COMMONWEALTH of VIRGINIA

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COMMISSIONER

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January 16, 2026

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

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

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

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

D. The Department shall report annually by November 15 to the Governor and the Chairmen of the House Committees for Courts of Justice and on Health and Human Services, the Senate Committees for Courts of Justice and on Education and Health, and the Behavioral Health Commission regarding the comprehensive crisis system and the effectiveness of such system in meeting the goals set forth in this section. The report shall include, for the previous calendar year, (i) a description of approved local Marcus alert programs in the Commonwealth, including the number of such programs operating in the Commonwealth, the number of such programs added in the previous calendar year, and an analysis of how such programs work to connect the Commonwealth's comprehensive crisis system and mobile crisis response programs; (ii) the number of calls received by the crisis call center established pursuant to this section; (iii) the number of mobile crisis responses undertaken by community care teams and mobile crisis teams in the Commonwealth; (iv) the number of mobile crisis responses that involved law-enforcement backup; (v) the number of crisis incidents and injuries to any parties involved; (vi) an analysis of the overall operation of any local protocols adopted or programs established pursuant to § 9.1-193, including any disparities in response and outcomes by race and ethnicity of individuals experiencing a behavioral health crisis and recommendations for improvement of the programs; (vii) a description of the overall function of the Marcus alert program and the comprehensive

crisis system, including a description of any successes and any challenges encountered; and (viii) recommendations for improvement of the Marcus alert system and approved local Marcus alert programs. The report shall also include (a) a description of barriers to establishment of a local Marcus alert program and community care or mobile crisis team to provide mobile crisis response in each geographical area served by a community services board or behavioral health authority in which such program and team has not been established and (b) a plan for addressing such barriers in order to increase the number of local Marcus alert programs and community care or mobile crisis teams. The Department of Criminal Justice Services shall assist the Department in the preparation of the report required by this subsection.

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

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

DBHDS

Virginia Department of Behavioral Health and Developmental Services

Report on Marcus Alert the Comprehensive Crisis System, FY 2025
(§ 37.2-311.1 of the Code of Virginia)

December 1, 2025

DBHDS Vision: A Life of Possibilities for All Virginians

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Preface

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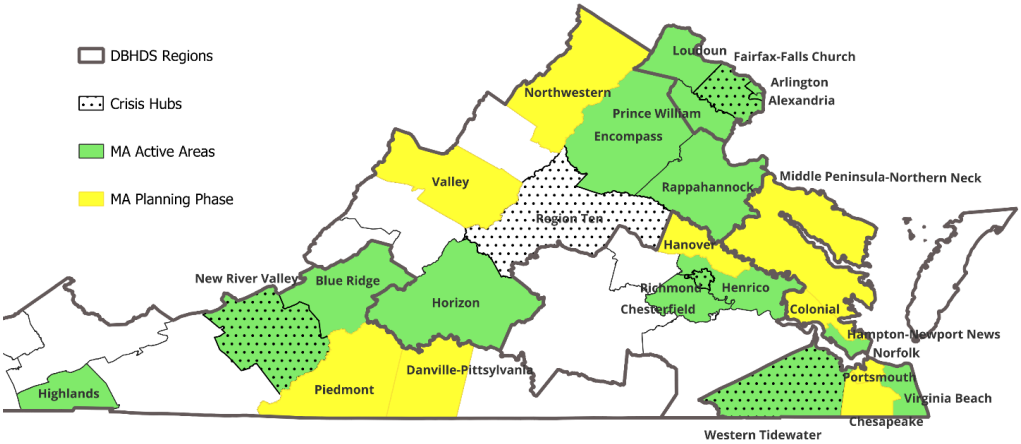
Executive Summary

During the 2020 Special Session I of the General Assembly, the Marcus-David Peters Act was written to support development of an interconnected statewide framework for behavioral health crisis response. The Act in its entirety includes the build-out of a comprehensive, statewide behavioral health response system, as well as a series of local protocols and supports to coordinate between law enforcement, 9-1-1, and the comprehensive crisis system. This report provides an overview of the implementation process thus far and progress made towards the measurement of each indicator required in the act. The summary of the state plan for implementation including details of the planning process of the Marcus-David Peters Act can be found here: State Plan for the Implementation of the Marcus-David Peters Act.[1]

Implementation of the Marcus-David Peters Act began with the first five sites launching on December 1, 2021. This continues to increase annually with 12 Marcus Alert programs implementing on July 1, 2024, and ten new programs implementing July 1, 2026. The availability of crisis services has grown tremendously since the passing of the legislation. All Marcus Alert sites have worked closely with their 988 Contact Centers and Regional Crisis Hubs to implement protocols for Marcus Alert. The Public Safety Answering Points (PSAPs) have incorporated Marcus Alert data collections elements within their Computer Aided Dispatch (CAD) systems to capture metrics related to Marcus Alert instances. The Department of Behavioral Health and Developmental Services (DBHDS) has also incorporated data collection from Community Care Teams beginning April 1, 2025. DBHDS is working to meet the statewide implementation of all 40 Marcus Alert programs by July 1, 2028, as required. At this time, funds have been allocated to continue to fund the currently active seventeen sites (Figure 1). Additionally, ten community services boards (CSBs) have entered into their planning year as of July 1, 2025, and will be active Marcus Alert sites FY 2026.

Figure 1

Active MA Sites and Crisis Hubs as of FY 2026



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

Areas of focus for this reporting period include:

- **Regional Implementation** – 17 Marcus Alert programs have launched in DBHDS' five regions.
- **Launching Additional Regional Sites** – DBHDS has begun discussions with the eleven sites identified as FY26 planning sites. These CSBs and their local partners are actively planning their program structures.
- **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 988 Contact Centers, 2) agreements between Regional Crisis Hubs and law enforcement, and 3) policies for law enforcement participation in the Marcus Alert system. The level of additional local supports for community coverage to be achieved statewide will be contingent on the level of funding available and the local planning processes.
- **Virginia's Comprehensive Crisis System** – Marcus Alert is one aspect of the ongoing infrastructure development known as Virginia's Comprehensive Crisis System. This transformation began during the 2020 session and continued to be supported by Governor Youngkin's *Right Help, Right Now* initiative. The purpose is to improve how individuals who are experiencing behavioral health crises receive services by providing someone to call, someone to respond, and somewhere to go. Marcus Alert connects these structural changes.
- **Progress Toward Measurement** – DBHDS continues to enhance the operating systems of Marcus Alert. Data collection has been incorporated in Virginia's Crisis Connect (VCC) platform in addition to the data collected by PSAPs and Community Care Teams. The incorporation of other functions, such as dispatching Mobile Crisis Response, state hospital tracking capabilities, and community resource dictionaries, was also launched in VCC. DBHDS and the Department of Criminal Justice Services (DCJS) continue to utilize statewide stakeholder meetings and site visits with the implemented areas as sources of measurement.
- **Addressing Barriers and Recommendations for Improvement** – DBHDS continues to coordinate with the areas who have already implemented Marcus Alert to inquire about barriers and collaborate on recommendations. This information is used to improve state lead implementation, policies, and procedures. As progress is made on implementation of Marcus Alert programs across Virginia, DBHDS will continue working with state and local partners to capture more data and expand reporting capabilities.

