department and shifts. In addition to the 40-hour CIT training, we put on the following 8-hour courses: Introduction to CIT for Recruits, CIT for Dispatchers, and CIT for Magistrates.

It is the belief of the Department that all members possess the aptitude to de-escalate and utilize the skills and strategies taught during the academy and CIT. We offer material focused on a wide range of special populations with the goal that every member can become familiar with each.

Manassas City PD

Manassas City currently has 81% of their 90 sworn officers trained in CIT. The goal is to have 100% certification for CIT Officers. This will enable us to confidently dispatch trained officers to mental health scenarios. We are also exploring expanding training in Stress First Aid for those that are not trained.

Manassas Park PD

Manassas Park currently has 68% of their 31 sworn officers trained in CIT.

Voluntary Participation:

Due to the small size of our agency, the attempt is being made to generate 100% certification. This will enable our department to ensure that a CIT trained officer will respond to all calls for service, and hopefully, minimize non-compliance and use of force scenarios.

Aptitude for the Population:

It is the belief of this department that all officers possess the ability to de-escalate and provide verbal direction in a manner compliant with that of CIT training.

List any components of your specialized response (protocol #3) that relate to specialized units or advanced training (e.g., advanced Marcus Alert training, Suicide by Cop training, advanced CIT training).

Prince William County PD

PWCPD collaborates closely with the PWC Community Services Board and other resources located within the community. This collaboration is described in several General Orders, Standard Operating Procedures, and Memorandums of Understanding.

PWCPD has a Co-Responder Unit that has been in place since December 2020. It is comprised of PWC officers and PWC CS clinicians that ride together to respond to calls involving persons in crisis. There are currently 3 teams assigned to the Unit. The Unit will be expanding by 1 team in November 2021 and 2 teams in January 2022.

PWC has a special operation division that has a full time SWAT team and a part time crisis negotiation team that responds to high-risk situations, hostage situations, and barricaded subjects. They have specialized training to handle these types of incidents and attempt to de-escalate and resolve each incident in the safest manner for all. A CSB mental health professional trained in negotiation tactics serves on the team and assists with call outs.

Our department is looking into advanced / refresher Crisis Intervention Team training on various topics. We understand the importance of continued training in this area. Several members have attended advanced / refresher training offered by other agencies.

Manassas City PD

The Manassas City Police Department has an Emergency Services Unit and hostage negotiation unit. They currently have 5 CIT instructors (who assist PWCPD with training). They also have two K-9 officers. This agency has applied for a grant to hire a mental health professional and one FTE officer which would fall under our Community Services and act as outreach teams.

The Emergency Services Unit (ESU) is a special unit of selected, trained, and equipped officers to contain, stabilize, arrest and / or terminate situations, including but not limited to armed and barricaded criminals, persons in crisis, hostage situations, sniper attacks and warrant services for major arrests and search warrants.

There is also a trained Crisis Negotiations Team (CNT) whose mission is to facilitate the peaceful resolution of situations where individuals have barricaded themselves with or without hostages. The team is also tasked with negotiating with distraught individuals and other situations where the team's abilities are of value. A CSB mental health professional trained in negotiation tactics serves on the team and assists with call outs.

As part of the selection process for the above teams, the applicant's personal file will be reviewed to determine if the applicant has any employment history incidents that may be of issue for team operations, such as but not limited to; insubordination, use of force issues, unethical complaints, sick leave abuse, or poor work habits. The applicants must also successfully complete a psychological screening by the Department's professional consultant

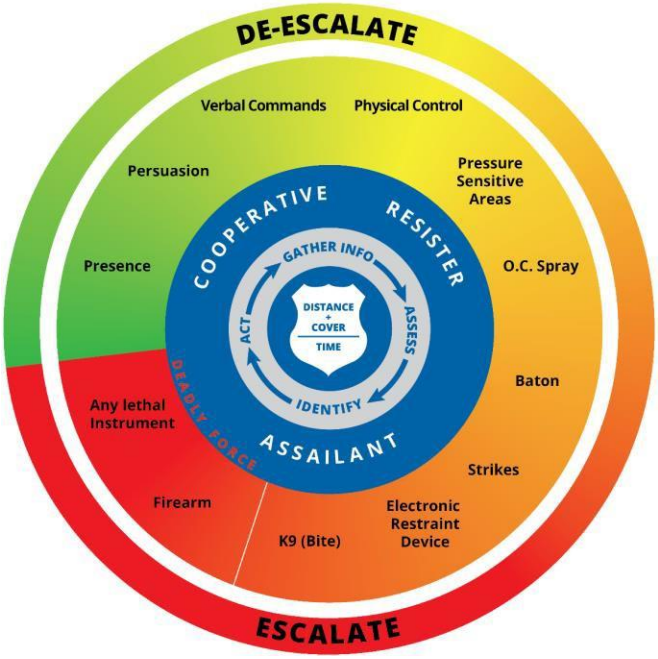
MCPD currently has 5 CIT instructors We also have two K-9 officers. This agency has applied for a grant to hire a mental health professional and one FTE officer which would fall under our Community Services and act as outreach teams.

Manassas Park PD

The Manassas Park Police Department maintains a Special Response Team (SRT) to counter unusual, high-risk situations, barricaded suspects, hostage situations, service of certain types of search warrants, and other similar life-threatening events where citizen and officer safety is at risk. We employ one officer who is certified in CIT Instruction. We also have one K-9 specialty unit who is assigned a bloodhound for human tracking. This tandem unit oversees our Project Lifesaver Plan, designed to aid in maintaining the safety of those residents with developmental disorders and/or cognitive impairments. Our agency is limited in its capacity to implement co-responder teams, outreach teams and/or other dedicated mental health teams at this time.

Use of Force Continuums

Prince William County Police Department


DE-ESCALATE
Verbal Commands
Physical Control
Persuasion
Pressure Sensitive Areas
Presence
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Baton
Any lethal Instrument
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Firearm
Electronic Restraint Device
K9 (Bite)
ESCALATE
COOPERATIVE
RESISTER
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GATHER:
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TAKE ACTION:
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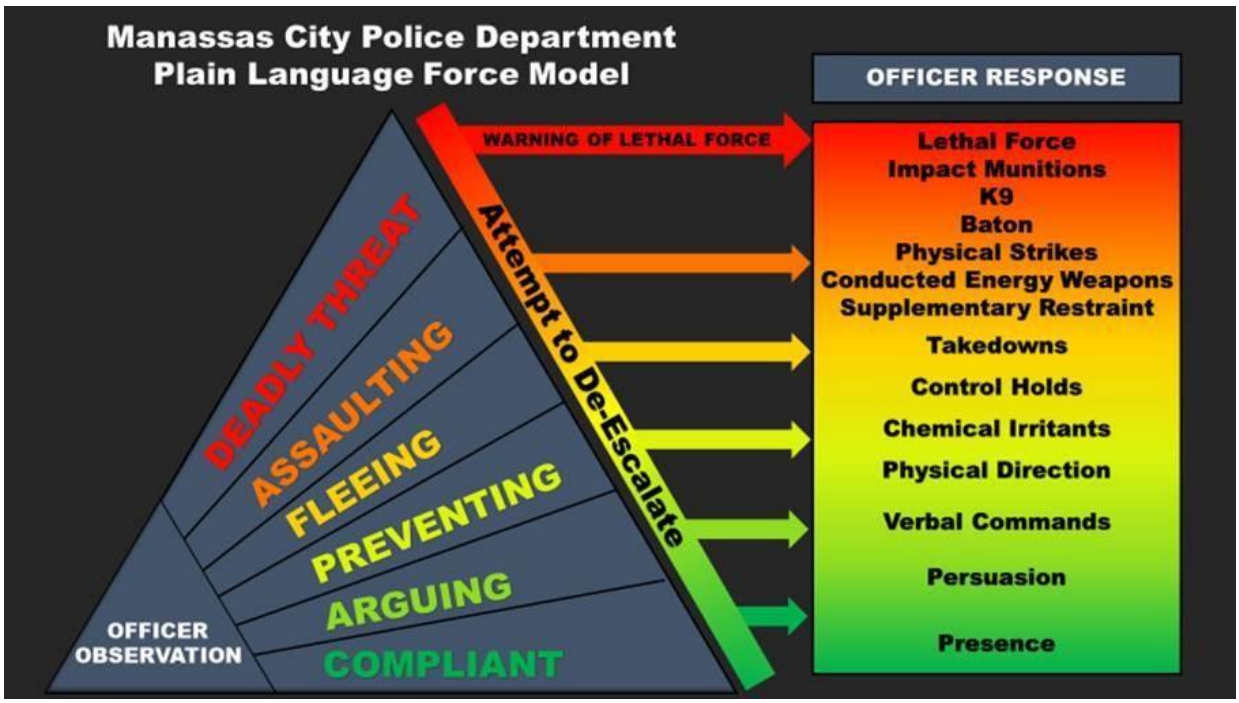
PRINCE WILLIAM COUNTY
POLICE

