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

Virginia Department of Behavioral Health and Developmental Services

Virginia Department of Criminal Justice Services

MARCUS Alert State Stakeholder Group

Draft last revised 4/26/2021

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Overview

Vision for Virginia's Behavioral Health Crisis Service Continuum

The vision for Virginia's behavioral health crisis services continuum includes recognition that behavioral health crises are common and can happen to anyone, and a robust, specialized community response system similar to fire, law enforcement, and EMS is warranted. A robust crisis response system is a collaborative effort across not only governmental agencies, but something supported by all healthcare payers, including those providing support for the uninsured, to ensure that an appropriate, health-focused response is available to *anyone*, *anywhere*, *anytime*. A robust crisis response system serves Virginians in the community with their natural supports, and all interventions are trauma-informed, developmentally-appropriate, and designed to provide a de-escalating, health-focused response in the least restrictive setting, utilizing involuntary custody or treatment arrangements only as a last resort to avoid "tragedy before treatment" events and ensure we provide a "treatment before tragedy" response.

Community based crisis supports include someone to call, someone to respond, and somewhere to go, with all three of these support categories being therapeutically appropriate and tailored for behavioral health emergencies. "Someone to call" means that there is an easily identifiable access point that does not require special knowledge or past experience in a crisis situation, preferably with text, phone, and web-based access. This access point is coordinated with but distinct from 9-1-1. The person on the other end of the line is trained to respond therapeutically to behavioral health crises, and there is language access available to provide services to all Virginians. This access point not only provides phone intervention, but also serves as an access point to the full crisis continuum. "Someone to respond" means that 24/7/365, there is someone available to respond in person (including use of real-time telehealth services) to provide on-scene stabilization services, assessment, and planning. Thus, our vision is a workforce that is comfortable responding in the community and has the necessary supports to do this difficult work competently without excessive burnout or secondary trauma. "Somewhere to go" refers to a place-based entity that turns no one away and provides a range of crisis supports that are appropriately matched to the risk of harm of the situation. This includes accepting walk-ins and law enforcement drop offs to avoid jail or other detention, including involuntary transfers.

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

The vision for Virginia's crisis system is a shift away from today's *de facto* reliance on law enforcement to respond to behavioral health emergency situations. The role of law enforcement in behavioral health crisis care shifts to a highly coordinated, peer-to-peer relationship that recognizes mutual expertise and respects multiple governmental interests in behavioral health crisis situations. The way a fire response would be expected at a fire, a behavioral health response is the default component of a behavioral health response (whether on scene or via a quick drop off). Law enforcement is considered an absolute preferred customer to the behavioral health crisis system, and the system takes a population-based view where there is a responsibility to connect all Virginians in behavioral health crisis to the behavioral health crisis continuum, regardless of acuity (i.e., there is not a certain acuity lower or upper threshold where jail becomes appropriate). A future system instead includes crisis trained law enforcement, fire, and EMS responders (i.e., all other first responders) who know how to triage behavioral health crises, have basic/general skills for interacting with individuals in behavioral health crisis, and have updated and efficient methods for communicating with and working together with the behavioral health crisis system. Specialized teams such as CIT are a key part of the system linking individuals in crisis to care safely, but are not a substitute for the behavioral health crisis care itself. LE and EMS are partners for triage as well as the coordination of any safety and health needs that go beyond the skills and abilities of the behavioral health crisis system.

We place equity on par with other primary considerations (e.g., funding), with a specific focus on racial equity due to an acknowledgment that there is a compounding impact of disparities in behavioral health and law enforcement governmental responses to individuals in crisis, and behavioral health specifically does not deflect these disparities onto a "law enforcement problem." We agree that a crisis system that is less accessible, less therapeutic, or more restrictive for certain races, ethnicities, or disability types is not a crisis system that works. We ensure that as crisis-related needs are identified, they are addressed to the best of the system's ability, including specialized needs for mental health, substance use,

developmental disabilities, youth, older adults, individuals with limited English proficiency, individuals without housing, and individuals with multiple system involvement (e.g., foster care, criminal justice).

We currently acknowledge with humility that a deficit-based perspective on the performance of law enforcement in responding to behavioral health crisis situations ignores the larger view, which requires we "right size" the collaboration and take accountability in the behavioral health system for an improved response in the community that does not divert the most vulnerable clients to more restrictive settings such as jails. We agree that pushing system-level stress for transformation onto the day-to-day work of individual professionals at the agency level is counterproductive and creates stressful work environments which may result in more easily escalated interactions between individuals in crisis and law enforcement. We take a realistic view of funding needs, and work across sectors to connect and leverage resources to build the system, with a cross-sector agreement to invest first and foremost in the health-focused supports missing from the system, but also acknowledging costs associated with supporting law enforcement to shift their role from the *de facto* crisis response and decision makers, to a trained and skilled partner in connecting individuals in crisis to the behavioral health crisis continuum. We make fiscally efficient and collaborative plans to ensure the health-focused supports are built as a priority, avoid blanket assumptions about law enforcement partners' ability to absorb costs, and instead work together to make transparent decisions to meet the transforming needs of the system without inadvertently increasing the role of law enforcement in crisis response with hasty decisions. For example, we acknowledge the vast budgetary and staffing differences between large metropolitan police forces and small rural departments. We submit this state plan for the implementation of the Marcus-David Peters Act acknowledging that a vision is only as powerful as its plan to arrive there, our ability to work together at multiple levels to solve complex problems, our ability to continue working towards shared goals even in the context of set-backs or stalemates, and an inclusive approach to ensure that Virginians, particularly those who have experienced harms under the existing system, to provide meaningful input into the implementation and ongoing development of the crisis continuum.

State Planning Workgroup

A state planning workgroup was formed to drive the development of the statewide Marcus Alert plan, with a number of stakeholder groups required to be involved per the Act. A full list of stakeholder group members is provided in Appendix X. The full workgroup met XX times between January, 2021 and June, 2021. Initial meetings focused on exposure to general systems information and the adoption of a

systems perspective. It was acknowledged early in the workgroup that the task of the workgroup is not one where a "roadmap" already exists; rather, other states have had separate initiatives to build out the crisis services continuum and/or to define and implement law enforcement reforms, but we did not have an example of when these have been done in tandem from a planning or implementation perspective. Yet, the workgroup agreed that the joint goals of the workgroup also provided a unique opportunity for Virginia to implement a crisis response system in an equitable manner.

General topics reviewed and discussed included Virginia's emergency services system, Virginia's Crisis Intervention Team (CIT) programs, CIT Assessment Centers (CITACs), some recent pilots in Virginia at 9-1-1 dispatch and co-responder models, implicit bias, peer roles throughout the continuum, considerations for youth, and models from other states and cities. There was early agreement in the workgroup that a systems approach was appropriate for the breadth of the work, considering other complex topics such as racial disparities in maternal mortality where a systems approach has been illuminating. There was also general agreement early in the workgroup regarding the adoption of the following values to guide the planning process:

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

The following workstreams were ultimately formed to create more detailed proposals for consideration in the state plan. First, the Community Input workstream focused on ensuring that there was community involvement in the development of the state plan, as well as required at the local planning level. This workstream held three community listening sessions and conducted a survey of individuals with lived experiences. Results are included throughout this report, and a report of survey results are in Appendix X. The triage workstream focused on the role of 9-1-1/Public Safety Answering Points (PSAPs) and the development of a general framework that could be used to triage and communicate about behavioral health calls and responses across sectors (dispatch, law enforcement, behavioral health). The Response Options workstream focused on identifying minimum standards and policies and procedures for law enforcement responses and co-responder models. The Equity at Intercept 0 workstream focused on addressing racial and

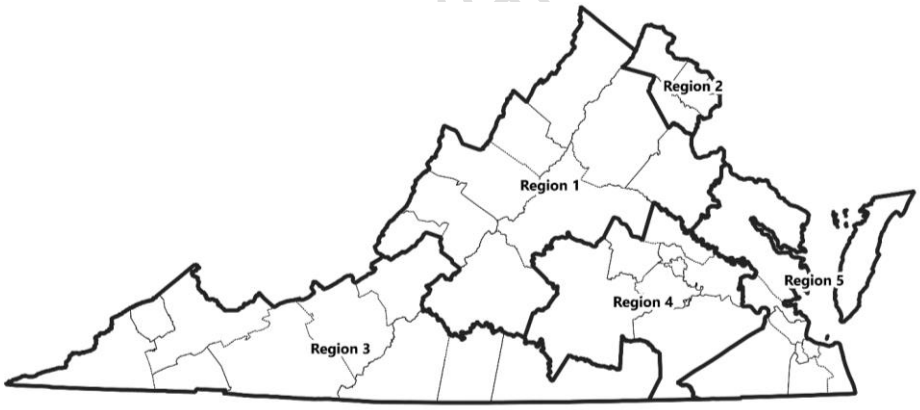
other bias at Intercept 0 (i.e., behavioral health crisis services) and developed a framework to bolster equal access to crisis care, cultural competency in crisis care, and the development of Black-led, BIPOC-led, and peer-led crisis services and supports at Intercept 0. The Data and Reporting workstream focused on identifying key outcomes and systems for measuring, reporting, and analyzing key outcomes, including racial disparities, to inform quality improvement over time. Finally, the Local Roadmap workstream focused on the development of documentation and processes for localities to engage in to develop their local implementation plans, submit plans for approval, approval process at the state level, and the coordination of local and state oversight for the implementation of the Marcus Alert.