Background

The Marcus-David Peters Act in its entirety includes the build-out of a comprehensive, statewide behavioral health response system, as well as a series of local protocols and supports to coordinate between law enforcement, Public Safety Answering Points (PSAPs), and the comprehensive crisis system. The five initial areas were implemented on December 1, 2021. This report provides a timeline and overview of the implementation process thus far and progress towards the measurement of each indicator.

Marcus Alert Systems

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

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

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

Each area has affiliated Law Enforcement Agencies and PSAPs outlined below (Table 1). The Law Enforcement Agencies identified are those participating in all three protocols outlined below. Please see Appendix A for details. All PSAPs are required to participate in Protocol 1.

A complete Marcus Alert System implements three required protocols:

1. 9-1-1 Call Diversion,
2. Memorandum of Understandings (MOU) between agencies that includes a requirement that participating Law Enforcement provide backup to Mobile Crisis Response, and
3. Specialized Response by Law Enforcement in accordance with minimum standards and best practices published by DBHDS and DCJS.

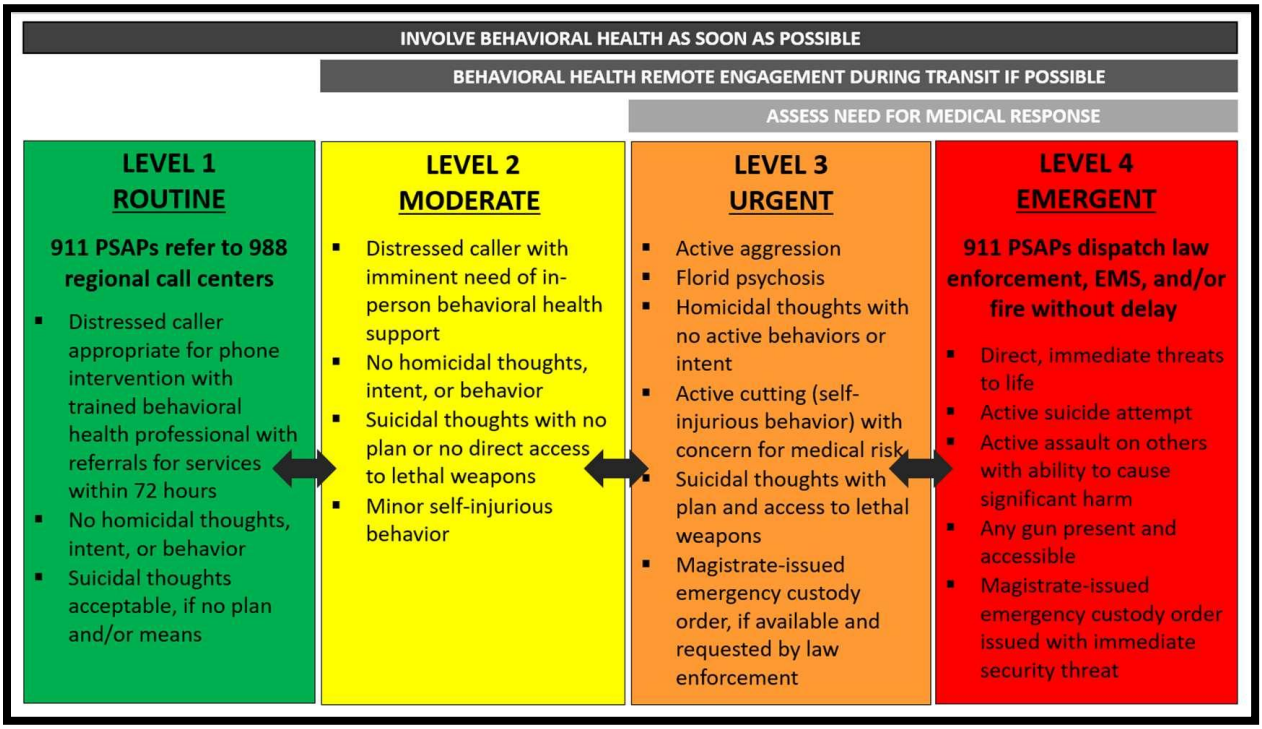
The three protocols were required statewide by July 1, 2022, and community coverage is being phased in over several years per the legislation.

The State Level Triage Framework (Figure 2, below) provides structured guidance for Public Safety Telecommunicators (PSTs) in determining the most appropriate response and facilitating diversion to the 988 Contact Centers or Regional Crisis Hubs when possible. Level 1 calls are required to be diverted to 988 when there is no indication of immediate risk, allowing behavioral health professionals to manage the situation without law enforcement involvement. Level 2 calls are recommended to have a mobile crisis dispatch when available; however, as mobile crisis coverage continues to expand across Virginia, localities may utilize alternative behavioral health or community-based resources to ensure timely response. Level 3 calls, which typically involve

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

more complex behavioral presentations, are best managed by specialized response teams such as CSB-led Community Care Teams, Children's Mobile Crisis, or Regional Education Assessment Crisis Services Habilitation (REACH) programs for individuals with developmental disabilities. These situations often include law enforcement presence and require specialized co-response approaches where behavioral health clinicians can assist law enforcement in determining behavioral health status and clarifying whether an individual poses a "clear and present danger." Establishing a process for law enforcement could help promote consistency and reduce subjective variability in this determination across jurisdictions. Finally, Level 4 calls require a 9-1-1 dispatch due to an imminent risk of harm, though in some localities, mobile crisis teams or co-response units are deployed to engage the individual once law enforcement has secured the scene.