Manassas City Police Department

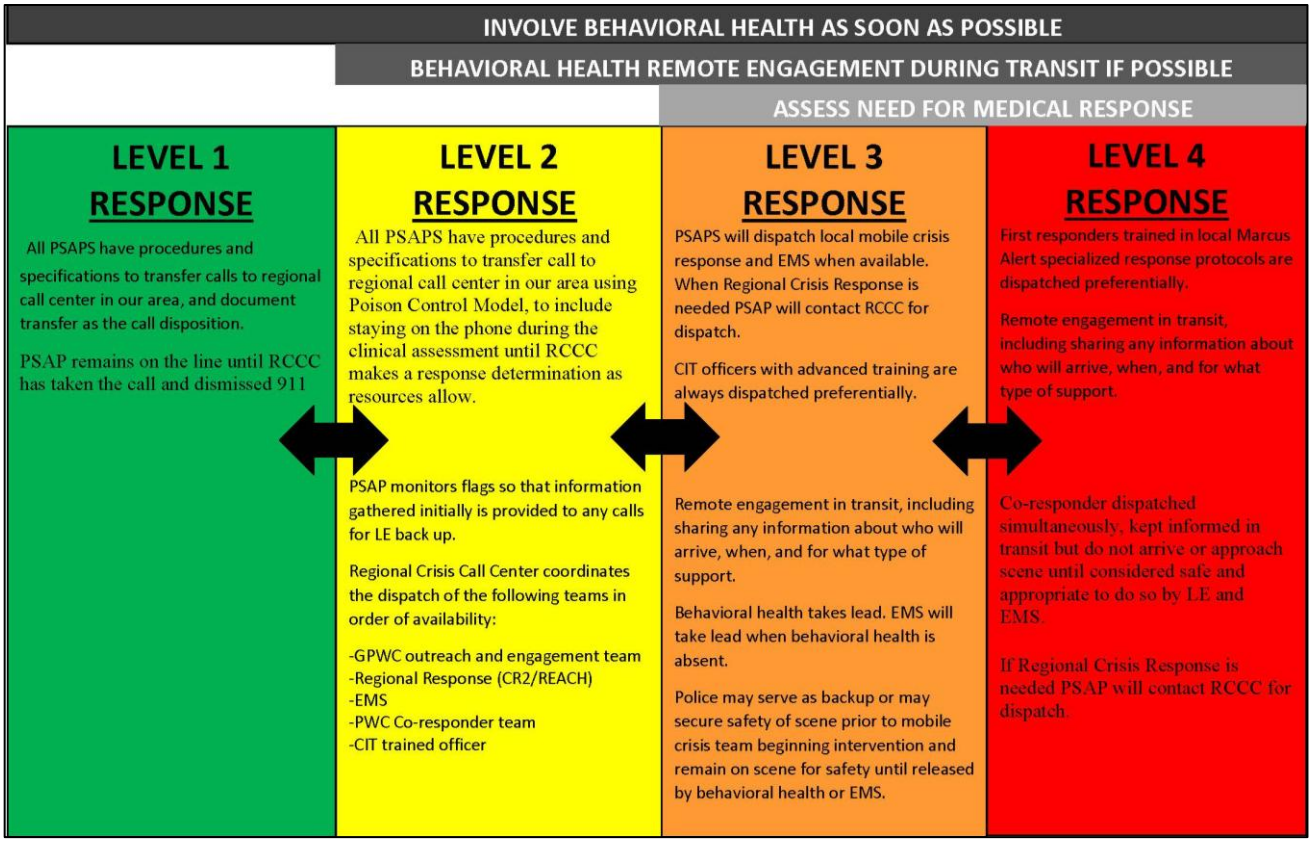


Community Coverage

State Description	***Local Description of Response/Coverage***
General Information These are cross-level triage components. Please describe any general elements of your response type plan. For example, does each level include multiple options that are dispatched based on availability? Or, does each level include multiple options that are determined appropriate based on triage/dispatcher decision making?	Responses will be based on assessment of situation by dispatch and availability of community care teams.
Level 1 STATE MINIMUM STANDARD: Level 1 calls must be transferred to the 9-8-8 call center BEST PRACTICE CONSIDERATION: Level 1 calls are fully diverted to 9-8-8	All PSAPS have procedures and specifications to transfer calls to regional call center in our area, and document transfer as the call disposition. 9-1-1 remains on the line until 9-8-8 has taken the call and dismissed 9-1-1

Level 2 STATE MINIMUM STANDARD: Level 2 calls are coordinated with 9-8-8 BEST PRACTICE CONSIDERATION: Level 2 calls follow a poison-control model with 9-8-8	All PSAPS have procedures and specifications to transfer call to regional call center in our area using Poison Control Model, to include staying on the phone during the clinical assessment until 9-8-8 makes a response determination as resources allow. 9-1-1 monitors/flags so that information gathered initially is provided to any calls for LE back up. 9-8-8/Regional call center coordinates the dispatch of the following teams in order of availability: -GPWC outreach and engagement team -Regional Response (CR2/REACH) -EMS -PWC Co-responder team -CIT trained officer
Level 3 State Minimum Standard: Level 3 calls include multiple response options across agencies/entities, and includes a behavioral health-only response option Developmental status (i.e., age, developmental disabilities) is taken into consideration when making dispatch decisions at Level 3 Best Practice Consideration: Level 3 calls involving youth are coordinated with 9-8-8 and specialized children's mobile crisis teams Level 3 calls involving individuals with ID/DD are coordinated with 9-8-8 and specialized developmental disability mobile crisis teams/REACH program training	PSAPS will dispatch mobile crisis response and EMS when available. Coordination with 9-8-8 for regional response from REACH and CR2 are considered for youth and ID/DD cases. CIT officers with advanced training are always dispatched preferentially. Remote engagement in transit, including sharing any information about who will arrive, when, and for what type of support. Behavioral health takes lead. EMS will take lead when behavioral health is absent. Police may serve as backup or may secure safety of scene prior to mobile crisis team beginning intervention and remain on scene for safety until released by behavioral health or EMS.

Level 4 STATE MINIMUM STANDARD: Level 4 calls include law enforcement or EMS (Best practice elements for Level 4 include the systems approach for Protocol #3. All elements do not have to be described here. Here, describe what type of response will be sent to Level 4 calls and how behavioral health is taken into consideration.)	First responders trained in local Marcus Alert specialized response protocols are dispatched preferentially. Remote engagement in transit, including sharing any information about who will arrive, when, and for what type of support. Co-responder dispatched simultaneously, kept informed in transit but do not arrive or approach scene until considered safe and appropriate to do so by LE and EMS. If case warrants response, CR2/REACH contacted once scene is deemed safe.



Appendix C. DBHDS Region Three: Highlands Community Services

A. Protocol 1. 9-1-1 Diversion to 9-8-8 Regional Crisis Call Centers

Triage Protocol:
Administrative processes, such as notifications of ECO issuance, or local partner outreach for emergency consultation/evaluations, will continue to be referred to the local CSB Emergency Services Department (current practice), and not transferred to The Crisis Call Center. (Local partners include medical providers, hospitals, jails, or other CSBs.)

TRIAGE LEVEL 1

(INCIDENTS APPROPRIATE FOR CRISIS CALL CENTER PHONE INTERVENTION)
9-1-1 to remain on the line until Crisis Call Center transfer confirmed
Examples may include (but not limited to):

- Individuals experiencing a non-life-threatening Mental Health Crisis.
- Individuals NOT actively attempting suicide or physically violent toward themselves or others.
- Individual has no homicidal/suicidal thoughts, intent, or behavior. Passive desires to harm oneself (or not be alive) with no plan/means or opportunity to carry out.
- Verbal disputes or disturbances only with a mental health component and there is no risk of violence.
- Parents requesting law enforcement due to a child having non-violent behavioral issues, regardless of whether the child has a known mental health diagnosis.
- Repeat callers with a known non-violent mental health history.
- Needs for listening, supports, and provision of referrals and information for resources.
- Connection to local CSB for Same Day Access or to provider of choice in the community.

TRIAGE LEVEL 2

(INCIDENTS THAT MAY BE APPROPRIATE FOR A MOBILE CRISIS TEAM RESPONSE)
9-1-1 to remain on the line until Crisis Call Center transfer is confirmed
Examples may include (but not limited to):

- Distressed person with imminent need for in-person behavioral health support.
- Calls requesting law enforcement law enforcement response due to a person experiencing a psychosis or altered mental state and are NOT physically violent towards themselves or others.
- No homicidal thoughts, intent, or behavior.
- Suicidal thoughts with no intent, plan or means/opportunity to carry out.
- Minor self-injurious behavior requiring no immediate medical intervention (an example would be someone not eating or taking their medicines, or lack of self-care). This does not include physical self-injury.
- Substance use without aggression.
- Second party calls concerning the welfare of someone who has a known/potential non-violent mental health history, or who may be suffering a non-violent mental health crisis.
- Calls which may meet the criteria of Level 2, but may be occurring in a location that presents physical hazards for response by only a mobile crisis team (at an intersection, in a crowded public location, etc…). In such settings, elevating to a Level 3 for co-response team dispatch may be warranted to help control safety within the surrounding environment.