Current System Catalog

Catalog of existing services and programs will appear here following analysis of the locality survey.

Crisis System Utilization (projections)

Monthly crisis estimates based on the Crisis Now model estimation tools are arranged by LOCUS level and CSB catchment as well as LOCUS level and County.



The following data sources were used to generate this map: U.S. Census Bureau TIGER/Line 2019 shapefiles for the U.S. and its coastline.

Commented [LJS1]: The current system catalog component will be included in draft 3 of this report once the locality survey results are analyzed.

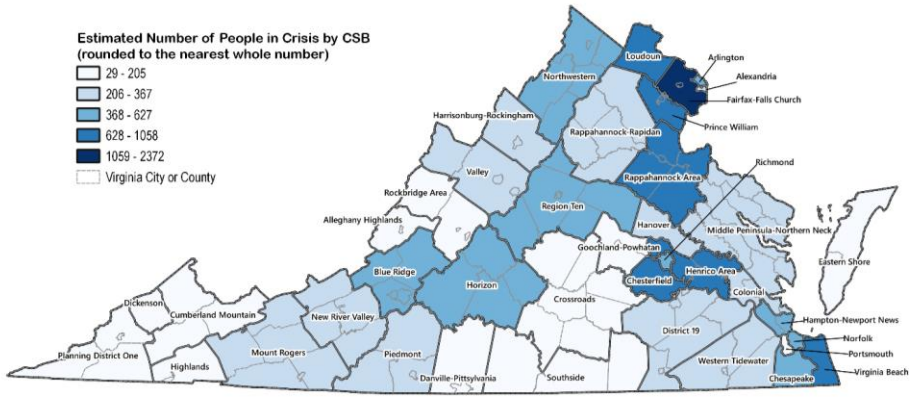
Commented [J(2]: Catalog CIT programs.* note: this section will be written by Stephen Craver and Toyin Ola using existing reports and the locality survey.
Catalog mobile crisis and CSUs.* note: this section will be written by Toyin Ola with input from Heather Norton, Mary Begor, and Nina Marino using existing reports and the locality survey.

Catalog cooperative arrangements between mental health and law enforcement.* This section will be written by Toyin Ola using the locality survey. Stephen C. and Patrick H. can review.
Discuss prevalence of crisis situations and any Virginia data.* Lisa JS will write some draft language here for the 3 points below then Toyin will write from there.
-tdo data, bed utilization data
-child crisis data
Catalog state and local funding of crisis and emergency services.*
Lisa will pull from the data call that Finance did last year. Josie an Erin/Nathan will review.

Commented [J(3]:
Core crisis system performance: all response teams (including mobile crisis, community care, co-responder), mobile crisis hubs, DBHDS, private providers under MOUs, DCJS.
Primary responsibilities: develop framework and standards, stand up best practice crisis system supports, communicate expectations and best practices for law enforcement and other first responder partners, create training materials to support statewide triage function, plan and hold quarterly meetings, submit data, review data, analyze data, analyze health disparities, and monitor compliance in crisis system.
All under broad goals of:
-statewide availability of someone to call when in crisis (988 roll out)
-statewide availability of mobile crisis teams to respond within 1 hour;
-targeted availability and support for local goals when building other teams such as coresponder, community care, etc. across the state (i.e., commitment to a layered approach)
-statewide availability of places that people in crisis can go for assessment and treatment that are not ERs or jails
-strong partnerships with law enforcement and 911 dispatch, and reframing the existing partnerships as a triage role for 911 and LE with BH being the appropriate responder; commitment to replace LE as the first responder to more BH emergencies
-maintaining a strong partnership with CIT and supporting areas to build on their CIT innovations while also not co-opting CIT or creating confusion

Monthly Crisis Flow by Community Services Board

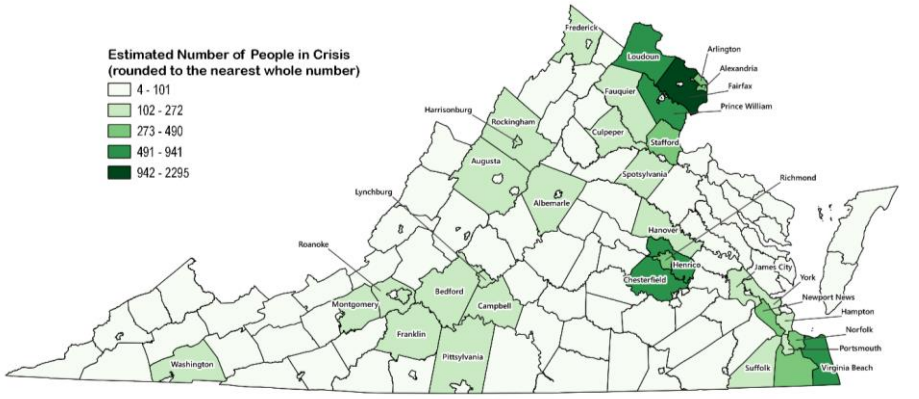
This map depicts the estimated monthly number of people in each CSB who will experience a behavioral health crisis.



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

Monthly Crisis Flow by City and County

This map depicts the estimated monthly number of people in each city or county who will experience a behavioral health crisis.



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

Marcus Alert System Summary

The Marcus-David Peters Act requires the state catalog components above as well as: protocol/framework for 9-1-1 diversion to behavioral health system, protocol/framework for relation between mobile crisis hubs (regional) and local law enforcement, minimum standards/best practices for law enforcement engagement in system, assignment of duties, responsibilities, and authorities across state and local entities,

and process for review, approval, and evaluation of locality's plans. To address those five requirements in a comprehensive plan, the Marcus Alert System state plan is organized into thirteen components, each of which are outlined in this document and associated Appendices.

1) A statewide 4-level cross-sector triage framework for Marcus Alert level 1, 2, 3, and 4 for shared communication across sectors, framework for local plan submission, evaluation, and approval, and performance management and evaluation at the state level
2) Protocol for full diversion from 9-1-1 to 9-8-8 (Protocol #1)
3) Protocol for mobile crisis teams to seek specially trained law enforcement back up (Protocol #2)
4) Protocol for all first responders to follow to triage behavioral health emergencies to the behavioral health system, even in situations where a behavioral health first responder is not on the scene (Protocol #3)
5) Community coverage by Marcus Alert response teams, which include:
    a. STEP-VA mobile crisis teams employed by the regional crisis hubs, which do not have law enforcement members but can call for law enforcement back up under Protocol #2
    b. Mobile crisis teams (private providers) under MOU/contract with the regional mobile crisis hubs
    c. Local community care teams without law enforcement members, but who can call for law enforcement back up with a similar protocol as mobile crisis teams
    d. Local community care teams with law enforcement members, such as co-responder units
6) An Equity at Intercept 0 initiative focused on building supports for public-private collaboration in Virginia's publicly funded crisis services, which includes:
    a. a Black-led coalition with a role in State planning and oversight for Marcus Alert system overall
    b. network leads that focus on creating infrastructure needed to ensure small, community-focused providers (with a focus on Black-led, BIPOC-led, and peer led providers) are available across Virginia, with a focus on building crisis supports and public-private partnerships in neighborhoods and areas that have been historically marginalized and may have reason to distrust a governmental response to a behavioral health crisis (and ensuring equal participation in reimbursement structures for these providers)