Figure 2. State Level Triage Framework



While the Triage Framework provides statewide structure, its implementation varies across PSAPs due to differences in available resources, definitions of key terms such as "clear and present danger," and differing levels of understanding or training on the framework's application. This variability can impact how calls are classified and which response is dispatched. Continued efforts toward interoperability, standardization of definitions, and consistent statewide training will be necessary to ensure that the framework is applied uniformly and that every community has access to the appropriate behavioral health response at each triage level.

Community Care Teams

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

Currently, approximately 29 first responder jurisdictions across the Commonwealth have formally partnered with CSBs to implement Community Care Teams. Several jurisdictions have invested in multiple teams to ensure broader coverage and more responsive service delivery, bringing the total number of active Community Care Teams in Virginia to 49. In addition, 10 CSBs are currently in their planning year and have indicated they will build upon the established models of existing Community Care Teams. This trajectory reflects not only measurable progress in expanding crisis response capacity, but also a commitment to equity, ensuring that more communities across Virginia will have access to timely, coordinated behavioral health support through public safety partnerships. In response to first responders' concerns about limited staffing and resources for behavioral health crisis calls, CSBs have advanced behavioral health–led co-response teams to create a more unified and effective approach.

Teams can consist of law enforcement, fire/EMS, clinicians, and/or peer recovery specialists. Each team varies in functionality and availability. Most are included as response options in the localities Marcus Alert Local Plan under community response to address intermediate Marcus Alert level calls. Some teams have the capability to be dispatched by the local PSAP.

Table 1. Marcus Alert Community Care Teams Implemented as of July 1, 2025

CSB	Jurisdiction(s) Served	Team Composition	Hours of Operation	# Teams Per Jurisdiction
Alexandria	City of Alexandria	CIT Officer, Licensed Clinician	10 AM–9 PM, 7 days/week	3
Fairfax-Falls Church CSB	Fairfax County, City of Fairfax, City of Falls Church, Town of Herndon, Town of Vienna	1 CIT Officer, 1 CSB Crisis Intervention Specialist	10 AM–12 AM, 7 days/week	4
Loudoun County CSB	Loudoun County, City of Leesburg, Purcellville, Middleburg	1 CIT Officer, 1 CSB Crisis Intervention Specialist	1 PM–9 PM, Mon–Fri	1
Arlington County	Arlington County	1 Clinical Supervisor, 2 Clinicians, 1 Peer Recovery Specialist, 1 Case Manager	1 PM–9 PM, Mon–Fri	1
Prince William County	Prince William County	6 Officers, 6 Clinicians, 2 Clinical Supervisors, 2 LIE Supervisors	8 AM–10 PM, Mon–Thurs; 8 AM–8 PM, Fri; 12 PM–10 PM, Sun	6
Hampton-Newport News	Newport News	EMS, BH Clinician	7 AM–9 PM, Mon–Fri; 9 AM–7 PM, Sat–Sun	2
Hampton-Newport News	Hampton	EMS, BH Clinician	10 AM–6 PM, Mon–Fri	2

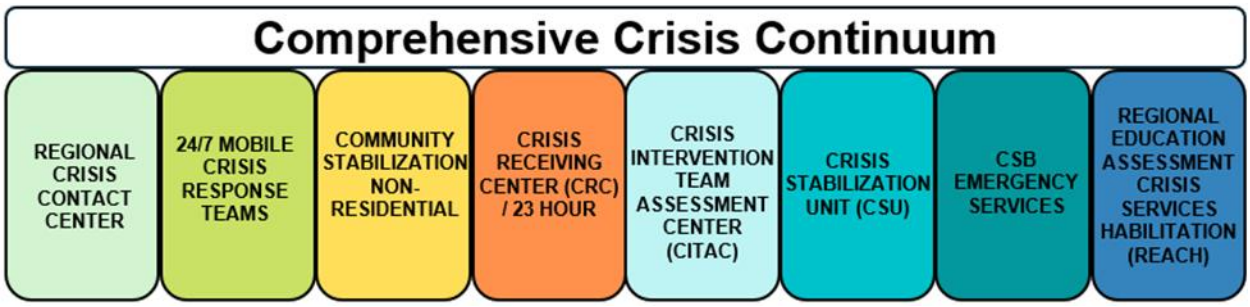
Virginia Beach	Virginia Beach	Officer, Clinician	10 AM–10 PM, Mon–Fri; 12 PM–10 PM, Sat–Sun	1–2
Western Tidewater CSB	Suffolk, Southampton, Isle of Wight, Smithfield, Franklin, Windsor, Courtland	Clinician Paramedic	11 AM–7 PM	1
Richmond Behavioral Health Authority	City of Richmond	LE Officer & Clinician Team	8 AM–6 PM, Mon–Fri; 2 PM–12 AM, 4 days/week	2
Chesterfield Mental Health Support Services	Chesterfield County	Clinician & Peer Recovery Specialist Team	8 AM–5 PM, Mon–Fri	1
Henrico Mental Health and Developmental Services	Henrico County	LE Officer & Clinician Team	9 AM–5 PM, Mon–Fri; 1 PM–9 PM, Mon–Fri	2
Highlands	Washington County	Officer & Clinician	8:30 AM–10:30 PM	2
Highlands	City of Bristol	Officer & Peer	8:30 AM–10:30 PM	1
New River Valley Community Services	Montgomery County	Montgomery Ride-along Model	14 hours, 7 days/week	4
New River Valley Community Services	Floyd County	Radford / RU “DSS” Model	10 hours, 4 days/week	1
Blue Ridge Behavioral Healthcare	Giles County, Pulaski County, Botetourt County, Craig County, Roanoke County, Roanoke City	Officer & Therapist	8 AM–1 AM	5 therapists
Encompass Community Supports	City of Radford, City of Salem, Town of Vinton, Fauquier, Madison, Culpeper, Amherst, Appomattox, Bedford, Rappahannock, Orange	Officer/Mental Health Professionals, Certified Peer	8 AM–8 PM	1–2
Horizon	Campbell, Lynchburg	Lynchburg Officer & LMHP	10 AM–8 PM	1
Rappahannock Area	Fredericksburg, Spotsylvania, Stafford, King George, Caroline	CIT Officer with Clinician	Stafford hours pending; Spotsylvania: 8 AM–6 PM, Mon–Thurs	2

Virginia’s Comprehensive Crisis System

Virginia is currently transforming public behavioral health services to develop a comprehensive crisis system that will be available for the entire Commonwealth. This shift began during the development of the Marcus Alert legislation and continues to be carried out by Governor Youngkin’s *Right Help, Right Now* initiative. That means all Virginians will be able to access high quality behavioral health services aimed at managing symptoms before they become crisis-level and avoiding expensive, restrictive in-patient services or possible incarceration. Combining

a series of components within workstreams one and two creates opportunities for community members to have someone to call, someone to respond, and somewhere to go (Figure 3). This initiative calls for a stronger crisis system that meets the needs of youth and adults in their communities, supporting them in the least restrictive environment where they can safely and successfully live. The graphic below highlights major components of Virginia's Comprehensive Crisis System.