TRIAGE LEVEL 3

(INCIDENTS REQUIRING LAW ENFORCEMENT/EMS RESPONSE. CRISIS CALL CENTER MAY BE CONTACTED/CONSULTED TO POTENTIALLY HELP DEFUSE THE SITUATION AND DETERMINE IF A C0-RESPONSE UNIT IS APPROPRIATE.)
Examples may include (but not limited to):

- Active aggression/combativeness
- Active psychosis
- Homicidal thoughts with no active behavior or intent or access to means.
- Active self-injurious behavior with concerns for medical risks (i.e., self-cutting)

• Suicidal thoughts with a specified plan (may or may not include access to means)
• Service of Emergency Commitment Orders by trained, but non-Marcus Alert Law Enforcement personnel, with continued access to CITAC for handoff and intervention. (Frontier Health Crisis Call Center to be consulted at the request of serving officers. If co-response team is dispatched, they are only as support to officers on scene for behavioral de-escalation.)

TRIAGE LEVEL 4

(LAW ENFORCEMENT/EMS/FIRE RESPONSE ONLY. CONTACT 9-1-1 FOR A C0-RESPONSE UNIT AT THE REQUEST OF AN INCIDENT COMMANDER OR OFFICER ON SCENE)
Examples may include (but not limited to):
• DIRECT IMMEDIATE THREAT TO LIFE
• Active suicide attempt where injuries have already occurred or a situation where suicide is imminent (with intent, plan, and means to commit are present)
• Actively assaultive violent towards others, or themselves, with the ability to cause significant harm.
• Homicidal/suicidal threats/intent and a weapon is present or easily accessible
• Substance impairment with physical aggression or severe psychiatric instability
• In progress criminal activity
• Domestic violence incidents

Call and Response Protocol:
A. The Frontier Health Crisis Call Center may receive a call directly or from PSAP/9-1-1. The calls will be handled as prescribed by the four triage levels.
B. If the Call Center determines a Mobile Crisis Unit (MCU) should be dispatched the Call Center will notify the Mobile Crisis Hub (or designee).
C. Upon dispatching a MCU the Mobile Crisis Hub will notify the Call Center of such. The Call Center will notify the respective PSAP/9-1-1 that a MCU has been dispatched. The PSAP will track the MCU according to its standard protocols. A Call for Service case number in this situation is not necessary. This action is primarily for the safety of the MCU. It will be the responsibility of the MCU to notify The Call Center when their assignment is completed and advise disposition. The Call Center will notify the respective PSAP that the MCU is no longer in the field. The PSAP does not need to track data in this instance.
D. During the response if either Frontier Health Crisis Call Center or PSAP/9-1-1 become aware of a change in circumstance requiring law enforcement response the entities will communicate such between them. The call will be re-classified as a Level Three Triage. Frontier Health Crisis Call Center will notify the MCU, which will stage until scene is secured.
E. If the MCU is on scene and requires a law enforcement response, the MCU will safely withdraw if necessary and notify PSAP/9-1-1. Law enforcement backup will respond as quickly as possible based upon the circumstances.
F. Washington County Virginia Emergency Management Services will serve as the primary PSAP for dispatching of Co-Response Teams for Triage Levels 3 and 4. Requests through Bristol Virginia PSAP/9-1-1 should be collaborated with and dispatched through Washington County PSAP for continuity and knowledge of availability. Once a CRU is dispatched by Washington County PSAP to the City of Bristol, the CRU will be advised to switch to the Bristol Police radio frequency for information and all further communications. CRU responses will be tracked on each agency's respective call sheet.
G. Whenever possible the PSAP will dispatch a CIT trained officer as part of the backup response. CIT officers will be designated in the CAD system. Law enforcement will serve in a protective capacity for all parties involved.
H. It will be the decision of backup law enforcement if a person in a mental health crisis needs to be restrained/taken into custody for the safety of themselves and others. The backup law enforcement officer will be responsible for execution of Emergency Custody Orders as well as any arrests for criminal matters.
I. Decisions to detain someone on a paperless Emergency Custody Order, may be made by either the backup law enforcement officer(s) or the co-response unit officer.
J. Service of Emergency Custody Orders, paperless or legal document, detainment, and transport involving a person in mental health crisis to CITAC/hospital for a mental health pre-screen, will be the responsibility of back up law

enforcement. If a subject in crisis agrees to a voluntary assessment the co-response officer, in consultation with the clinician, may provide transport to CITAC/hospital if feasible.
K. Marcus Alert law enforcement officers will defer actions regarding criminal matters to the backup law enforcement, except in emergent circumstances.
L. Anytime a law enforcement response is required the primary officer will complete an incident report which denotes the disposition. The co-response unit will also document their disposition for data collection purposes.

B. Protocol 2. Mobile Crisis Team Emergency Back-Up

This locality submitted a draft of a Memorandum of Understanding governing the MARCUS Alert Co-Response Program for the Washington County, Virginia – City Of Bristol, Virginia Service Area For Highlands Community Services (Agreement), between Highlands Community Services (HCS), New River Valley Community Services (NRVCS), Planning District 1 Behavioral Health Services (PD1), Frontier Health (FH), Washington County Virginia (County), Washington County Virginia Sheriff's Office (WCSO), City of Bristol Virginia (City), Bristol Virginia Police Department (BPD), Bristol Virginia Sheriff's Office (BVSO), Abingdon Police Department (APD), Damascus Police Department (DPD), Glade Spring Police Department (GSPD), Emory & Henry College Police Department (EHCPD), Virginia Highlands Community College Police Department (VHCCPD) and Virginia State Police Division 4 (VSP4) (collectively, "the Parties").

This draft is available at https://dbhds.virginia.gov/wp-content/uploads/2022/05/Highlands-Marcus-Alert-MOU-04.26.2022.pdf

C. Protocol 3. Law Enforcement Specialized Response

List any components of your specialized response (protocol #3) that fall at the leadership level (organization-wide policies, procedures, training, culture).

As with any professional agency or organization, the culture, attitude and mindset of the entire agency begin at the administrative or leadership level. The responsibility for the success of the subsequent components of this section falls directly on our partner agencies leadership and administration. Currently we have four (4) partner agencies that are accredited at either the state or national level. All of our remaining partner agencies have departmental policies and procedures but are not currently accredited. Six (6) of our partner agencies have "Biased Based Policing Policies" contained in their procedure manuals. Leadership from all of our partner agencies understand the importance and benefits of de-escalation training and especially CIT Training. Per DCJS requirements, all of our local and state officers have to have at least two hours of cultural diversity training every two years to maintain their law enforcement or jail certifications. Oftentimes implicit bias training may be included therein. All of our partner agencies have officers/deputies who have been trained in de-escalation and many of our partner agencies have sent their officers/deputies through our CIT training. The respective administrations of our partner agencies understand the concept and goals of the Marcus Alert program and as such have agreed to cooperate fully with any additional training that may be required. This includes the additional DCJS trainings that will be required but are yet to be developed surrounding de-escalation, mental health, cultural humility/competence, and anti-racism trainings.
During the past few years area law enforcement agencies have made great strides in the area of officer wellness. All of our partner law enforcement agencies have been made aware of the Virginia Law Enforcement Assistance Program, VALEAP, as well as crisis intervention stress management services offered by Highlands Community Services. In the case of a traumatic event involving one of our partner agencies, the CIT Coordinator or HCS Crisis Services Director also directly outreaches the effected agency administration offering services and or assistance.
One of our partners, the Virginia State Police, is a nationally accredited law enforcement agency. Due to this they have a specific policy in reference to "Handling individuals with Mental Illness or Disability" that is very specific and on point. We have distributed this policy section to our other partner agencies and have a goal (with verbalized commitment) of 100% adoption.

List any components of your specialized response (protocol #3) that relate to the training that all officers receive.

Currently all agency new hires that attend the local law enforcement academy receive at least (16) hours of verbal de-escalation as part of their basic academy training. All of these new hires receive the (8) hour Mental Health First Aid class taught by employees of our CSB during the same basic academy class, an arrangement we secured approximately three

years ago due to mutually identified need. During their basic academy they also all receive a six (6) hour block of training titled “Intro to CIT” during which they learn what CIT is, how it works, as well as how their respective CITACs operate. This is also taught by our CSB CIT Coordinator.
For officers/deputies who may have attended the local law enforcement academy prior to the above adopted training regimen. Sixteen (16) hour verbal de-escalation trainings as well as eight (8) hour Mental Health First Aid classes are available but are currently not a DCJS requirement.
One of our local partners, the Bristol Virginia Police Department, recently required all of their sworn members to go through sixteen (16) hours of additional verbal de-escalation training taught by our law enforcement academy staff.

List any components of your specialized response (protocol #3) that relate to intermediate, voluntary training (e.g., CIT training or CIT enhancement).

Currently we offer three CIT Basic classes a year. Our partner agencies routinely send personnel to this training sometimes by assigning them, other times the officers/deputies attend voluntarily. We have a good cooperative relationship with our partner agencies in identifying officers/deputies whose attendance would be a positive benefit for the program, the agency, and the community. We also have a large contingent of officers from our region that are outside of our catchment area that attend our CIT Basic classes, including multiple VSP Troopers who have completed our course to date. We can certainly attest to the quality of the training we conduct, such that even those few who may have been assigned by their administrations to attend the training end up with a meaningful experience that helps to change their every-day policing practice.

Highlands CITAC currently requires its full time CITAC Officers and clinicians to attend the forty (40) hour CIT Basic Class.

We offer a CIT for Dispatchers class to improve dispatcher understanding of crisis services, CITAC and CIT as a whole.

We have recommended to all of our partner agencies that they send members of their hostage negotiation teams to our CIT Basic Class. We fully anticipate our partner agencies will cooperate with this recommendation.