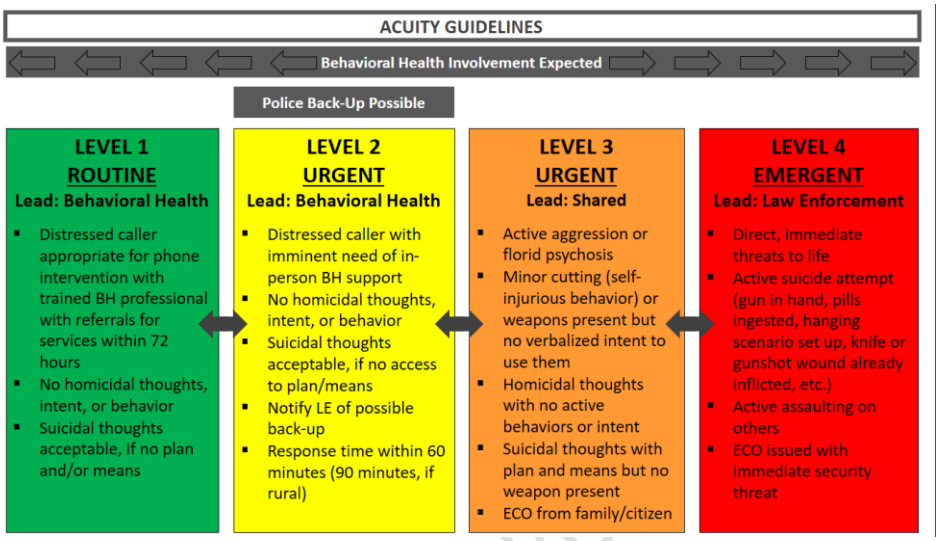
c. Training and academic partnerships to ensure a pipeline of crisis professionals with incentives to provide services in the public sector and high quality evaluation of any health disparities and the impact of efforts to improve the system

7) Training standards including a Marcus Alert specific advanced training required for leadership, dispatch, law enforcement, other first responders, and behavioral health crisis supports
8) Data and reporting requirements (primarily quarterly), including:
    a. Response team data requirements (regardless of funding source)
    b. CAD call type and call disposition data submission (to capture data on all Marcus Alert 1, 2, 3, and 4 calls even if a Marcus Alert response team is not dispatched)
    c. Marcus Alert resolution data submission (to capture data on Marcus Alert 1,2,3, and 4 situations that do not result in a Marcus Alert response team response)
9) Documentation and tools to assist in local planning for Marcus Alert system
10) Recommendations for the voluntary database requirement for each 9-1-1 center
11) Guidelines for local plan submission, review, and approval
12) Frameworks for accountability including:
    a. A framework for local accountability within the Marcus Alert system (across sectors) and to the local community
    b. A framework for regional accountability for the performance of the behavioral health crisis system, which is in ongoing development
    c. A framework for state accountability for performance of the Marcus Alert system (across sectors) and to the broader (statewide) community
13) Description of public service campaign focused around 9-8-8 with additional local outreach requirements for locality-specific Marcus Alert information

State Framework: Four Level Triage Framework

The four level state framework creates a way for stakeholders to communicate across sectors as well as across areas of the state. Each area plan will be required to complete more detailed definitions of each level, and how it is defined in the context of existing protocols (particularly those that are standardized as part of an EMD which cannot be altered by the PSAP). The four levels are a framework for understanding variation in risk of harm (overlapping with, but also with distinction from, acuity) as well as planning variation for response protocols.

Commented [LJS4]: Note: developmental considerations- better placed at each level or for each response type? I would say something at both- our dispatch partners mentioned that dispatchers are really black and white, so if it says "has a weapon" that is a yes/no to them unless there is further info provided.



Caption

Insert caption: Four-Level Triage Responses

The four level triage serves multiple purposes in the state plan. First, the four level triage system provides guidelines for evaluating and classifying the risk of harm associated with behavioral health emergency situations, to ensure that the details of the situation are evaluated directly (vs. relying on more general decision making processes under stress, which would be more prone to implicit bias). Second, the four level triage system provides the common language across sectors (i.e., you do not have to have a clinical background or law enforcement background to understand and be part of the assessment, triage, or response to the four levels). Third, the four level triage system provides the framework for the state plan to outline appropriate response options for different levels of risk and acuity, which then will be used by local implementations to communicate their plans for state approval. Fourth, the four level triage system provides the framework for ongoing assessment and continuous quality improvement. It would not be possible for the system to be clearly described and evaluated across the state without a common language to discuss levels of acuity, approved response options, and assess compliance and accountability for enacting the Marcus Alert plan. The intentions and spirit of each level is described here, acknowledging that each local plan will have further details to work out regarding how they will classify calls. Some contributing factors to this variation include the presence of mental-health related protocols in law enforcement dispatch

Commented [J(5]: we should find a way to crosswalk this with the LOCUS item "risk of harm"- it isnt a perfect crosswalk, but since the idea is that triage from 988 and 911 would be as aligned as possible, it would be good to insert it somewhere: adult: 3 - Moderate risk of harm
a-
Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
b-
No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
c-
History of chronic impulsive suicidal/homicidal behavior or threats and current expressions does not represent significant change from baseline.
d-
Binge or excessive use of substances resulting in potentially harmful behaviors without current involvement in such behavior.
e-
Some evidence of self neglect and/or compromise in ability to care for oneself in current environment.
20 LOCUS 2000 Training Manual
4 - Serious risk of harm
a-
Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
b-
History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from baseline.
c-
Recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with no demonstrated ability to abstain from use.
d-
Clear compromise of ability to care adequately for oneself or to be adequately aware of environment.
5 - Extreme risk of harm
a-
Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior...
- without expressed ambivalence or significant barriers to doing so, or
- with a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or
- in presence of command hallucinations or delusions which threaten to override usual impulse control.
b-
Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
c-
...

EMDs as well as medical EMD protocols. Further, not all PSAPs use EMDs, but all PSAPs will be required to use an EMD for medical dispatch by XXX. Thus, the level definitions will be defined based on making system addition and changes where allowed to capture each level (since the details of standard EMDs cannot be changed by local users), and ensuring that data capture of these four levels are consistent across PSAPs.

Level 1 Routine Response

The recommendations for the first and lowest level of response to a behavioral health emergency centers on 988 regional call center interventions, warm lines, and is intended to be a behavioral health led response. The routine response will include a conversation with behavioral health experts who may provide proper referrals, assist with follow-up appointments and assess the urgency of the behavioral health emergency. Public-Safety Answering Points (PSAP) will be able to refer level one calls to the 988 regional call centers for interventions by trained behavioral health providers. The recommendation will be for PSAP personnel to stay on the line for a reasonable amount of time, consistent with the model utilized when contacting poison control centers, and be able to immediately dispatch available behavioral health assets, mobile crisis teams, community care teams, or law enforcement should the call be escalated to a higher level of acute response. If the call continues at the routine level, PSAP personnel should remove themselves from the behavioral health led call. The behavioral health providers at the 988 regional call centers may upgrade any call or referral to an urgent or emergent level and have proper behavioral health teams, co-response, or law enforcement dispatched. This is unlikely to occur.

The acuity level would be the lowest for the routine response level. Non-life threatening situations including passive desires not to be alive with no plan or active suicidal intent, requests for referrals and information, and initial calls for behavioral health issues would fit this response, but not be all-inclusive.

Level 2 Urgent Behavioral Health Response

The second level of response, the urgent behavioral health response, is recommended for situations where emergency first response (law enforcement, fire, or EMS) is not immediately recommended based on the 988 regional call center or PSAP question and answers with the caller. This level may include 988 regional call center intervention while behavioral health is dispatched in the form of a mobile crisis team (available statewide) or a community care team (where those resources are in place). Based on expected response times, noting that some large rural areas take longer to get a law enforcement response, an initial dispatch of law enforcement and first responders may be more appropriate with the behavioral health response than in urban areas where assistance can be more readily available. The second level of response will be a behavioral health led response, which can be upgraded by the behavioral health representative based on call content through the 988 call or once on the scene. The second level response centers on

Commented [N(6]: That is not entirely true based on the staffing of 988 call centers- it can be a volunterr, bachelor level, or Licenssed--- this implies all call responders will be licensed and that is not what is envisioned.

Commented [LJS7]: May need further explanation of the difference between level 1 and 2. Level 2 might also go to 988 call center, and presumably would need further "warmth" in the hand off

Commented [N(8R7]: I think I know what is meant here- it could be no to one of these or multiple of these- but do we need to clarify for the General public who may read this report and explain no plan or a plan with no means/capability, or no weapons, or weapons where another assures no access? I worry that someone will read this and think it must be no to everything instead of the naunce

Commented [LJS9]: Consider adding the piece about special consideration if it comes in through the non emergency line and is a (non descript) BH situation

responding to individuals where they are located in the community in hopes of avoiding hospitalizations and escalation of symptoms.

The appropriate acuity level for the second level response include situations where clinical intervention is needed to reduce the advancement of greater risk. Individuals without homicidal thoughts, behaviors or intent, as well as individuals with suicidal thoughts but no intent, plan, means, capability or weapons would be appropriate for a level two urgent behavioral health response. 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 will also fit the recommended response for level 2.