Figure 3. Components of the Virginia Comprehensive Crisis System



In 2021, Virginia was the first state to pass a 988 cell phone tax, via Senate Bill 1302. The infrastructure changes that followed Marcus Alert implementation allowed for increased utilization of Regional Crisis Call Centers and the three-digit 988 Suicide and Crisis Lifeline supports and services. The 988 Suicide and Crisis Lifeline is managed by two agencies across the state who coordinates with Regional Crisis call Hubs under the purview of five CSBs representing each DBHDS region: Region Ten CSB (Region 1), Fairfax-Falls Church (Region 2), New River Valley (Region 3), Richmond Behavioral Health Authority (RBHA; Region 4), and Western Tidewater (Region 5).

Marcus Alert plays a critical role in connecting the interoperability of law enforcement and behavioral health systems, as well as services under the Comprehensive Crisis Continuum. This is shown by outlined roles and responsibilities within the MOUs for Public Safety Telecommunicators to transfer Level 1 calls to 988, relieving PSAPs of non-emergency calls. While not required within the Marcus Alert legislation, the areas mutually agreed to transfer Level 2 calls to 988 with the intention of utilizing Mobile Crisis Response as appropriate.

Additionally, sites continue to develop various compositions of co-response teams with each implementation year (Table 4 & Table 5). These teams increase behavioral health-led responses while offering further relief for law enforcement agencies. In conjunction with the ability to divert individuals in crisis in the community, co-response teams also utilize the less restrictive community-based services such as CITACs, CRCs, and CSUs. In short, Marcus Alert provides a framework to support the efforts of *Right Help, Right Now* by addressing behavioral health crises within various levels of severity, providing a behavioral health-led response to each incident that reduces the reliance on law enforcement, and encourages the utilization of community-based services defined in the Comprehensive Crisis Continuum.

Progress toward Measurement – Comprehensive Crisis System

DBHDS is responsible for data from VCC, which includes behavioral health only responses, behavioral health responses with law enforcement back up, and calls transferred from 911 to 988. DCJS is ultimately responsible for data from law enforcement only encounters, although DBHDS and DCJS are working together to create processes which work for all partners. DBHDS continues to work with DCJS and other community partners to ensure viable and accurate data is being collected to effectively measure progress.

Virginia Crisis Connect (VCC) Platform Overview

VCC, originally referred to as the Crisis Call Center Data Platform, is built on the Behavioral Health Link platform. It provides the foundation for Virginia's comprehensive crisis response system through modules for intake, mobile crisis dispatch, facility referral (including CSUs, private psychiatric hospitals, and state hospitals), resource referral, and data analytics. These components support consistent crisis service delivery across regions, with ongoing training provided to new and existing users as additional functionality is deployed.

System Milestones and Expansion

- Statewide Operations: VCC has been live since December 2021 and is now fully operational across all regions. Functionality for receiving and triaging crisis calls has been stabilized and continues to be refined.
- Mobile Dispatch: 2024 marked the first full year of implementation following the December 2023 launch of centralized statewide dispatch for Mobile Crisis Response. Both public and private providers utilize VCC to dispatch mobile crisis response.
- Enhancements in 2024:
    - Community Resources Integration – National 211 resources were successfully embedded into the platform, enabling call center staff to connect individuals to community resources as follow-up to crisis intervention.
    - Messaging and Communication Module – Real-time communication tools were introduced for call center agents, dispatchers, and mobile crisis response. This enhancement improved coordination of mobile response and increased efficiency in service delivery. Both modules are now in active use statewide, with positive feedback from users regarding accessibility and functionality.

Facility Referral and Bed Registry

The facility referral module advanced significantly in 2024. The platform now supports referral activity, acceptance, and real-time tracking of bed availability across crisis stabilization units, state hospitals, and private facilities.

Implementation Progress:

- CSBs: Emergency Services programs completed a pilot phase in early 2024 and are now actively using the platform to send referrals to state and private hospitals.
- State Hospitals: Automated updates of state hospital bed inventory were finalized in 2024, reducing manual reporting.
- Private Hospitals: Private hospital admissions staff completed initial user training and began responding to referrals.

Full participation across all user types was achieved by late 2024, marking the first year of near-complete statewide functionality of the bed registry system. Enhancements continue to be made based on feedback from CSB and hospital staff, and refinements will carry forward into 2025.

Looking Ahead

In 2025, DBHDS will focus on:

- Expanding use of data analytics tools to better evaluate system performance and service outcomes;
- Enhancing user training to support ongoing system adoption and optimize use of new modules; and
- Completion of Facility Referral rollout to Crisis Stabilization Units across the Commonwealth.

Virginia 988 Data for Calendar Year 2024

In calendar year 2024, a total of 135,665 calls to 988 were routed to Virginia, with an average answer rate of 80 percent. The Virginia queue for 988 chats and texts was established in January 2024, and data became available in February 2024. A total of 12,610 chats were routed to Virginia, with an average answer rate of 39 percent. Virginia's text metrics are similar to chat because they are a shared staff responding simultaneously to both modalities, 21,641 texts were routed to Virginia centers and answer rates averaged at 37 percent. Table 2, below, shows a monthly breakdown of calls, chats, and texts provided by Vibrant Emotional Health, the National 988 Administrator.