When available, we also have select officers/deputies attend other advanced trainings, such as CISM, to enhance our overall team.

List any components of your specialized response (protocol #3) that relate to specialized units or advanced training (e.g., advanced Marcus Alert training, Suicide by Cop training, advanced CIT training).

We plan to require all members, both law enforcement and clinical, of our Co-response Unit to attend the advanced Marcus Alert training once it is developed. As time permits and the program grows, we will also require our full time CITAC Officers to attend this advanced training as well.

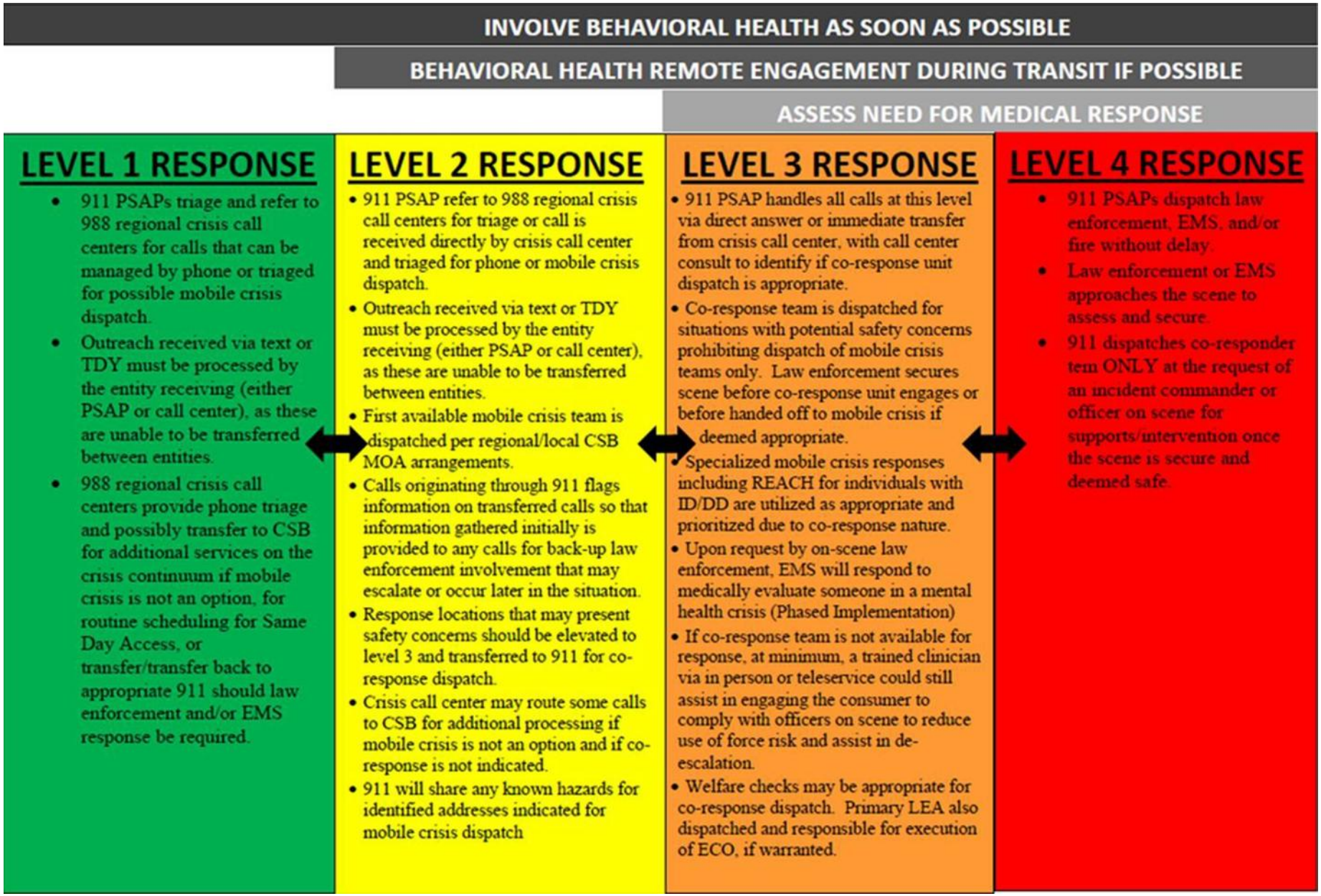
It was also recommended all of our partner agencies send members of their hostage negotiation teams to the Advanced Marcus Alert training once it is developed. Our stakeholder group recommended that administrative staff of the partner agencies also complete the Advanced Marcus Alert Training when available.
We are currently developing a law enforcement familiarization/safety training for our co-response clinicians to be taught by our law enforcement partners. This training would be required for any clinician who may respond in a co-response capacity and would address basic operations and scene safety and terminology within the law enforcement world.
We are open to any and all other advanced training opportunities that may be available that will enhance our team and local partner’s ability to better serve the community in a consistent, safe, and effective manner.

D. Community Coverage

State Description	***Local Description of Response/Coverage***

General Information These are cross-level triage components. Please describe any general elements of your response type plan. For example, does each level include multiple options that are dispatched based on availability? Or does each level include multiple options that are determined appropriate based on triage/dispatcher decision making?	Each level includes multiple options that can be dispatched as available, but also as are deemed appropriate by the individual conducting the phone triage. Once passed to an identified clinician (as appropriate), should the recommended triage level differ, additional options are explored, and all levels of the handoff process are updated. For levels 3 and 4, law enforcement input for triage feedback is also considered. Text and TDY contacts are unable to transfer across systems.
Level 1 STATE MINIMUM STANDARD: Level 1 calls must be transferred to the 9-8-8-call center BEST PRACTICE CONSIDERATION: Level 1 calls are fully diverted to 9-8-8	Regional Crisis Call Center receives all Level 1 calls either directly or via PSAP transfer. Callers will receive phone triage/warm line services and may be handed off to community providers for follow-up service scheduling/contact.
Level 2 STATE MINIMUM STANDARD: Level 2 calls are coordinated with 9-8-8 BEST PRACTICE CONSIDERATION: Level 2 calls follow a poison-control model with 9-8-8	Regional Crisis Call Center receives all Level 2 calls either directly or via PSAP transfer. Call Center managers outreach for referral/dispatch of Mobile Crisis Units, if escalated up to Co-Response, handed off to PSAP. Call Center keeps PSAP advised of all MCU dispatched teams for expedited access in emergency.
Level 3 STATE MINIMUM STANDARD: Level 3 calls include multiple response options across agencies/entities, and includes a behavioral health-only response option Developmental status (i.e., age, developmental disabilities) is taken into consideration when making dispatch decisions at Level 3 BEST PRACTICE CONSIDERATION: Level 3 calls involving youth are coordinated with 9-8-8 and specialized children's mobile crisis teams Level 3 calls involving individuals with ID/DD are coordinated with 9-8-8 and specialized developmental disability mobile crisis teams/REACH program training	Calls triaged Level 3 will always be cleared by law enforcement at a minimum, before potentially de-escalating back down to a Level 2, allowing for Mobile Crisis Unit response without law enforcement. Collaborations are ongoing with law enforcement on scene, and specialized response units may be requested to join co- response teams or mobile crisis teams (i.e., youth mobile response or REACH).

Level 4 STATE MINIMUM STANDARD: Level 4 calls include law enforcement or EMS (Best practice elements for Level 4 include the systems approach for Protocol #3. All elements do not have to be described here. Here, describe what type of response will be sent to Level 4 calls and how behavioral health is taken into consideration.)	Law Enforcement or EMS approach and clear scene and behavioral health units are brought in only as support/intervention at the request of an incident commander once the scene is secure and deemed safe and appropriate for on-scene interventions.


INVOLVE BEHAVIORAL HEALTH AS SOON AS POSSIBLE
BEHAVIORAL HEALTH REMOTE ENGAGEMENT DURING TRANSIT IF POSSIBLE
ASSESS NEED FOR MEDICAL RESPONSE
LEVEL 1 RESPONSE
911 PSAPs triage and refer to 988 regional crisis call centers for calls that can be managed by phone or triaged for possible mobile crisis dispatch.
Outreach received via text or TDY must be processed by the entity receiving (either PSAP or call center), as these are unable to be transferred between entities.
988 regional crisis call centers provide phone triage and possibly transfer to CSB for additional services on the crisis continuum if mobile crisis is not an option, for routine scheduling for Same Day Access, or transfer/transfer back to appropriate 911 should law enforcement and/or EMS response be required.
LEVEL 2 RESPONSE
911 PSAP refer to 988 regional crisis call centers for triage or call is received directly by crisis call center and triaged for phone or mobile crisis dispatch.
Outreach received via text or TDY must be processed by the entity receiving (either PSAP or call center), as these are unable to be transferred between entities.
First available mobile crisis team is dispatched per regional/local CSB MOA arrangements.
Calls originating through 911 flags information on transferred calls so that information gathered initially is provided to any calls for back-up law enforcement involvement that may escalate or occur later in the situation.
Response locations that may present safety concerns should be elevated to level 3 and transferred to 911 for co-response dispatch.
Crisis call center may route some calls to CSB for additional processing if mobile crisis is not an option and if co-response is not indicated.
911 will share any known hazards for identified addresses indicated for mobile crisis dispatch
LEVEL 3 RESPONSE
911 PSAP handles all calls at this level via direct answer or immediate transfer from crisis call center, with call center consult to identify if co-response unit dispatch is appropriate.
Co-response team is dispatched for situations with potential safety concerns prohibiting dispatch of mobile crisis teams only. Law enforcement secures scene before co-response unit engages or before handed off to mobile crisis if deemed appropriate.
Specialized mobile crisis responses including REACH for individuals with ID/DD are utilized as appropriate and prioritized due to co-response nature.
Upon request by on-scene law enforcement, EMS will respond to medically evaluate someone in a mental health crisis (Phased Implementation)
If co-response team is not available for response, at minimum, a trained clinician via in person or teleservice could still assist in engaging the consumer to comply with officers on scene to reduce use of force risk and assist in de-escalation.
Welfare checks may be appropriate for co-response dispatch. Primary LEA also dispatched and responsible for execution of ECO, if warranted.
LEVEL 4 RESPONSE
911 PSAPs dispatch law enforcement, EMS, and/or fire without delay.
Law enforcement or EMS approaches the scene to assess and secure.
911 dispatches co-responder tem ONLY at the request of an incident commander or officer on scene for supports/intervention once the scene is secure and deemed safe.