Mobile crisis statewide response will have a performance benchmark of responding within 1 hour 90% of the time through the STEP-VA initiative and other crisis system transformation initiatives. There is national data indicating that in very rural areas, a benchmark of 90 minutes may be most appropriate, and this will be monitored during Virginia's implementation. As described further below (coverage by Mobile Crisis teams), law enforcement are considered a preferred customer, and requests for behavioral health response by law enforcement will be treated as highest priority calls to work towards a response that is significantly less than 60 minutes, but this cannot be guaranteed statewide. Understanding that behavioral health response times may be 60 to 90 minutes for level two responses, 988 regional call centers will be available to provide ongoing assessment, support, de-escalation, treatment options and assessment over the phone, as well as provide updates to responding personnel.

Level 3 Urgent Co-Response

The third level of response calls for a co-response to the behavioral health emergency when the possibility of safety concerns exists or the safety conditions are unknown based on information gathered through the 988 regional call center or a 911 PSAP. Co-response will look different from jurisdiction to jurisdiction. Urgent co-response does not require that law enforcement be on the scene, although it is expected that some plans will include law enforcement at level 3. For example, a community care team that is closely coordinated with law enforcement (e.g., CAHOOTS model) or a mobile crisis team that can arrive on a quicker timeline than the 1 hour response and is coordinated for back up if needed would be consistent with a Level 3 response. The co-response may be a behavioral health provider and a police officer, mobile crisis unit or community care team. With a level 3 response with simultaneous dispatch of teams, law enforcement will ensure a safe scene while working with co-responders. Following the designation of a secure and safe scene, the intent will be for the behavioral health component of the co-

Commented [LJS10]: How can we add the developmental consideration here? Developmentally-expected homicidal thoughts or statements?

Commented [N(11)]: That is the goal when fully staffed do we need to clarify that?

Commented [N(12)]: This answers my question from above :-)

response to take on a primary role in the response. The level three response will require coordination and cooperation between behavioral health providers, co-response options, and law enforcement in the field based on known facts when approaching the scene, recognizing one prescribed method of co-response will not fit every behavioral health emergency situation. Law enforcement personnel trained in Crisis Intervention Team (CIT) and behavioral health may be on the scene and nothing precludes them from partnering or aiding the efforts to de-escalate when working with the available co-responders during a level three mental health emergency. Based on response time and available co-response assets, law enforcement may be on the scene much quicker than behavioral health co-responders and must respond to assess the situation as quickly as possible during a level three mental health emergency. Law enforcement can then begin de-escalation efforts as behavioral health co-responders are able to get to the scene to assume the lead role. As with levels one and two, if the situation changes, the response can be upgraded by the behavioral health provider should they feel the threat level has changed.

Individuals with a history of recent or active aggression as well as active psychosis disconnected from reality would be considered a level three co-response, as well as individuals with homicidal thoughts with no active intent or access to means. Individuals with suicidal thoughts with intent and/or a specified plan, but no weapons present also fall under a level three response. Individuals with minor cutting or other self-injurious behavior related to a behavioral health emergency or possible weapons present, but no verbalized intent to use them also will call for a co-response to ensure scene security. Third party calls for service where there may not be enough details on the scene safety will primarily fall under the level three response. Emergency custody orders issued by a magistrate with unknown situations, obtained by a family member or citizen, could utilize a level three response. In service calls for magistrate issued ECOs, it should be acknowledged that the decision to take custody is pre-determined when the court or magistrate issues an emergency custody order (ECO) ordering law enforcement to take custody. The belief is a trained behavioral health provider could still assist in garnering cooperation and compliance from the individual to reduce the risk of use of force and assist in de-escalating the potential for an emerging behavioral health crisis. In determining the definitions of levels 3 and 4, and the associated responses, developmental considerations and child-serving partners must be engaged for planning. For example, youth with minor cutting behavior may manifest as use of a paperclip or deep scratching, which would be a level 2 situation most likely, as compared to an adult with minor cutting behavior may manifest as using glass or a knife, which would be a level 3 situation most likely. Additional considerations related to youth and the distinction between Levels 3 and 4 are provided below in Level 4.

Commented [LJS13]: I'd like to discuss this more. I think level 4 LE will always "start their work" when they arrive, but I think there might be a rationale for having general practice at level 3 be LE assess from a distance but await BH for a coordinated response (in terms of actually approaching the area, etc. even though LE will lead)

Commented [N(14R13]: It will also depend on whether it is during a time MCT is available- but I agree- just because they got there first does not mean they should automatically assess and serve

Commented [N(15]: I am worried about the specificity of the clinical presentations being called out for these levels, I think these may shift as the call center becomes active and more individuals become known to the system and what individuals feel comfortable responding to and how this will potentially shift the way REACH as an example currently responds.

Commented [N(16R15]: Can we add something about the levels being reassessed at some point by the call center in coordination with PSAPs

Commented [LJS17]: This may be too down in the weeds, but I do think that localities with a community care team w/o law enforcement should be able to consider these situations holistically to place them at level 2 or 3. If we say that LE MUST always clear the scene in person, that might limit some level 2 responses. It might come down to building out what is meant by "there are not enough details"

Level 4 Emergent Response

The fourth level of response is emergent, and is termed an "active rescue" in other states. When originating from a 9-1-1 call, Level 4 situations send first responders (law enforcement, EMS) immediately, and the assumption is that the dispatched first responder, likely law enforcement, will be the initial lead on the emergency response, including responding in-person to the scene even if they are the only responder there. If co-responder units are available to respond urgently, this would be the preferred response. The general philosophy remains the same, in that the role of law enforcement is to safely triage the person in crisis to the behavioral health system—not to be the sole respondent or to take responsibility for managing all aspects of the situation. Once an immediate response is dispatched, if mobile crisis teams and community care teams are not dispatched simultaneously, mobile crisis teams and community care teams should also be dispatched, but assuming they arrive on the scene and the threat level has not been downgraded yet, mobile crisis and community care teams are expected to maintain a safe distance until the threat is assessed or reduced by law enforcement. Behavioral health providers may then be able to take the lead in emergent cases after law enforcement de-escalates the immediate threat or initial information of a higher threat is deemed no longer present.

The emergent fourth level of response revolves around situations too unpredictable and potentially life threatening to deploy behavioral health teams or co-response without law enforcement first securing the scene. These situations include direct threats to life, individuals who are actively assaultive or 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 eminent would also be recommended for a level four response. Those eminent 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 intent. Also under emergent situations are emergency custody orders (ECO) obtained by family or citizens where the situation involves a known security threat. Although each plan will create a definition for Level 4 based on their internal coding, processes, and definitions, as we move toward an integrated "no wrong number" approach, consideration of the LOCUS "risk of harm" item and its definition of "extreme risk of harm" may be useful, as this will be a tool used at 9-8-8 to make overall level of care determinations (which include 6 factors total, one of which is risk of harm).

Extreme risk of harm:

a- Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior…

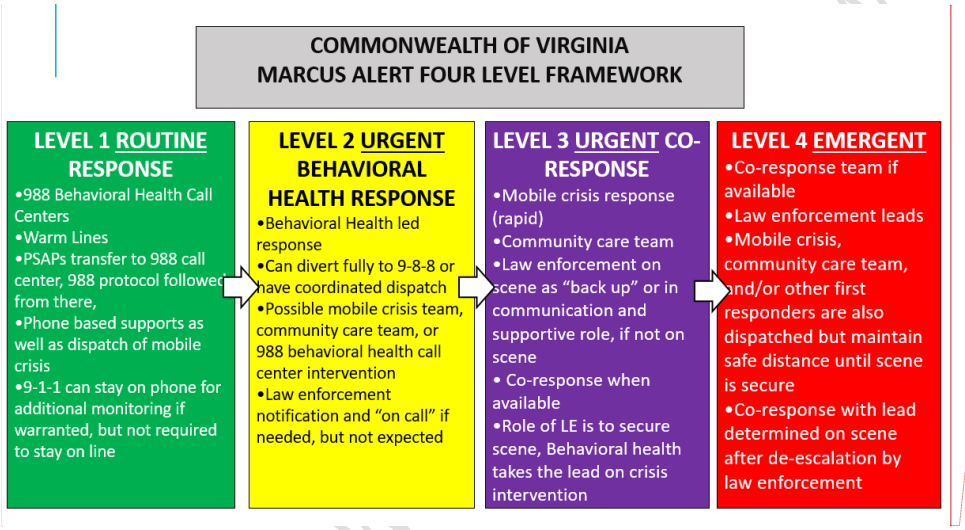
- without expressed ambivalence or significant barriers to doing so, or

- with a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or

- in presence of command hallucinations or delusions which threaten to override usual impulse control.

b- Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.