Table 2. Summary of In-State 988 Metrics: KPIs for Calls, Chats, and Texts in Virginia

		Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Call	Routed	8,336	8,149	9,216	10,181	11,903	12,814	11,533	11,207	11,587	14,196	13,385	13,158
	Answered	7,381	6,748	7,383	8,892	9,999	10,912	9,598	9,272	9,384	11,136	9,038	7,340
	Answer Rate	89%	83%	80%	87%	84%	85%	83.2%	82.7%	81.0%	78.4%	67.5%	55.8%
	Abandoned	839	1,115	1,271	1,060	1,436	1,483	1,348	1,384	1,468	1,582	1,899	2,157
	Abandon Rate	10%	14%	14%	10%	12%	12%	11.7%	12.3%	12.7%	11.1%	14.2%	16.4%
	Avg. Speed to Answer	0:33	0:41	0:47	0:33	0:40	0:41	26.5	26.6	27.8	30.2	32.0	33.0
Chat	Routed	0	47	605	399	945	1,166	777	1,155	1,740	1,876	1,719	2,181
	Answered	0	35	269	142	287	282	356	418	626	679	556	754
	Answer Rate	NA	74%	44%	36%	30%	24%	45.8%	36.2%	36.0%	36.2%	32.3%	34.6%
	Abandoned	0	1	24	11	49	47	0	1	4	5	5	6
	Abandon Rate	NA	2%	4%	3%	5%	4%	0.0%	0.1%	0.2%	0.3%	0.3%	0.3%
	Avg. Speed to Answer	0	0:12	0:03	0:06	0:04	0:05	18.4	17.6	19.6	18.5	21.6	19.3
Text	Routed	0	82	1,277	1,957	2,114	3,036	2,577	2,036	2,185	2,148	2,141	2,088
	Answered	0	56	562	689	721	729	874	696	702	697	653	757
	Answer Rate	NA	68%	44%	35%	34%	24%	33.9%	34.2%	32.1%	32.4%	30.5%	36.3%
	Abandoned	0	0	0	20	15	38	0	0	0	0	0	0
	Abandon Rate	NA	0%	0%	1%	1%	1%	0%	0%	0%	0%	0%	0%
	Avg. Speed to Answer	0	0:14	0:17	0:17	0:16	0:16	19.0	17.6	17.3	19.8	20.1	22.3

Note: This is a monthly breakdown of calls, chats, and texts routed to Virginia 988 contact centers. The in-state rate is the total number of answered in-state contacts over the total number of contacts routed to the state.

Mobile Crisis Response Data

DBHDS began to collect mobile crisis utilization for youth services from our five regional hubs on July 1, 2021. With the anticipation of the Crisis Data Platform, adult mobile crisis utilization was not collected. The regional hubs are managed by a local community service board, listed below, and, together, they served over 5,500 individual youths in FY 2025 (Figure 4):

Region 1: Region Ten Community Services Board

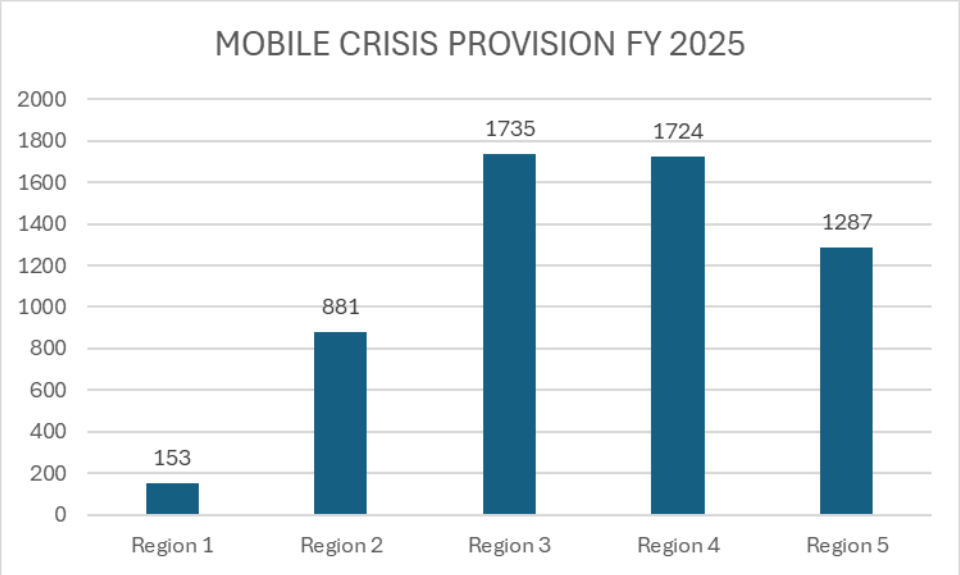
Region 2: Fairfax-Falls Church Community Services Board

Region 3: New River Valley Community Services Board

Region 4: Richmond Behavioral Health Authority

Region 5: Western Tidewater Community Services Board

Figure 4. **Youth served through mobile crisis, FY 2025**



Progress toward Measurement – Marcus Alert

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

Virginia's Marcus Alert programs have primary PSAP centers collecting data for Marcus Alert calls. This is done in tandem with the build out of VCC. Additionally, PSAP centers are tasked with incorporating the data elements required within each unique CAD system. These data points

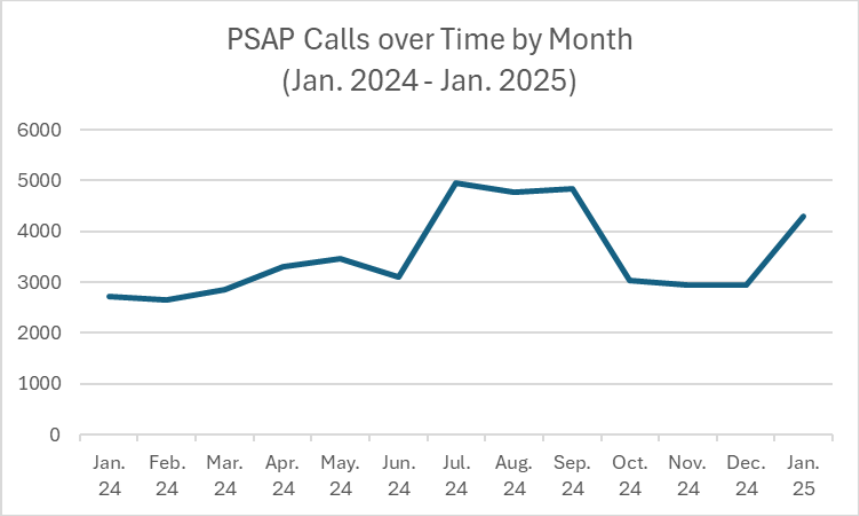
are collected to identify response trends, call volumes, the various Marcus Alert levels encountered, and track the transferring of calls (Figure 5). Data points that are currently required from PSAPs include date, time, PSAP or incident number, and dispatch outcomes. With the implementation of PSAPs each fiscal year, trends indicate that call volumes increase in July during the calendar year.