Appendix D. DBHDS Region Four: Richmond Behavioral Health Authority

A. Protocol 1. 9-1-1 Diversion to 9-8-8 Regional Crisis Call Centers

State Description	*Local Description*
General Information These are cross-level triage components. Please describe any general triage elements used to identify Marcus Alert situations. For example, does your agency plan to begin calls with, "Police, Fire, Ambulance, or Mental Health?" Or, that all calls that come in through non- emergency line and are answered by 9-1-1 will be screened for appropriateness of a behavioral health response Please describe any elements used to address implicit bias in the determination of level 3 vs. 4 calls.	• *Address/location of the emergency* • *Phone number calling from* • *Name of caller/name of subject* • *Nature of emergency/what happened* • *Is caller/subject at the location now* • *Immediate danger/serious self-harm or harm to others* • *Description of subject (age, gender, race, other distinguishing features)* • *Injuries* • *If third party caller, does the caller personally know the subject and what is the relationship?*
Level 1 Level 1 is the lowest urgency level. Callers are distressed, but there is no immediate threat. Non- life-threatening situations include passive desires not to be alive with no plan or active suicidal intent, requests for referrals and information, general feelings of overwhelm, stress, loneliness, and fatigue. Level 1 calls are likely to be able to be resolved with time spent on the phone with a trained 9-8-8 call taker, including call takers with lived and family experience themselves, who can provide listening, empathy, support, resources, connection to services, and follow up.	• *Use of drugs or alcohol* • *Suicidal thoughts* • *Is the subject cooperative* • *Is the subject/caller one in the same*

Level 2 Level 2 situations include situations where clinical intervention is needed to reduce the advancement of greater risk. Individuals with suicidal thoughts but no intent, plan, means, capability or weapons would be considered Level 2. Minor self-injurious behavior that would not require medical attention beyond basic first aid, such as scratching into the skin with a paperclip or pin, would also be considered Level 2. Individuals experiencing withdrawal from non-life-threatening substances or dependence on alcohol, benzodiazepines or barbiturates, but not in active withdrawal with no history of withdrawal seizures or detox symptoms may fit the recommended response for Level 2 from a behavioral health crisis response, and EMS dispatch is needed to evaluate withdrawal symptoms.	• *Suicidal thoughts with no plan or immediate means* • *Subject speaking/able to talk/reasonably coherent* • *Is the subject currently under the influence of alcohol or drugs – if yes consider Level 3 or 4* • *Subject is responsive to questions* • *Note: the expression of anger, conflict, or distress without other significant symptoms does not necessitate a Level 2 or higher response if de-escalation is successful.* • *Note: presentation of raised voice, pressured speech, and/or slight confusion alone does not* *require a Level 2 response*
Level 3 Situations involving active aggression would be classified as Level 3. Individuals with active psychosis disconnected from reality would be considered Level 3, as well as individuals with homicidal thoughts with no active intent or access to means. Individuals with suicidal thoughts and a specified plan, but no lethal weapons present, are classified as a Level 3 situation. Individuals engaging in self-injurious behavior that could cause life-threatening bodily injury (e.g., using a sharp knife) would be a Level 3 situation. Third- party calls for service, if missing important details on the scene safety would likely be considered Level 3.	• *Responding appropriately vs incoherent/disorganized behavior (disorganized behavior associated with active psychosis requires a coordinated behavioral health/law enforcement response if adult, may not be needed if involves a child)* • *Cooperative* • *Thinking of or threatening harm to self or others* • *Appears to have difficulty with self-care* • *Homeless* • *Minor self-injury (such as superficial scratching/cutting) does not in itself require a Level 3 or 4 response.* • *For children/youth, any report of physical aggression should be carefully considered in light of age and risk (potential for* *serious injury, legal status)*

Level 4 Level 4, or Emergent, situations are situations too unpredictable and potentially life threatening to have any delay in dispatch, and law enforcement (and EMS if needed) should be dispatched. These situations include direct threats to life, individuals who are actively assaultive and possess the means to cause life threatening harm to others or themselves. Individual who have made active suicide attempts where injuries have already occurred or a situation where suicide is imminent would be considered Level 4. Those situations may include a gun in the hand, pills ingested, a hanging scenario in place, a knife in hand with an unwillingness to secure the knife, all along with expressed homicidal or suicidal intent and without expressed ambiguity or significant barriers to acting on the intent or plan.	• *Access to firearm/weapon* • *Threatening use of weapon* • *Assaultive behaviors with potential for injury* • *Assaultive behaviors in children does not include minor physical altercations without injury or threat of escalation* • *Need for immediate rescue or medical attention* • *Unconscious* • *In need of immediate medical attention*

PSAP staff have received basic CIT dispatch training and will receive training/orientation to Levels 1, 2, 3, and 4 through regular daily roll call. The descriptors above will be the basis for refining screening questions within the PSAP CAD system.

Callers/subjects assessed to require an either Level 1 or 2 response will be linked through warm handoff to the Region IV Call Center (NSPL provider).

Implicit bias will be addressed in all aspects of training for 9-1-1 dispatchers, law enforcement officers, and behavioral health specialist.

It is understood that calls from third party callers require special consideration as to the context and what has led the caller to make the call. Parents or group home operators are likely to have more knowledge about the subject whereas an unrelated community member may have limited information. The extent of information provided goes directly to confidence in any clinical or situational risk determination.

B. Protocol 2. Mobile Crisis Team Emergency Back-Up

This locality submitted a draft of a Memorandum of Understanding between Richmond Police Department (RPD), Richmond Department of Emergency Communications (RDEC), and Richmond Behavioral Health Authority (RBHA), political subdivisions of the Commonwealth of Virginia. RPD, RDEC, AND RBHA may be collectively referred to as the "Parties" and individually as the "Party."

This draft is available at https://dbhds.virginia.gov/wp-content/uploads/2022/10/RBHA_Protocol21.docx

C. Protocol 3. Law Enforcement Specialized Response

The Richmond Police Department's mission states, "We make Richmond a safer city through community policing and engagement." Our Customer Value Proposition declares that, "We seek to improve the quality of life in the city of Richmond through a proactive team approach to timely, innovative intervention and community problems. We will be the catalyst for positive social change through persistent personalized and cost-effective application of public safety resources." The Richmond Police Departments operations are rooted firmly in the Community Policing model and is supported through required trainings.

The Richmond Virginia Police Department leadership is comprised of numerous CIT trained commanders, middle managers, and first line supervisors. The Richmond CIT training contingent, which has been active since 2009, includes one instructor who received the Virginia CIT Officer of the Year from Virginia CIT Coalition and another who received the CIT Trainer of the Year from the Central Virginia Chapter of the National Alliance on Mental Illness. The program and our regional partners have been recognized by NAMI. The program's coordinator has been recognized for "Meritorious Service to Law Enforcement." *The Richmond Police Department, in partnership with the Richmond Behavioral Health Authority, is in the process of developing two co-response teams consisting of law enforcement officer/behavioral health clinician pairs. They will be equipped with alternate/specialized vehicles, soft uniforms, and technology to deliver field services. Co-response teams will primarily focus on Level 3 Marcus Alert Calls, but will be positioned to respond to Level 4 Calls when available and appropriate from a risk perspective. The two co-response teams will include another team consisting of a QMHP and Certified Peer in a supporting roll (i.e., follow-up, wellness checks, etc.). The co- response teams will be housed out of a non-law enforcement facility and will be under the joint supervision of RPD and RBHA.*

Since its formation, the Richmond CIT program has trained over 600 law enforcement officers, emergency medical personnel, mental health professionals, and members of the Department of Emergency Communications. In addition, Richmond CIT has supported developing operational CIT programs across the state, offering training slots in the 40-hour core CIT and Train-the- Trainer events, and traveling to share expertise as consultants with developing programs in over 11 cities and counties throughout the region. Richmond's CIT program is a member of the VACIT Coalition and follows the principles outlined in the Essential Elements for Virginia's CIT Programs. Over two-thirds of RPD officers are CIT trained. RPD's goal is to reach the elusive goals of 100 percent patrol officers trained in CIT.