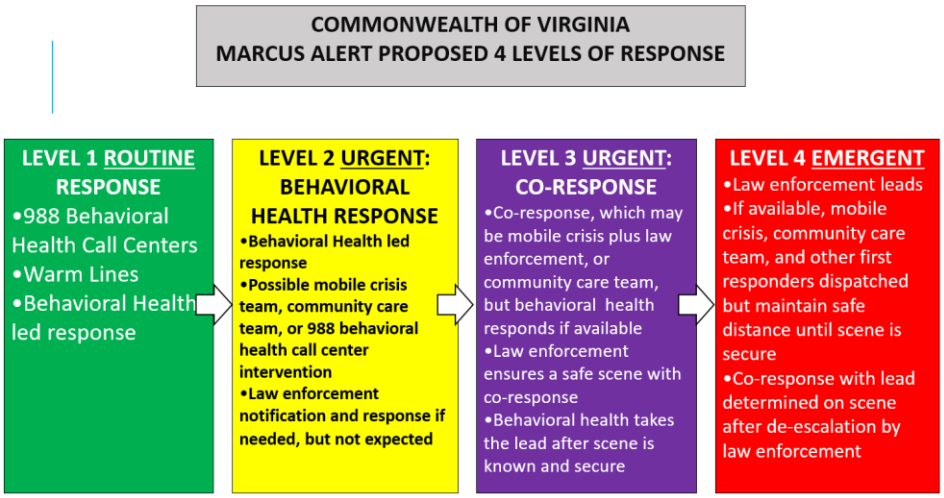
c-Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.



Caption. Summary chart of response guidelines. Blank copy for local completion included in Roadmap.

Original version from subgroup:

Commented [LJS18]: This is an edited version, shifting the focus at level 3 to make clear that a rapid mobile crisis response is also an appropriate response at this level. Particularly if we keep the acuity guidelines as is, where a number of child crises will fall at level 3, we do not want to give conception that LE is a standard part of the level 3 response based on stakeholder feedback.

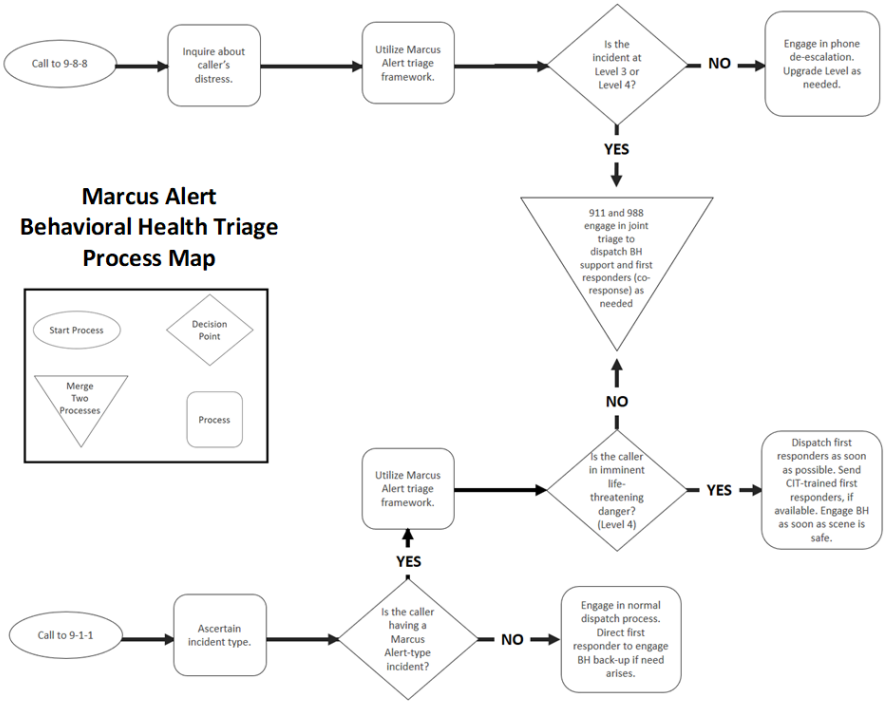


It is important to acknowledge the role of implicit bias in differentiating between Level 3 and 4 situations, and the approach to address this is three pronged: 1) the advanced/specialized training will address as directly as possible in a number of modalities, 2) the requirement of specific definitions based on observations vs. speculation, and 3) requirements that local plans describe specific developmental considerations for decision making. Police response for youth in mental health crisis is rarely needed, even in chaotic situations involving threats, physical violence, and weapons other than lethal firearms and large/sharp knives (e.g., BB guns, kitchen knives, sticks), rather, as the *de facto* response to crises, it has become normalized. Family members, front line staff in the foster care system, front line staff in group homes, and many behavioral health providers manage situations on a daily basis which, if not examined closely, could be objectively defined as a level 3 or 4 based on using an adult lens or law enforcement lens. Clearly, this is an intersectional issue where implicit racial bias and adultification compound one another, with negative impacts accumulating on children of color.

Protocol for Diversion from 9-1-1 to 9-8-8 (Marcus Alert Protocol #1)

A major shift for PSAP operations will be the ability to transfer Marcus Alert level one designated calls to the 988 regional centers. Additionally, there will also be the added ability to move to a level two response, which may be slower than normal immediate 911 dispatch responses. Based on localities availability, PSAPS will have to be familiar with all assets in place such as mobile crisis teams and community-care

teams, and will need to have these assets documented as options for call dispositions for reporting purposes. Ultimately, the goal is a system where a call to 9-8-8, 9-1-1, or other crisis lines all connect the individual or family in crisis to an all-payer crisis services continuum, and that the response does not differ based on the access point used (I.e., "no wrong number"). Because the 9-8-8 system is currently under development and Virginia's PSAPs are high in number and generally set policies and workflows in an autonomous manner, we provide this high level graphic to demonstrate the connection between the 9-8-8 system and the 9-1-1 system, and how these two processes can be coordinated based on a four level triage framework. This should not be interpreted as a substitute for the detailed workflows that will be required for each PSAP and community to design to implement the Marcus Alert, rather, this is the overarching /guiding hueristic.



The committee recognized that referring calls should not become a situation where callers are being transferred back and forth between 911 PSAP and 988 regional call centers, but should instead be a smooth transition ("no wrong number"). When a PSAP makes the determination to transfer a behavioral health

emergency call to a 988 regional call center, the recommendation will be for the dispatcher to stay on the call for a reasonable amount of time to ensure the situation is not escalating. For Marcus Alert level 1, this is at the discretion of the dispatcher, as the transfer is considered a "full diversion" to 9-8-8 and 9-8-8 protocols for evaluation will be followed. For level two responses that include a transfer to 9-8-8 for further evaluation or phone support, the PSAP should remain on the line for further coordination, including to provide updated information on level two calls for the responding personnel until they are on scene. The 988 regional call centers and 911 PSAP will have to work together to coordinate dispatch of assets and co-response for level three and four responses, with the ultimate goal of the quickest behavioral health response possible at levels 3 and 4. In localities where law enforcement may have greater distances to travel to respond, the same coordination will occur for level two responses to ensure that law enforcement is available in the general geographic vicinity in a "stand by" capacity.

Protocol for Mobile Crisis Teams to Seek Specially Trained Law Enforcement Back Up (Marcus Alert Protocol #2)

Over time, it is expected that 9-8-8 will experienced increase use and call volume, which will ultimately include increased call volume at all levels of acuity. Coordination with law enforcement is a key principle of the Crisis Now model. From a Virginia perspective, coordination with law enforcement in crisis services serve three specific civil functions:

1) **"Treatment before tragedy" legal custody function** where law enforcement is the only party authorized to take individuals into custody involuntarily and transport them for a mental health evaluation (pre-screen).
2) **"Treatment before tragedy" physical restraint function** where, in addition to being the authorized party per Virginia code, law enforcement is also the party with the skills and authority to physically restrain a person to stop an attempt to harm oneself or to transport them to treatment or assessment using restraint. This includes physically disarming armed individuals in mental health crisis.
3) **To serve in a protective capacity for bystanders, family members, or other third parties** including behavioral health clinicians if the individual in crisis is posing a risk to others or behaving in a manner that is so unpredictable that bystanders, family members, or third parties cannot reasonably predict whether their safety is at risk or not.