DBHDS has expanded data points to be collected from community care teams operating within the CSBs. The inclusion of this data will increase the opportunities DBHDS will have to follow crisis incidents from beginning to end. Additionally, DBHDS will have the opportunity to share pertinent information such as time saved on behavioral health crises for law enforcement, racial and ethnic disparities related to response and disposition, injuries during behavioral health crises, and further identification of populations in need of resources during behavioral health crises such as neurodivergent and homeless groups. The collection of this data began April 1, 2025. Due to its infancy, DBHDS continues to assist sites with consistency and efficacy of data submissions. DBHDS also remains alert of necessary changes to add or remove data points to ensure an accurate depiction of progress is provided.

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

Subsequent Marcus Alert reports will include an expected summary of metrics, including response times, demographic information, and outcomes of Marcus Alert related instances. To do so, DCJS will continue to work to identify ways for these indicators to be made available through PSAP data, expanded CIT data collection, or another form of data collection for law enforcement-only encounters.

Figure 5. PSAP Calls over Time by Month



Identified Barriers for Implementation

All local plans for implementing Marcus Alert sites require a barrier statement which is representative of each implementing area's CSB, law enforcement agencies, and PSAPs. While each area stated barriers specific to their community, common themes regarding implementation barriers are addressed below. As implementation continues to grow across Virginia, barriers remain consistent to previously implemented sites.

Culture Shift

The Marcus Alert framework promotes a shift in how behavioral health crises are handled, encouraging the involvement of behavioral health professionals when appropriate. However, this change has faced some resistance, as many individuals remain reluctant to embrace the new approach and continue to anticipate a law enforcement response when they call 9-1-1. This reluctance reflects a broader cultural shift, requiring a redefinition of behavioral health emergencies for both the public and first responders. Feedback to DBHDS shows that some community members still prefer to rely on traditional first responder services for non-emergent crises. Some PSAPs have reported instances where callers refuse to be transferred to 9-8-8, even after the situation has been classified as a low-level behavioral health crisis. Additionally, frequent callers continue to specifically request law enforcement or Fire/EMS, highlighting their hesitation to fully adopt the behavioral health-focused response. Liability concerns have also emerged, particularly when transferring calls to 9-8-8 after someone expresses suicidal ideation or when behavioral health professionals respond without law enforcement present. Lastly, communities report a lack of commitment and overall awareness of the Marcus Alert, contributing to this reluctance.

Staffing

Staffing continues to remain a barrier for all agencies participating in Marcus Alert programs. CSBs report difficulties finding licensed clinicians to participate in co-response teams, especially for individuals with experience working in crisis situations and collaborating with law enforcement. PSAP and law enforcement agencies also report difficulties with hiring and retaining staff. Law enforcement specifically noted challenges identifying applicants interested in co-response.

Interoperability between Systems

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

challenges in developing policies and procedures to adopt the Marcus Alert triage framework, collecting data, and continuing to build relationships with 9-8-8 call centers.

Additional Funding

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

Training

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

Community-Based Services Accessibility

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

Addressing Barriers

Addressing Marcus Alert Barriers

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

DBHDS has made increased commitments to engage with partnered agencies through site visits and/or virtual meetings for those implementing Marcus Alert to assist with training and cultural shift practices. These include thorough revision of training materials submitted by CSBs during their planning year to ensure consistent messaging to be dispersed throughout the Commonwealth. DBHDS is currently in the final steps of developing a statewide in-person

training for all behavioral health professionals, law enforcement officers, and public safety telecommunicators, which will provide further education on roles and responsibilities. The training consists of health equity content, triage frameworks, legislative information, and role plays to apply course content in real time. Lastly, DBHDS is also developing an eLearning training specific to 911/988 interoperability to be available to the public by the Spring of 2026.

In 2024, DBHDS increased efforts to bring community awareness towards the 988 Suicide and Crisis Lifeline by creating the 988va.org website and also creating the Virginia 988 logo and developing toolkits for local marketing. Regional Marcus Alert coordinators as well as CSBs have utilized relevant social media platforms, awareness months, and community events to assist with education of 988 and increase utilization. DBHDS has also taken advantage of similar practices in conjunction with the public awareness campaign to reinforce cultural shifts. Lastly, DBHDS continues to provide support and education on the ongoing development of community-based services as part of the Comprehensive Crisis System.

Addressing Mobile Crisis and Community Care Team Barriers

Mobile Crisis Coverage – At the end of 2024, there were 100.4 funded MCR teams operating 24/7/7 representing 69.1 percent of the goal of 140 fully staffed MCR teams. There were more than 13,520 completed dispatches in 2024, with an average response time of 31 minutes, which is within the national target. In 2024, DBHDS allocated $1.7 million to each of the five regional HUBs for additional recruiting and expansion of cross-trained teams. All MCR staff are trained in cross-disability lifespan-inclusive instruction, ensuring consistency in training delivery. MCR data reports with real time tracking are available in VCC, which allows accurate access to data points that assist in tracking outcome expectations.

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

Recommendations for Improvement

Additional funding

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

For PSAPs, 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 PSAPs on triaging Marcus Alert calls or making the required technical changes into their CAD systems for Marcus Alert data collection.

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

To achieve full 24/7 community coverage by Mobile Crisis and Community Care teams, additional funding is required for specialized staffing, training, and programmatic costs. Due to the diverse population size and needs throughout Virginia, an equal disbursement of funds to each CSB hinders addressing service gaps in the crisis continuum. Some highly concentrated populated areas require a different pot of funding than localities with a smaller population. Allowing DBHDS to disburse funds based on program needs instead of the blanket $600,000 will allow for more effective expansion of Marcus Alert programs.