Another successful effort supported by our department is the Crisis Triage Center (CTC), or CITAC, which is part of the CIT continuum of diversion that law enforcement officers are asked to consider, as outlined in the *CIT Essential Elements*. Opened in 2013 and operated collaboratively by RBHA, RPD, and Bon Secours Richmond Community Hospital (RCH), the CTC is a central location to which individuals in crisis and under Emergency Custody Order can be transported and receive a comprehensive medical and psychiatric evaluation and triage.

Officers taking these individuals into custody in the community can transfer custody to law enforcement on duty at RCH. The CTC provides an alternative to arrest and incarceration; and, is a valuable resource for citizens who are served by Richmond CIT officers.

Richmond Police Department provides CIT training to Department of Emergency Communications training personnel to assure efficient coordinated crisis response between dispatchers and Richmond Police patrol officers.

The Richmond Police Department has a long commitment to developing training on best practices for responding to behavioral health crisis. That commitment is evidenced by setting the goal that 100% of our officers will receive CIT training. Additional training and policies are set forth to guide officers in their engagements with individuals experiencing a behavioral health crisis. These policies include:

a. Response to Person with Mental (Awareness Response Training)
b. Fair and Impartial (as well as a Booster class)
c. Mental Health First Aid for the Recruits
d. CIT
e. Implicit Bias
f. LGBTQ+ Awareness
g. Autism Awareness
h. Human Trafficking
i. Tactical Brain Training
j. Duty to Intervene
k. Pain Behind the Badge (Clark Paris)
l. Surviving Verbal Conflict De-Escalation Techniques
m. Officer and Agency Wellness Training
n. Navigating Officer Involved Shootings
o. Peer Support and Mentoring Training
p. Bulletproof Mind
q. Empathy Based Interrogation
r. Law Enforcement Response to Dementia (along with a TTT course)
s. Law Enforcement Response to Intellectual Disabilities (along with a TTT course)
t. Preventing Veteran Suicides
u. Substance Abuse Prevention Training
v. Officer Wellness
w. Ethical Decision Making
x. Trauma and Resilience Training
y. Law Enforcement Suicide Prevention and Intervention Training

In concert with our extensive training standards and substantial community resources, the police department in collaboration with the Department of Emergency Communications and Richmond Behavioral Health Authority is developing a Community Response Team that will provide mobile, coordinated behavioral health and law enforcement response in the community.

Richmond Police Department will adopt new standards for staff development as they are established by DCJS. The table below highlights the current training plan within the Richmond Police Department:

All Officers	• Mental Health First Aid in the Basic Police Recruit Academy • In-service Mental Health Training (Including Autism, Intellectual Disabilities, Traumatic Brain Injury, Mental Health, Substance Use, Alzheimer's, and others) • Cultural Diversity Training • Fair and Impartial Policing Programs • Police Ethics • Community Policing Strategies • Use of force and de-escalation training via classroom and scenario-based training strategies (both live and video simulation). • LGBTQ awareness • CIT 40-hour basic training
Advanced Training	• Refer to the list above (to include here) • Train the Trainer for CIT • SWAT Officers • School Resource Officers • Crisis Negotiators • Community Policing • Warrants • Additional advanced training as identified by DCJS
Proposed Community Response Team	In addition to CIT 40, Community Response Team personnel will also receive specialized training on effective co-response strategies and protocols. *Additional advanced training will be provided upon guidance from DCJS.* In addition to *acquiring* training for officers*,* RPD will be *providing* specialized training to mobile crisis providers to assure that behavioral health professionals are instructed how to work safely in close coordination with police officers in the field. Training may include, but not limited to, emergency radio operation, concealment and cover, mayday alerts, weapons safety.

The Richmond Police Department and RBHA commit to the development and requirement of Advanced Marcus Alert Training as the curriculum is developed and implemented. Specifically, officers deployed in specialized Marcus Alert related assignments and the behavioral health co-response and mobile crisis staff will participate.

Each year, RPD police officer's complete re-certification requirements including Use of Force in compliance with DCJS standards. Please refer to the DCJS training standards. A copy of the RPD Use of Force Policy and Training Syllabus will be provided when available.

The RPD will consider the approved Marcus Alert Implementation Plan as interim policy until formally developed.

RPD does have an officer wellness policy (listed above). A copy of the policy has been requested. Two specific officer wellness trainings are required, and the department has a CISM peer support program in place. In addition, RPD contracts with RBHA for post critical incident support.

D. Community Coverage

State Description	***Local Description of Response/Coverage***
General Information These are cross-level triage components. Please describe any general elements of your response type plan. For example, does each level include multiple options that are dispatched based on availability? Or, does each level include multiple options that are determined appropriate based on triage/dispatcher decision making?	*Generally, the goals of the Richmond implementation plan are reflected in the following crosswalk, incorporating the vision to: diminish the role of police in behavioral health crisis response (BH takes lead in Levels 1-3); involve police in a supporting role (Level 3); shift primary response to qualified BH professionals, as resources permit; and prioritize use of non-lethal force (CRT team components). Level options do recognize that 9-1-1/9-8-8 dispatch may resort to available resources.*
Level 1 STATE MINIMUM STANDARD: Level 1 calls must be transferred to the 9-8-8 call center BEST PRACTICE CONSIDERATION: Level 1 calls are fully diverted to 9-8-8	Behavioral Health takes the lead: PSAP has procedures and specifications to transfer calls to regional call center in our area, and document transfer as the call disposition. 9-1-1 remains on the line until 9-8-8 has taken the call and dismissed 9-1-1.
Level 2 STATE MINIMUM STANDARD: Level 2 calls are coordinated with 9-8-8 BEST PRACTICE CONSIDERATION: Level 2 calls follow a poison-control model with 9-8-8	Behavioral Health takes the lead: Mobile crisis response, using Poison Control Model, to include staying on the phone during the clinical assessment until 9-8-8 makes a response determination as resources allow.

	9-1-1 monitors/flags so that information gathered initially is provided to any calls for LE back up. 9-8-8/Regional call center coordinates the dispatch of mobile crisis response based on team availability If mobile crisis response not immediately available, 9-1-1/9-8-8 follow Level 3 protocols
Level 3 STATE MINIMUM STANDARD: Level 3 calls include multiple response options across agencies/entities, and includes a behavioral health-only response option Developmental status (i.e., age, developmental disabilities) is taken into consideration when making dispatch decisions at Level 3 BEST PRACTICE CONSIDERATION: Level 3 calls involving youth are coordinated with 9-8-8 and specialized children's mobile crisis teams Level 3 calls involving individuals with ID/DD are coordinated with 9-8-8 and specialized developmental disability mobile crisis teams/REACH program training	Behavioral Health takes the lead: PSAP will dispatch Co-Responder team when available. 9-1-1 communicates with 9-8-8 for mobile crisis response dispatch, when CRT not available. CIT officers with advanced training are always dispatched preferentially. If CRT or mobile crisis not available, PSAP will engage with RBHA Emergency Services to dispatch ES clinician with LE. Remote engagement in transit, including sharing any information about who will arrive, when, and for what type of support. Behavioral health takes lead. Police may serve as backup or may secure safety of scene prior to mobile crisis team beginning intervention and remain on scene for safety until released by behavioral health. If no behavioral health/mobile crisis support is available, LE will transport individual to nearest CITAC for evaluation.
Level 4	Police take lead:

STATE MINIMUM STANDARD: Level 4 calls include law enforcement or EMS (Best practice elements for Level 4 include the systems approach for Protocol #3. All elements do not have to be described here. Here, describe what type of response will be sent to Level 4 calls and how behavioral health is taken into consideration.)	First responders trained in local Marcus Alert specialized response protocols are dispatched preferentially. Remote engagement in transit, including sharing any information about who will arrive, when, and for what type of support. Co-responder team may be dispatched simultaneously, kept informed in transit but do not arrive or approach scene until considered safe and appropriate to do so by LE or EMS.

Level 1 **Behavioral Health Leads**	**Level 2** **Behavioral Health Leads**	**Level 3** **Behavioral Health Leads**	**Level 4** **Police take lead**
PSAP has procedures and specifications to transfer calls to regional call center in our area, and document transfer as the call disposition. 9-1-1 remains on the line until 9-8-8 has taken the call and dismissed 9-1-1.	Mobile crisis response, using Poison Control Model, to include staying on the phone during the clinical assessment until 9-8-8 makes a response determination as resources allow. 9-1-1 monitors/flags so that information gathered initially is provided to any calls for LE back up. 9-8-8/Regional call center coordinates the dispatch of mobile crisis response based on team availability If mobile crisis response not immediately available, 9-1-1/9-8-8 follow Level 3 protocols	PSAP will dispatch Co-Responder team when available. 9-1-1 communicates with 9-8-8 for mobile crisis response dispatch, when CRT not available. CIT officers with advanced training are always dispatched preferentially. If CRT or mobile crisis not available, PSAP will engage with RBHA Emergency Services to dispatch ES clinician with LE. Remote engagement in transit, including sharing any information about who will arrive, when, and for what type of support.	First responders trained in local Marcus Alert specialized response protocols are dispatched preferentially. Remote engagement in transit, including sharing any information about who will arrive, when, and for what type of support. Co-responder team may be dispatched simultaneously, kept informed in transit but do not arrive or approach scene until considered safe and appropriate to do so by LE or EMS.