These functions are not mutually exclusive or clearly articulated. Yet, the state planning group determined that they are important to differentiate between in guiding law enforcement policies and procedures for serving as back up for behavioral health responses. Behavioral health professions are guided by ethics similar to "do no harm" and other provisions to refrain from endangering public health, safety, and welfare and only providing interventions that have a therapeutic purpose. These principles are not inconsistent with, but also not identical to "protect and serve" responsibilities of law enforcement. Some examples include:

Virginia Profession	Practice Regulations regarding harm
Virginia QMHP	*1. Practice in a manner that is in the best interest of the public and does not endanger the public health, safety, or welfare.*
Virginia Social Work	*A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board. Regardless of the delivery method, whether in person, by telephone or electronically, these standards shall apply to the practice of social work.* *B. Persons licensed as LBSWs, LMSWs, and clinical social workers shall:* A. *1. Be able to justify all services rendered to or on behalf of clients as necessary for diagnostic or therapeutic purposes*
Virginia Registered Peer Recovery Specialist	*A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board.* *B. Persons registered by the board shall:* *1. Practice in a manner that is in the best interest of the public and does not endanger the public health, safety, or welfare.* *2. Be able to justify all services rendered to clients as necessary.*

Thus, co-responder teams and other coordinated activities between behavioral health (QMHPs, clinicians, and peer support specialists) and law enforcement require a detailed understanding of each others' professional responsibilities and ethics and should, ultimately, have a shared understanding of what interventions are used and why, and what governmental interest takes precedence in determining response options. Further, research on implicit bias demonstrates that racial bias exists in risk assessments, wherein ambiguous behaviors are interpreted as more risky when displayed by Black or Brown individuals as compared to white individuals, as well as more risky when displayed by men as compared to women (white women being perceived as lowest risk, Black men being perceived as highest risk). Thus, decision making processes for clinicians and decision making processes for law enforcement are invariably changed when the other arrives on the scene, as the law enforcement officer now must provide for the safety of the clinician as well as the individual in crisis and any other third parties, and the clinician must now consider actions taken on their behalf by law enforcement (i.e., use of force against an individual in crisis to protect a clinician) when ensuring that they meet their ethical responsibility to do no harm and provide only therapeutic interventions. Finally, it is important to note that implicit bias is exacerbated under stress and time pressure, which is considered a normative part of responding to crisis situations.

Primary interventions associated with reducing impact and risk of implicit bias focus on broad goals of slowing down decision making processes, activating logical and reflective, versus reactive, parts of the brain, and using tools for standardized (i.e., not based on stereotypes or implicit associations) evaluation and decision making. Taken together, this pattern of contingencies supports the development of specialized training and protocols that focus on advanced de-escalation training, a specific focus on "time as a tactic" and the highlighting of some specific de-escalation techniques that may have explicit relevance, advanced intersectional training related to implicit bias and risk assessment, and decision making supports to clearly consider the primary governmental function at any given moment of a crisis response when law enforcement and behavioral health responsibilities may be at odds with one another. Additional details of training framework is provided below in component #6 of the state plan.

In addition to the training requirements to provide specialized back up to behavioral health emergency response, memorandums of understanding (MOU) between the mobile crisis regional hub and any law enforcement agencies that will be requested for back up must be in place to achieve compliance with Marcus Alert protocol #2. These MOUs must include:

1) Technical processes needed to request back-up in the most efficient manner possible

2) Procedures for communicating between behavioral health and law enforcement to provide details of the scene and ensure that there is shared understanding of the situation and the request for back up before back up arrives (i.e., treatment before tragedy custody function, treatment before tragedy restraint/force function, or protection for other individuals involved from an individual in crisis posing a safety risk to others).
3) Assurances that back-up sent will be specially trained per this state plan.
4) Responsibilities for both parties under the MOU.

Standard language for an MOU between a regional crisis hub and a law enforcement agency is provided in Appendix X.

Protocol for all first responders to follow to triage behavioral health emergencies to the behavioral health system, even in situations where a behavioral health first responder is not on the scene (Protocol #3)

Even as robust crisis care builds across Virginia, law enforcement will continue to interface with individuals in behavioral health crisis in the foreseeable future, and these interactions cannot be reliably predicted, systematically avoided, or always accompanied by a mental health professional or peer support specialist. Thus, protocol #3 ensures that there is a state framework to ensure that law enforcement personnel and other first responders have the skills needed to respond to behavioral health crises in a general sense, with the primary role and goal to be to connect individuals in behavioral health crisis to behavioral healthcare quickly and safely.

The Marcus Alert state plan for Protocol #3 is built around an organizational approach provided in the 2020 National Association of State Mental Health Program Directors (NASMHPD) report, "Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies."

Marcus Alert Protocol #3 requires an approved plan addressing the four areas in the diagram above (leadership/organizational, basic training, intermediate training, and specialized and advanced training). There is not currently evidence of a single protocol or stand-alone program to provide this function for communities, instead, it is accepted that it is a systems problem and protections should be built into all levels of the system to continually decrease risk of tragedy.

At the systems level, considerations include intersections of behavioral health crisis and community policing policies and initiatives, guardian vs. warrior trainings, use of force continuum and how behavioral health crises and de-escalation are built into the use of force policy, implicit bias trainings and policies, and officer wellness supports and culture.

At the basic training level, a Marcus Alert component will be added to the broader DCJS training changes. This will be fully integrated into the academy requirements to ensure that all officers receive this. Other basic trainings for departments to consider in their plan for protocol #3 is the 8 hour mental health first aid training.

At the intermediate level, it is recommended that agencies have coverage each shift by an appropriate amount of officers who have completed 40 hour CIT training in context of voluntary participation, aptitude/interest in working with individuals in behavioral health crisis, and supervisor approval. These supports can be provided in an "on call" format based on agency staff and size, but should be available for response. CIT recommends that 20% of officers are trained to achieve adequate coverage; percentage of appropriate coverage will vary based on side of agency. Future plans for system development

include a potential joint CIT module regarding the intersection of implicit bias and behavioral health crisis response. If any law enforcement agency has difficulty achieving what they consider to be sufficient coverage with the requirement of voluntary participation for intermediate training, then this must be communicated in the annual plan so that a collaborative plan for coverage can be developed that maintains both the voluntary nature of CIT training and the Marcus Alert Protocol #3 requirement that a specialized response be available.

The advanced level of training intersects with the development of community coverage and team development (next section in the plan). Advanced training refers to CIT trained officers who further develop their skills through additional advanced trainings beyond the standard CIT curriculum requirements. DBHDS and DCJS will collaborate on a state-sponsored version of an advanced training that is specific to the Marcus Alert to ensure that all agencies regardless of size or budget can access a high quality advanced training if desired as part of the plan for protocol #3. Additional details about the trainings are in component #6 of this plan.

Community coverage by mobile crisis response teams

Mobile crisis response and specific team types for mobile crisis response are defined in a general sense by the Marcus-David Peters Act.

"Mobile crisis response" means the provision of professional, same-day intervention for children or adults who are experiencing crises and whose behaviors are consistent with mental illness or substance abuse, or both, including individuals experiencing a behavioral health crisis that is secondary to mental illness, substance abuse, developmental or intellectual disability, brain injury, or any combination thereof. "Mobile crisis response" may be provided by a community care team or a mobile crisis team, and a locality may establish either or both types of teams to best meet its needs.

Mobile crisis teams

Mobile crisis teams are defined generally by the Marcus-David Peters Act, and as a behavioral health service, also have key definitional components in DBHDS licensing regulations, STEP-VA requirements, and DMAS Medicaid State Plan. It is important to note that each of those documents are subject to change under different authorities and timelines. Most recently, mobile crisis services have been operationalized through STEP-VA and Project BRAVO. To align with the Marcus Alert initial implementation areas, four crisis reimbursement codes were defined collaboratively with stakeholders (under the "Behavioral Health

Enhancements" workgroup structure) and submitted to CMS for consideration for Virginia's state plan with a proposed start date of December 1, 2021. Thus, it is possible that CMS approval process could include changes to these definitions, so it is important that all crisis reimbursement definitions provided here are considered to be in draft form and for informational purposes only to describe how the Marcus Alert system components work together.

Per the Act,

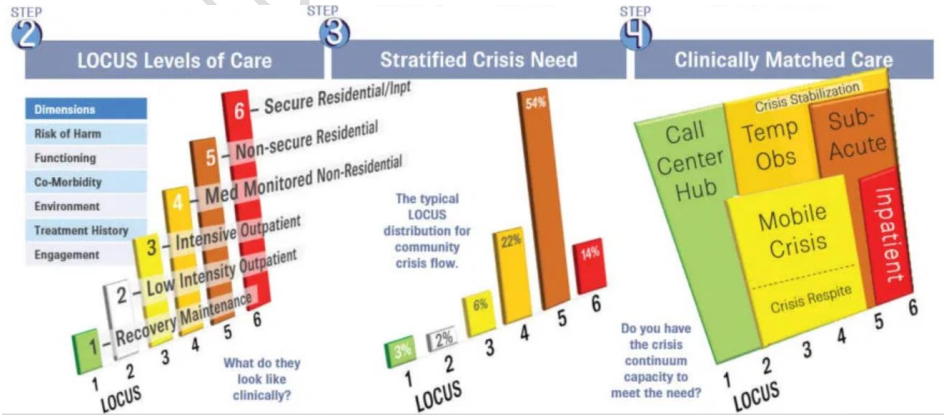
"Mobile crisis team" means a team of one or more qualified or licensed mental health professionals and may include a registered peer recovery specialist or a family support partner. A law-enforcement officer shall not be a member of a mobile crisis team, but law enforcement may provide back up support as needed to a mobile crisis team in accordance with the protocols and best practices developed pursuant to § 9.1-193.