Staffing

PSAPs currently face similar hiring shortages that Law Enforcement Agencies are struggling with. This shortfall in the workforce makes implementing additional initiatives such as Marcus Alert much harder on PSAPs, especially smaller agencies (Table 4)

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

Behavioral Health providers are also an increasingly constrained resource in Virginia. With a depleted workforce, standing up 24/7 Regional Mobile Crisis teams is a multi-year initiative. Individual CSBs, Health planning Regions, and DBHDS are all working on initiatives to recruit and retain more providers statewide (Table 5).

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

Table 4. MCR Staffing as of FY24

State		Funded FTEs	Filled FTEs	% filled teams
	REACH	159	114	71.7%
	BH	204	137	67.2%
Total Funded MCR		363	251	69.1%

Note: FTE = Full Time Employee

Table 5. MCR Staffing Goal

State	GOAL	Current	% met
	140 teams	101.4 teams	69.1%

Interoperability between Systems

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

988 is not federally designated an "emergency line," which prevents the transmission of detailed location information for 988 and crisis line calls. Instead, georouting was approved by the FCC for 988 calls. Georouting triangulates the caller's location based on the nearest cell tower, a major change from the current 988 area code routing method. Georouting is completed with the three major carriers and FCC compliance for all carriers is required by 2026. Without georouting, when a caller located in Virginia with a 703 area code called 988, the Lifeline routed the call to a Virginia Lifeline call center regardless of the caller's exact location. Georouting connects a caller with the closest center based on the wireless phone's current location, and in the rare case an emergency rescue is needed, the caller's general area is known.

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

Standardization of Marcus Alert

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

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

Conclusion

Thus far, the implementation of the Marcus-David Peters Act has been achieved for 17 sites with 10 new sites implementing July 1, 2026. There have been improvements made to various aspects of the legislation since the original date of December 21, 2021. This includes the continued development and expansion of the VCC platform, community resource dictionaries, and the inclusion of data collection. The interoperability between 911 and 988 which allows for collaboration between behavioral health professionals and law enforcement. Statewide training for Marcus Alert policies and procedures is currently being developed to identify barriers and tools required for seamless coordination.

Of the required data elements of this annual report, data sources and reporting mechanisms have been identified for MCR and PSAPs. DHBDS has identified a difficulty in obtaining reliable and valid data from community care teams but continues to collaborate with CSBs regarding the appropriate manner to obtain this information. The inclusion of data reporting from multidisciplinary agencies will allow a holistic evaluation of Marcus Alert.

The 17 areas that have implemented Marcus Alert report positive outcomes, including a reduction in unnecessary law enforcement involvement, increased behavioral health lead responses, and an increase in least restrictive services available to the public. Increases in community resources and MCR have improved the treatment experience individuals have during a behavioral health crisis. The policies and procedures outlined in the legislation and state plan allow for partnerships between first responders and behavioral health professionals which connect these systems. The level of additional implementation will be contingent on the funding availability.

Appendices

Appendix A

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

Community Services Boards	Law Enforcement Agency Exercising Population-Based Opt-Out	Law Enforcement Agencies	Public Safety Answering Points
Encompass Community Services	• Orange Sheriff's Office • Town of Orange Police Department • Town of Gordonsville Police Department	• Culpeper Sheriff's Office • Culpeper Police Department • Fauquier Sheriff's Office • Madison Sheriff's Office • Rappahannock Sheriff's Office • Remington Police Department • Warrenton Police Department • Virginia State Police • Germanna Community College Police Department • Lord Fairfax Community College Police Department	• Culpeper County Sheriff's Office • Fauquier County Sheriff's Office • Madison County Emergency Communication Center • Orange County Emergency Communication Center • Rappahannock County Sheriff's Office
Prince William Community Services		• Prince William Police Department • Manassas City Police Department • Manassas Park Police Department • Dumfries Police Department • Quantico Police Department • Occoquan Police Department • George Mason University Police Department • Northern Virginia Community College Police Department	• Prince William Emergency Communication Center • Manassas City Emergency Communication Center • Manassas Park Emergency Communication Center

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 Emergency Communication Center • Washington County Sheriff's Office • Virginia State Police District 4
Richmond Behavioral Health Authority		• Richmond Police Department • Virginia Commonwealth University Police Department • Virginia Union University Police Department	• Richmond Emergency Communication Center
Virginia Beach Community Services		• Virginia Beach Police Department • Virginia Beach Sheriff's Office	• Virginia Beach Emergency Communication Center

Table 2. Second Round of Implementation Marcus Alert as of July 1, 2024

Community Services Board	Law Enforcement Agency Exercising Population-Based Opt-Out	Law Enforcement Agency	Public Safety Answering Points
Rappahannock Area Community Services Board	• King George County Sheriff's Office • Caroline County Sheriff's Office	• Fredericksburg Police Department • Spotsylvania County Sheriff's Office • Stafford County Sheriff's Office • University Of Mary Washington Police Department	• Fredericksburg Police Department • Spotsylvania County Sheriff's Office • Stafford County Sheriff's Office • Caroline County Sheriff's Office • King George County Sheriff's Office

Fairfax Falls Church Community Services Board		• Fairfax County Police Department • City of Fairfax Police Department • City of Falls Church Police Department • Town of Herndon Police Department • Town of Vienna Police Department • George Mason University Police Department • Northern Virginia Community College Police Department	• Fairfax County Department of Public Safety Communications
Blue Ridge Behavioral Health	• Craig County Sheriff's Office	• Botetourt County Sheriff's Office • Roanoke Police Department • Roanoke City Sheriff's Office • Roanoke County Police Department • Roanoke County Sheriff's Office • Salem Police Department • Salem Sheriff's Office • Vinton Police Department • Virginia Western Community College Police Department	• Botetourt County Sheriff's Office • Craig County Sheriff's Office • Roanoke City • Roanoke County • City of Salem • Town of Vinton
Chesterfield Community Services Board		• Chesterfield County	• Chesterfield Emergency Communications
Hampton-Newport News Community Services Board		• Hampton Police Department • Newport News Police Department • Hampton University Police Department • Virginia Peninsula Community College Police Department • Christopher Newport University Police Department	• Hampton Emergency Communications Center • Newport News Emergency Communications Center