		Behavioral health takes lead. Police may serve as backup or may secure safety of scene prior to mobile crisis team beginning intervention and remain on scene for safety until released by behavioral health. If no behavioral health/mobile crisis support is available, LE will transport individual to nearest CITAC for evaluation.	

Appendix E. DBHDS Region Five: Virginia Beach Community Services

A. Protocol 1. 9-1-1 Diversion to 9-8-8 Regional Crisis Call Centers

State Description	*Local Description*
General Information These are cross-level triage components. Please describe any general triage elements used to identify Marcus Alert situations. For example, does your agency plan to begin calls with, "Police, Fire, Ambulance, or Mental Health?" Or, that all calls that come in through non-emergency line and are answered by 9-1-1 will be screened for appropriateness of a behavioral health response Please describe any elements used to address implicit bias in the determination of level 3 vs. 4 calls.	Calls that come through the Virginia Beach 9-1-1 Call Center will be answered, "Virginia Beach 9-1-1, where is your emergency?" 9-1-1 dispatchers will use the ECCS standard operating procedures (SOP) to determine if a behavioral health response is needed and, if so, identify the corresponding Marcus Alert level. The Public Safety Answering Point (PSAP) General Order provides specific questions to be asked and provides defined criteria for each level. In addition, clear and specific call processing protocols will be in place to direct these determinations in an effort to address implicit bias. When making determinations about the level of response, all effort will be made to assess level of safety, developmental status (age, development disabilities, etc.), and reported/known history of the individual.
Level 1	<u>Defining Criteria Examples:</u> • Person is expressing feelings of depression, anxiety,

Level 1 is the lowest urgency level. Callers are distressed, but there is no immediate threat. Non-life-threatening situations include passive desires not to be alive with no plan or active suicidal intent, requests for referrals and information, general feelings of overwhelm, stress, loneliness, and fatigue. Level 1 calls are likely to be able to be resolved with time spent on the phone with a trained 9-8-8 call taker, including call takers with lived and family experience themselves, who can provide listening, empathy, support, resources, connection to services, and follow up.	or other psychological distress without a suicidal or homicidal plan of action. • Person is expressing suicidal thoughts, a desire or wish to harm self with no direct/current plan to commit suicide, and no means at hand to harm self or complete death by suicide. • Person is experiencing conflict with those around them, distress related to interpersonal relationships, but without homicidal thoughts, intent, or plan to harm others. • Low levels of agitation and confusion where the individual can be assisted without the need for a mobile or in person response. Level 1 (Routine) responses will be transferred to the regional call center under the management of the Western Tidewater Community Services Board (WTCSB). This call center will be clinically staffed, 24/7, and provide phone screening and assessment that meets National Suicide Prevention Lifeline (NSPL) guidelines regarding suicide risk assessment and engagement.
Level 2 Level 2 situations include situations where clinical intervention is needed to reduce the advancement of greater risk. Individuals with suicidal thoughts but no intent, plan, means, capability, or weapons would be considered Level 2. Minor self-injurious behavior that would not require medical attention beyond basic first aid, such as scratching into the skin with a paperclip or pin, would also be considered Level 2. Individuals experiencing withdrawal from non-life threatening substances or dependence on alcohol, benzodiazepines or barbiturates, but not in active withdrawal with no history of withdrawal seizures or detox symptoms may fit the recommended response for Level 2 from a behavioral health crisis response, and EMS dispatch is needed to evaluate withdrawal symptoms.	<u>Defining Criteria Examples:</u> • Person expressing suicidal thoughts, a desire or wish to die, with no current plan or no direct access to lethal weapons or means to complete suicide, but who appears to need in-person behavioral health support, i.e., not responding appropriately to questions, expresses desire to see someone, distress is escalating, challenging, etc. • Person does not express homicidal thoughts, intent, or behaviors. • Person may have minor self-inflicted injuries, such as cutting, burning/freezing, or marking skin in a non-lethal manner, but does not require or refuses EMS resources. Situations involving increased levels of agitation (e.g., voice raised, pressured speech, slight confusion) where a mobile response is indicated, and no safety concerns are noted. Presence of psychosis, to include disorientation, hallucinations, delusions, extreme paranoia, disorganized thinking, disjointed speech, disorganized behavior, and/or erratic emotional responses where no safety concerns are noted. Level 2 (Moderate) responses will be transferred to the regional call center where triage and screening will occur to determine if a mobile crisis response is needed.

	The call center will coordinate local dispatch of mobile crisis teams and maintain communication with mobile teams while deployed (please refer to MOA between the Western Tidewater Call Center and Virginia Beach Police and Emergency Communications & Citizen Services).
Level 3 Situations involving active aggression would be classified as Level 3. Individuals with active psychosis disconnected from reality would be considered Level 3, as well as individuals with homicidal thoughts with no active intent or access to means. Individuals with suicidal thoughts and a specified plan, but no lethal weapons present, are classified as a Level 3 situation. Individuals engaging in self-injurious behavior that could cause life-threatening bodily injury (e.g., using a sharp knife) would be a Level 3 situation. Third-party calls for service, if missing important details on the scene safety would likely be considered Level 3.	<u>Defining Criteria Examples:</u> • Active aggression being reported towards others in the vicinity. • Presence of psychosis, to include disorientation, hallucinations, delusions, extreme paranoia, disorganized thinking, disjointed speech, disorganized behavior, and/or erratic emotional responses where safety concerns may be present. • Suicidal ideation with a plan and/or intent, without weapons present. • Active cutting or other self-injurious behavior that may need medical attention. • Acute distress or withdrawal reported by others that make them fearful for the wellbeing of the individual. Level 3 (Urgent) calls will be assessed by the Regional Crisis Call Center to determine if a Behavioral Health Mobile Crisis Team, REACH, or a Mobile Co Responder Team is the appropriate level of intervention. If a Behavioral Health Mobile Crisis Team or REACH is determined to be the appropriate level of response, the RCC will dispatch a team. If the Mobile Co-Responder Team is determined to be the most appropriate level of response, the RCCC will provide a warm transfer to Virginia Beach 9-1-1. These calls will result in the PSAP dispatching a Mobile Co- Responder Team comprised of a CSB Emergency Services Certified Pre-Screener and a Crisis Intervention Team (CIT)-trained police officer, or a behavioral health crisis unit with CIT back-up. Presenting issues are such that psychiatric hospitalization is a possible needed intervention, and an Emergency Custody Order or Temporary Detention Order may need to be executed.
Level 4 Level 4, or Emergent, situations are situations too unpredictable and potentially life threatening to have any delay in dispatch, and law enforcement (and EMS if needed) should be dispatched. These situations include direct threats to life, individuals who are actively assaultive and possess the means to cause life	<u>Defining Criteria Examples:</u> • Direct and immediate threat to life to include an active suicide attempt, overdose, or reported weapon present. • Active assault on others that is likely to require law enforcement and medical response due to potential

threatening harm to others or themselves. Individual who have made active suicide attempts where injuries have already occurred or a situation where suicide is imminent would be considered Level 4. Those situations may include a gun in the hand, pills ingested, a hanging scenario in place, a knife in hand with an unwillingness to secure the knife, all along with expressed homicidal or suicidal intent and without expressed ambiguity or significant barriers to acting on the intent or plan.	for harm. • Active homicidal ideations and/or intent • Any report of a firearm or other lethal weapon being present. Level 4 (Emergent) responses will result in the PSAP dispatching law enforcement, EMS, and/or fire without delay according to normal 9-1-1 protocols. The PSAP will make every attempt to dispatch the Mobile Co-Responder Team or minimally a CIT-trained officer if the Mobile Co-Responder Team is not available. Law enforcement will ensure that the scene is safe prior to inviting the behavioral health clinician onto the scene.

B. Protocol 2. Mobile Crisis Team Emergency Back-Up

This locality submitted a draft Memorandum of Understanding between the City of Virginia Beach, a municipal entity in the Commonwealth of Virginia, by and through its Police Department (VBPD), Department of Human Services (DHS), and Department of Emergency Communications and Citizens Services (VBECCS) and the Western Tidewater Community Services Board ("WTCSB"), a political subdivision of the Commonwealth of Virginia, whose principal place of business is located at 7025 Harbourview Blvd. Suite 119, Suffolk, Virginia 23435. The City AND WTCSB may be collectively referred to as the "parties" and individually as "party." The terms used herein shall have those meanings as set forth in Virginia Code §9.1-102, §9.1-193, and §37.2-311.1.

The draft can be found at https://dbhds.virginia.gov/wp-content/uploads/2022/05/MOU-WTCSB-and-VBPD-Marcus-Alert.docx

C. Protocol 3. Law Enforcement Specialized Response

Virginia Beach Police Department has a strong relationship with Behavioral Health Responders and a leading Crisis Intervention Team. VBPD leadership is comprised of several CIT trained commanders, middle managers, and first line supervisors. This includes two of the three sitting Deputy Chiefs, receiving CIT awards. One received the Virginia CIT Officer of the Year in 2014 and the other received the CIT International Law Enforcement Executive of the Year in 2020. In 2020, Virginia Beach was awarded the Virginia CIT Program of the Year and Virginia CIT Coordinator of the Year.