State general funds to build mobile crisis services on a regional basis were appropriated in state fiscal year 2019 (operationalized as children's mobile crisis in FY 2020) and state general funds to support adult mobile crisis teams are appropriated for state fiscal year 2022 (initially appropriated for 2021 but frozen due to COVID-19 and then re-allotted for 2022). It is the goal of DBHDS and DMAS to align STEP-VA mobile crisis funding and Project BRAVO mobile crisis reimbursement rates in service of an ultimate goal of a behavioral health mobile response that provides a standard response regardless of payer source (or lack of payer). State-generally funded teams alone, even when accounting for expected Medicaid revenue, will not achieve 24/7 coverage statewide, which is defined as a response within 1 hour 90% of the time. In addition to capacity needs, the state planning group determined that it is important to include small, community based private providers (for example, neighborhood providers) as part of the dispatched response, particularly when responding to calls by individuals or families who have historic reasons to distrust governmental responses to behavioral health emergencies. Thus, mobile crisis teams will include teams contracted by the regional mobile crisis hubs (STEP-VA funded teams) as well as individual CSBs who invest in this approach and private Medicaid providers. All mobile crisis responders to be dispatched via the Marcus Alert system must be under MOU with the regional mobile crisis hub to be connected to the technological infrastructure for dispatch. The Equity at Intercept 0 initiative defined later in the report has additional information regarding public-private partnerships with a focus on equity in mobile crisis response services.

The most up-to-date and official information regarding Medicaid rates, service definitions, and medically necessary criteria can be accessed via DMAS website:

https://www.dmas.virginia.gov/#/behavioralenhancement

The draft service definitions and rate study assumptions defined different rates for different team types, most of which are two-person teams. Decisions regarding dispatch are made at the regional call center hub and/or collaboratively with 9-1-1 dispatch centers for Marcus Alert level 2 and 3 responses. Triage decisions at the regional call center will utilize the Levels of Care Utilization Standards (LOCUS) to clinically triage calls. It is important to note the difference between the 4 risk levels that are considered an overarching framework for the Marcus Alert system and the clinical triage conducted by the call center. The LOCUS is a tool that does not require clinical expertise to administer, so it is possible that it could be used by 9-1-1 centers in some capacity during the triage process as well to facilitate communication. But, the key difference is that risk/acuity triage is used to determine the overall system response and responsibility to respond, whereas the LOCUS is used to clinically assess the situation or caller and determine what level of crisis response or service is likely warranted (risk of harm is one of six domains considered). The below heuristic from the Crisis Now model provides some information about the expected volume of calls at different levels and the expected disposition. As can be seen, the majority of situations are most appropriate for a mobile crisis response and/or crisis respite, temporary observation, or subacute residential services.



All draft rates were defined for 15 minute intervals. The two person team types included: LMHP (including LMHP-E) and CPRS, LMHP and QMHP, 2 QMHP, and QMHP and Peer. One person response type is defined as LMHP response. Provisions for other response patterns as well as allowances for telehealth availability of LMHP will appear in the service definitions. One person response rate study suggested a rate of $63.18 per 15 minute interval, and two person response rates ranged from $101.20 to $117.27 based on composition per 15 minute interval. Mobile crisis response is defined as the response to a behavioral health crisis within the initial 72 hours of contact (i.e., 9-8-8 or 9-1-1 call). Community based stabilization supports for the period beyond 72 hours until linkages to ongoing care are made were also defined, as well as a per diem rate for 23-hour observation services and a per-diem rate for crisis stabilization units. Together, these four rates were designed to provide the crisis supports necessary to maintain Virginians in the community with their natural supports and utilize alternate, short term and sub-acute interventions such as 23 hour observation and short term residential crisis stabilization as alternatives to inpatient hospitalization.

Community Care Teams

Community care teams are defined by the Act as,

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

Both co-responder models and non co-responder models meet the definition of community care team in the Act. Because they are different at their core and have a number of variables between them, Co-response and Community Care team model standards are provided separately below. Under this legislation localities and cooperative regions have the flexibility to choose specific aspects of how they develop any community care teams that are developed. The decision to invest in mobile crisis teams, community care teams (including co-responder and non co-responder), or both, is multifaceted, and may be based on local resources, local need, community feedback, as well as other considerations. It is important to note that

while community care teams are not required to contain law enforcement officers as members of the primary response team, communities may choose to do so because current Virginia codes require law enforcement for the service of emergency commitment documents. For the simple reason that law enforcement *may* end up involved in any emergency mental health crisis that reaches Triage levels 3 or 4 (the two associated with the team descriptions contained herein), considerations for the appearance, response, and cooperation of law enforcement are detailed in the following response options.

Co-response team (specific type of community care team)

Co-response teams are comprised of a law enforcement officer and a mental health professional. Co-response teams are recommended at the highest risk/acuity level (Level 4) and are also an option at Level 3. The following recommendations pertain to the team composition, experience, presentation, response & intervention, and training specific to this type of team.

Commented [LJS19]: We may want to transition these to chart format for the team types

1. Composition & Experience:

Law Enforcement Officer

Recommended Minimum: a law enforcement officer who is assigned to a co-response team as a full time duty assignment should have a minimum of one year working in the field as a certified officer and have completed CIT core training. Every effort should be made to ensure that any officer responding in a ride-a-long or separate but mutual co-response capacity, even when not assigned to the role on a full-time basis meet the same recommended minimums.

Recommended Best Practice: the officer is self-selected (or even chosen through competitive process), supervisor approved for the assignment, have a minimum of three (3) years as a sworn officer, and a minimum of two (2) years as an active CIT officer.

Mental Health Professional

Recommended Minimum: The mental health worker should have at least one year of clinical experience.

Recommended Best Practice: The mental health profession would have at least some time working specifically in crisis work and an established working relationship with local law enforcement agencies.

*There are understood workforce challenges that may affect the ability to provide either or both of these personnel at the level of recommended best practice, however this should in no way be seen as a barrier to or recommendation against implementing a co-response team program.

2. Education and Training

Prior to Inclusion on the Co-Response Team

Law Enforcement Officer

Recommended Minimum: A law enforcement officer must have completed at least some specialized mental health awareness and de-escalation training beyond that received in the basic law enforcement academy*. Within twelve (12) months of inclusion on the co-responder team, that officer must have completed the CIT core (40hr) training course. Additionally, any officer assigned as a full time co-responder should have access to additional training for recognition and de-escalation of intellectual and developmental disabilities and acquired brain injuries above the minimum often included in the core CIT training curriculum.

Recommended Best Practice:

Prior to inclusion as either a full-time co-response team member officers should have at least three (3) years of field experience as a certified officer and two (2) years as a CIT trained officer with field responsibilities and the opportunity to actively apply CIT knowledge and skills during crisis encounters.

Mental Health Professional

Recommended Minimum: Has met all of the requirements for appropriate licensure and/or certification required by state and local law, guidelines, and policy to conduct mental health crisis work with a Community Services Board

Recommended Best Practice: The level of certification and licensure of the mental health professional will provide guidance for additional training and education needs. Many master's degree programs in this field contain content specific to defined need populations (e.g. children and youth, developmental disabilities, etc.). When those content areas have not previously been part of an education program for the team's mental health worker, the best practice would include additional focused training and/or education that supports crisis intervention for all populations of need that are likely to be encountered in the worker's response area.

All Personnel

To meet the minimum standards identified in the Code of Virginia for SB5038 and HB 5043 of 2020 Special Session I, all team personnel assigned to the communicate care team must have completed implicit bias, anti-racism, cultural competency, and disability justice awareness training. This education and

training may be accomplished at the local level, may require collaboration amongst regional resources, and/or may require additional support from DBHDS and/or DCJS. Additionally, personnel assigned to the team may receive facets of these training topics under standards currently in development by DCJS or through formalized education to achieve a social work degree, as two examples. Any need to verify acceptance of knowledge and training to meet minimum standards may be addressed with the DBHDS program staff.

A best practice for members of community care teams is to include cross-discipline familiarization to include data sharing and security, scene safety, common language protocols, and cross-discipline policies and procedures for field activities and responsibilities. Training may include familiarization for all team members to law enforcement defensive equipment, EMS equipment, the use of police and ems radios, and common technology platforms (mobile CAD, etc.).