Table 3. Third Round of Implementation Marcus Alert July 1, 2024

Community Services Board	Law Enforcement Agency Exercising Population-Based Opt-Out	Law Enforcement Agency	Public Safety Answering Points
Horizon Behavioral Health	• Amherst County Sheriff's Office • Appomattox Sherrif's Office	• Lynchburg City Police Department • Liberty University Police Department • Central Virginia Community • College Police Department • Bedford County Sheriff Office • Town of Bedford Police Department • Campbell County Sheriff Office	• Amherst County Public Safety Communications • Appomattox County Public Safety • Bedford Emergency Communications Center • Campbell County Public Safety • Lynchburg Department of Emergency Services
Loudoun Community Services Board		• Loudoun County Sheriff Office • Leesburg Police Department	• Loudoun County Fire and Rescue • Loudoun County Sheriff Office • Leesburg Police Department
Arlington Community Services Board		• Arlington County Police Department • Arlington County Sheriff's Department	• Arlington County Emergency Communication Center
Alexandria Community Services Board		• Alexandria Police Department	• City of Alexandria Department of Emergency and Customer Communications
New River Valley Community Services Board	• Giles County Sheriff's Office • Pearisburg Police Department • Radford City Police Department • Pulaski County Sheriff's Office • Pulaski Police Department • Dublin Police Department	• Montgomery County Sheriff Office • Blacksburg Police Department • Christiansburg Police Department • Virginia Tech Police Department • Radford University Police Department	• New River Valley 911 Authority • Pulaski 911 Communications Center • Giles County Sheriff Office 911 • Floyd County Sheriff Office 911 • Radford City Emergency Communication Center • Radford University Police Department
Henrico Area Mental Health & Developmental Services	• New Kent County Sheriff's Office • Charles City County Sheriff's Office	• Henrico County Police Department • J. Sargent Reynolds Community College Police Department • University of Richmond Police Department	• Henrico County Department of Emergency Communications • New Kent County • Charles City County

		• Richmond Airport Police Department	
Western Tidewater Community Services Board	• Southampton County Sheriff Office • Courtland Police Department • Franklin Police Department • Isle of Wight County Sheriff Office • Smithfield Police Department • Windsor Police Department	• Suffolk Police Department	• Suffolk Emergency Communications Center • Isle of Wight Emergency Communications Center • Southampton Emergency Communications Center • Franklin Emergency Communications Center

Table 4. Fourth Round of Implementation to begin on July 1, 2026

Community Services Board	Law Enforcement Agency Exercising Population-Based Opt-Out	Law Enforcement Agency	Public Safety Answering Points
Valley Community Services Board	**TBD**	• Augusta County Sheriff's Office • Highland County Sheriff's Office • Staunton Police Department • Waynesboro Police Department • Blue Ridge Community College Police Department	• Augusta County Public Safety Communications • Highland County Public Safety Communications • Staunton Police Department Public Safety Communications • Waynesboro Public Safety Communications
Northwestern Community Services Board	**TBD**	• Clarke County Sheriff's Office • Berryville Police Department • Frederick County Sheriff's Office • Middletown Police Department • Laurel Ridge Community College Police Department • Stephens City Police Department • Warren County Sheriff's Office • Front Royal Police Department	• Clarke County Sheriff's Office Public Safety Communications • Frederick County Public Safety Communications • Warren County Sheriff's Office Public Safety Communications • Shenandoah County Public Safety Communications • Page County Public Safety Communications • City of Winchester Public Safety Communications

		• Shenandoah County Sheriff's Office • New Market Police Department • Mount Jackson Police Department • Strasburg Police Department • Woodstock Police Department • Page County Sheriff's Office • Town of Shenandoah Police Department • Town of Stanley Police Department • City of Winchester Police Department	
Danville Pittsylvania Community Services Board	**TBD**	• Danville Police Department • Pittsylvania County Sheriff's Office • Chatham Police Department • Gretna Police Department • Hurt Police Department • Danville Community College Police Department • Averett University Police Department	• Danville Fire Department Emergency 911 Center • Pittsylvania County Emergency Safety 911 Center
Piedmont Community Services Board	**TBD**	• Franklin County Sheriff's Office • Henry County Sheriff's Office • Patrick County Sheriff's Office • Martinsville City Sheriff's Office • Martinsville Police Department • Patrick & Henry Community College Police Department • Rock Mount Police Department • Ferrum College Police Department • Boones Mill Police Department	• Franklin County 911 Emergency Communications Center • Martinsville-Henry County 911 Communications Center • Patrick County Emergency 911 Center

Hanover County Services Board	**TBD**	• Hanover County Sheriff's Office • Town of Ashland Police Department	• Hanover County Public Safety Communications
Middle Peninsula Northern Neck Behavioral Health	**TBD**	• Richmond County Sheriff's Office • Town of Warsaw Police Department • Westmoreland County Sheriff's Office • Town of Colonial Beach Police Department • Northumberland County Sheriff's Office • Lancaster County Sheriff's Office • Town Kilmarnock Police Department • White Stone Police Department • Essex County Sheriff's Office • Tappahannock Police Department • Middlesex County Sheriff's Office • Urbanna Police Department • King and Queen County Sheriff's Office • King William County Sheriff's Office • Town of West Point Police Department • Mathews County Sheriff's Office	• Richmond County Sheriff's Office Public Safety Communications • Westmoreland County Sheriff's Office Public Safety Communications • Northumberland County Sheriff's Office Public Safety Communications • Lancaster County Sheriff's Office Public Safety Communications • Essex County Sheriff's Office Public Safety Communications • Middlesex County Sheriff's Office Public Safety Communications • King and Queen County Sheriff's Office Public Safety Communications • King William County Sheriff's Office Public Safety Communications • Mathews County Sheriff's Office Public Safety Communications
Colonial Behavioral Health	**TBD**	• James City County Police Department • City of Poquoson Police Department • City of Williamsburg Police Department • York County Sheriff's Office • William and Mary Police Department • Virginia Peninsula Community College Police Department	• Peninsula Regional Emergency Public Safety Communications

Chesapeake Integrated Behavioral Healthcare	**TBD**	• Chesapeake Police Department	• Chesapeake Public Emergency Communications
Norfolk Community Services Board	**TBD**	• Norfolk Police Department • Old Dominion University Police Department • Norfolk State University Police Department	• Norfolk Emergency 911 Division
Portsmouth Behavioral Healthcare	**TBD**	• Portsmouth Police Department	• Portsmouth Emergency Communication Center