As the department prepares for the implementation of Marcus Alert, the General Order has been amended to include the Marcus Alert Protocols to include the 4-level urgency determination and the utilization of the Regional Crisis Call Center for mobile behavioral health responders. The changes are in draft format awaiting signature from the chief. The Virginia Beach Police Department has several policies that address specialized response in various situations that could potentially involve an individual in a behavioral health crisis. These policies include:

I. Response to Person with Mental Illness Policy
II. Interactions with Juveniles Policy
III. School Resource Officer Policy
IV. Victim Witness Assistance Policy
V. Peer Support Policy
VI. Biased Based Profiling Policy
VII. Use of Force Policy
VIII. Special Weapons and Tactics Policy
IX. Biased Policing Policy

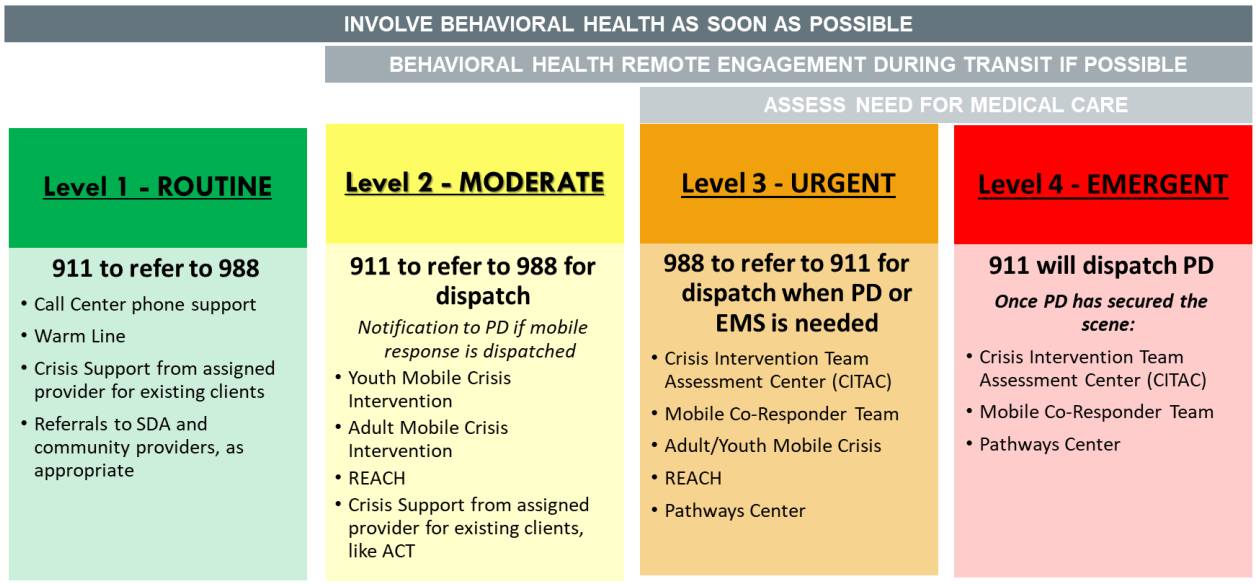
X. Field Interviews Policy
XI. Constitutional Issues Policy
XII. Constitutional Issues Field Guide

Training standards for all officers in the department align with the content of the Presidents Commission on 21st Century Policing report regarding building trust and legitimacy, community policing, and emphasizing training and education. When CIT was implemented in the city, the decision was made for CIT training to be voluntary among the officers to ensure that those officers who attend and complete the training are those who truly believe in the philosophy of CIT. Additionally, several of the more specialized units in the police department will only consider officers who have successfully completed CIT training. Even with the voluntary nature of CIT, more than half of the department has attended the full 40-hour course. With our advanced training standards, the police department already offers a specialized mobile co-responder training, the department is awaiting further guidance and definition for DCJS requirements regarding specialized and advanced training. The table below highlights the police training plan within the City of Virginia Beach.

ALL OFFICERS	• Mental Health First Aid in the Basic Police Recruit Academy • Inservice Mental Health Training (Including Autism, Intellectual Disabilities, Traumatic Brain Injury, Mental Health, Substance Use, Alzheimer's, and others) • Cultural Diversity Training • Fair and Impartial Policing Programs • Police Ethics • Community Policing Strategies • Use of force and de-escalation training via classroom and scenario-based training strategies (both live and video simulation). • Juvenile Perspectives/Policing the Teen Brain
MOST (50%+) OFFICERS	CIT 40-Hour Certification – Training is voluntary to ensure the best possible responses; however, is required for 6 units: • SWAT Officers • School Resource Officers • Crisis Negotiators • Oceanfront Community Policing • Warrants • Mobile Co-Response Specialized Unit
MOBILE CO-RESPONSE SPECIALIZED UNIT	In addition to CIT 40, these MCRT officers also received specialized training on effective co-response strategies and protocols. *Additional advanced training will be provided upon guidance from DCJS.*

D. Community Coverage

In the City of Virginia Beach, the PSAP and the Regional Crisis Call Center have collaborated to outline how to assess crisis situations using the Marcus Alert Triage Levels and what services exist within our city to respond according to the assessed level of need. During Levels 1 and 2, crisis responses will be managed by the Regional Crisis Call Center. Levels 3 and 4 will be managed by the PSAP. At all times, both entities will work with warm handoffs and follow up, as outlined in the MOU, to assure safety of the individuals in crisis, the staff responding, and the general public.



State Description	*Local Description of Response/Coverage*
General Information These are cross-level triage components. Please describe any general elements of your response type plan. For example, does each level include multiple options that are dispatched based on availability? Or, does each level include multiple options that are determined appropriate based on triage/dispatcher decision making?	• **The PSAP has established a General Order and will provide training to staff in order to determine the caller's level of need and corresponding Marcus Alert level.** • PSAPs will be screening calls to determine urgency level but will not be making clinical decisions as to what behavioral health intervention is needed. That decision will be made by clinical staff at the Regional Crisis Call Center and based on service availability. • Each level of response, especially 2 & 3 offer multiple response options depending upon the situation. Please see community coverage crosswalk. • Services that are available 24/7 include Emergency Services, CIT Assessment Center, Regional Call Center/9-8-8, police, and EMS. Current funding and workforce resources do not support other service availability 24/7.
Level 1 STATE MINIMUM STANDARD: Level 1 calls must be transferred to the 9-8-8 call center BEST PRACTICE CONSIDERATION: Level 1 calls are fully diverted to 9-8-8	• If an individual accesses 9-1-1 and is subsequently assessed to be at a Level 1, the PSAP will transfer that call to the Regional Crisis Call Center (future 9-8-8).
Level 2 STATE MINIMUM STANDARD: Level 2 calls are coordinated with 9-8-8	• If an individual accesses 9-1-1 and is subsequently assessed to be at a Level 2, the PSAP will transfer that call to the Regional Crisis Call Center (future 9-8-8).

BEST PRACTICE CONSIDERATION: Level 2 calls follow a poison-control model with 9-8-8	• 9-8-8 will contact the Western Tidewater Regional Call Center who will dispatch mobile crisis clinicians and contact the Virginia Beach PSAP. • Upon notification that a Level 2 call is being responded to by a regional mobile crisis provider, the PSAP will inform any local units
Level 3 STATE MINIMUM STANDARD: Level 3 calls include multiple response options across agencies/entities, and includes a behavioral health-only response option Developmental status (i.e., age, developmental disabilities) is taken into consideration when making dispatch decisions at Level 3 BEST PRACTICE CONSIDERATION: Level 3 calls involving youth are coordinated with 9-8-8 and specialized children's mobile crisis teams Level 3 calls involving individuals with ID/DD are coordinated with 9-8-8 and specialized developmental disability mobile crisis teams/REACH program training	• Level 3 calls will be reviewed to determine the most appropriate response option based on the initial screening (including risk factors, age and developmental disabilities), background, and acuity. • Multiple response options include, but are not limited to, Clinician/Peer Response, Clinician/Peer Support with EMS Medical Services, EMS, Mobile Co-Responder Unit, or CIT trained Virginia Beach Law Enforcement response. • If the Level 3 call occurs when the Mobile co-responder team is available, that team will be dispatched with the BH Clinician taking the lead. If triage information indicates that it is safe, the behavioral health clinician will initiate the behavioral health-only response with the CIT Officer standing by. • If the Mobile Co-Responder Team is deployed, screening information will determine if the team will engage jointly or if the behavioral health clinician will initiate the behavioral health-only response with the CIT Officer standing by in the vehicle. • If mobile behavioral health resources are not available, the PSAP will request a CIT officer to respond and coordinate with Emergency Services to determine if assessment at the CITAC is warranted. ***If upon arrival, the scene is more accurately a level 4, PD will take the lead and secure the scene first.*
Level 4 STATE MINIMUM STANDARD: Level 4 calls include law enforcement or EMS (Best practice elements for Level 4 include the systems approach for Protocol #3. All elements do not have to be described here. Here, describes what type of response will be sent to Level 4 calls and how behavioral health is taken into consideration.)	• The PSAP will dispatch police, requesting CIT officers and EMS to stabilize the situation and ensure safety. • Police responders will follow procedures for a specialized response per the policies outlined in Section 6 of this document. • Once scene is secure, police will request that either mobile co-responder team or mobile BH crisis team provide a behavioral health response with the behavioral health provider taking the lead.