After selection for a full time position on a Co-response team

Law Enforcement Officer

Recommended Minimum: Any law enforcement officer who is assigned to a co-response team as a full-time duty position would be expected to maintain updated knowledge and training of special topics to include but not limited to: advanced CIT training modules (youth, geriatrics, etc.), refresher training in ID/DD and acquired brain injury skills and techniques, and any refresher training as indicated by the MARCUS ALERT program manager to remain in compliance with the mandates of the legislation.

Recommended Best Practice: In addition to meeting the recommended minimums, law enforcement officers would continue to seek specialized training in recognition and de-escalation for all previously listed topics and would seek to become a trainer (when applicable) and create opportunities for cross-discipline training in their locality.

Mental Health Professional

Recommended Minimum: Meets requirements for appropriate licensure or registration, as required by state and local law, guidelines, and policy, for the purpose of behavioral health crisis response as a Community Services Board employee.

Recommended Best Practice: A professional's licensure status or registration as a QMHP provides guidance for additional training needs. Licensed or licensure-eligible professionals possess Master's-level education in an appropriate field that includes formal education and training on a wide range of populations, including child and adolescent development and developmental disabilities. For professionals who lack a Master's-

level education, best practice dictates the addition of focused training on identified populations of need that are likely to be encountered in the providers' community

All Team Personnel

To meet the minimum standards identified in the Code of Virginia for SB5038 and HB5043 of the Virginia Special Session I, all full-time assigned co-responder team personnel must complete implicit bias, anti-racism, cultural competency, and disability justice awareness training. This education and training may be accomplished at the local level or alternatively may require collaboration amongst regional resources and/or require additional support from state agencies. Additionally, personnel assigned to the team may receive facets of these training topics under standards currently in development by DCJS or through formalized education to achieve a social work degree, as two examples. Any need to verify acceptance of knowledge and training to meet minimum standards may be addressed with the DBHDS program staff. Every member of a Team must have completed training in the listed topics within ninety (90) days of assignment to the crisis response team.

A best practice for members of co-response teams is to include cross-discipline familiarization to include data sharing and security, scene safety, common language protocols, and cross-discipline policies and procedures for field activities and responsibilities.

3. Presentation, Response, & Intervention

Recommended Minimum

Response: the law enforcement officer and mental health professional will arrive at the scene at the same time (ride along model) or very close to the same time (separate but mutual response). Because of resource considerations and geography, it is understood that some communities may experience more challenges with creating a ride a long co-responder team.

Presentation: There are various viewpoints, each with valid concerns, regarding the modification of uniforms for law enforcement officers responding to behavioral health crises. A "soft" uniform that is less formal than a typical duty uniform may provide easier initial communications in some circumstances while still allowing officers access to all necessary safety equipment. Because of the resources in some communities and the team assignment (full time duty vs. available responder), it is not feasible to make a soft uniform a minimum requirement or standard, however it should be considered when feasible. It is a minimum recommendation for mental health professionals on co-responder teams to be easily identifiable

as mental health professionals both for the professional purpose of identification to persons in crisis as well as any potential additional law enforcement resources that could respond to crises of high acuity.

Intervention: Mental health professionals should lead the communication and intervention with the person in crisis as soon as the scene is safe to do so. The circumstances of the call for service, the tenure of the co-responder working relationship, level of experience, and other variables may influence the amount of time it take to make a "safe scene" determination that is acceptable to both responders. Programs should demonstrate police and/or protocols that make the clinical lead a priority for co-responder teams.

Recommended Best Practice:

Response: Law enforcement and mental health arrive together in an unmarked vehicle. Law enforcement and mental health staffing for this position are full time duty assignments. It is understood that resources may not allow this practice in some communities therefore it is suggested as a best practice guidelines for communities where this model is a good fit for the area (i.e., it is not suggested that this model be used if a full time co-response team could not be supported due to the population size).

Presentation: Law enforcement officers assigned to the co-responder team as a full-time duty assignment wear a modified uniform that takes into account the authority displayed by a traditional uniform and how that may affect the ability to create rapport and support de-escalation for the person in crisis. There are many variations of this including inner vs. outer vest carriers, "class A" shirts and pants vs. polo (or other) shirts and more casual slacks or pants. Nothing in this section however, should be construed to indicate that the best practice suggests removing any necessary safety equipment from any law enforcement officer. Decisions to alter equipment or uniforms will be a local responsibility and all team members must abide by the policies and direction of their agencies.

It is recommended that mental health workers assigned to a co-response program wear clothing indicating they are a co-responder to provide for quick identification by other first responders in the instance that a life-threatening emergency while the clinician is on scene with law enforcement.

Intervention: Every reasonable effort will be taken to ensure that the mental health worker leads the communication and intervention with the person in crisis as soon as the scene is safe to do so. The circumstances of the call for service, the tenure of the co-responder working relationship, level of experience, and other variables may influence the amount of time it take to make a "safe scene" determination that is acceptable to both responders.

Community Care Teams (non co-response)

Commented [LJS20]:

Community Care Teams are another option for communities to choose as their crisis response model and may be comprised of any combination of professionals capable of providing support during behavioral health crises.

Community Care Teams may also fill a more expansive role at the discretion of the locality, and work with a population across a wider spectrum of acuity. Because of this a community care team may be staffed and equipped in any number of combinations that support responses for varying acuity levels of clients. With the understanding that outreach work carries a different set of priorities, the recommendations in this document specifically refer to guidelines for Community Care Teams that may be responding to levels 2 (community care teams without law enforcement members), 3 (any configuration) and 4 (any configuration) as identified by the Triage subgroup under the umbrella of the larger project workgroup.

1. Composition and Experience

The members of a community care team may differ based on local choice, risk level of responses, local resources, and identified partnerships. Teams may be comprised of any combination of law enforcement, mental health professionals, peers, emergency medical responders, or other specialists (e.g. substance abuse counselors). The recommendations outlined below do not assume or mandate the inclusion of any particular combination of personnel. Rather, they seek to outline recommendations for each type of personnel *if and when* a community chooses to include them as response team members.

Law Enforcement Officer

Note: This workgroup recognizes that many crisis response philosophies aim to remove law enforcement, and that crisis response without the need for law enforcement has tremendous potential for those in crisis. It must be clarified however, that the current emergency custody statutes in Virginia (Code §37.2-808/9) specifies that involuntary custody in emergency situations for mental health crises and the associated custody documents may only be completed by law enforcement officers. While this can be accomplished by requesting police as a backup to crisis calls, the existing relationships in the Commonwealth may initially rely on law enforcement agencies to participate actively in the program. This document does not recommend *that* law enforcement automatically be included in a community care team, only that *if* they are included that certain training and experience benchmarks be met to ensure the highest potential for successful outcomes.

Recommended Minimum: A law enforcement officer must have completed at least some specialized mental health awareness and de-escalation training beyond that received in the basic law enforcement academy*. Within twelve (12) months of inclusion on the co-responder team, that officer must have completed the

CIT core (40hr) training course. Additionally, any officer assigned as a full time co-responder should have access to additional training for recognition and de-escalation of intellectual and developmental disabilities and acquired brain injuries above the minimum often included in the core CIT training curriculum.

Recommended Best Practice:

Prior to inclusion as either a full-time co-response team member officers should have at least three (3) years of field experience as a certified officer and two (2) years as a CIT trained officer with field responsibilities and the opportunity to actively apply CIT knowledge and skills during crisis encounters.

Mental Health Professional

Recommended Minimum: The mental health worker should have at least one year of clinical experience.

Recommended Best Practice: The mental health profession would have at least some time working specifically in crisis work and an established working relationship with local law enforcement agencies.

Peer Recovery Specialist

Recommended Minimum: must have a consistent period of recovery commensurate with the human resources policy of the employing stakeholder.

Recommended Best Practice: At least one (1) year post certification providing crisis response in a career or volunteer capacity. Completion of CIT core training, preferably with the local CIT partnership group.

Emergency Medical Service Provider

Recommended Minimum: Current certification as an emergency medical technician through the Virginia Department of Health.

*There are understood workforce challenges that may affect the ability to provide either or both of these personnel at the level of recommended best practice, however this should in no way be seen as a barrier to or recommendation against implementing a co-response team program.

2. Training & Education

Prior to inclusion on the community care team

Law Enforcement:

A law enforcement officer must have completed at least some specialized mental health awareness and de-escalation training beyond that received in the basic law enforcement academy*. Within twelve (12) months of inclusion on the community care team, that officer must have completed the CIT core (40hr) training course. Additionally, any officer assigned to the team as a full-time assignment should have access

to additional training for recognition and de-escalation of intellectual and developmental disabilities and acquired brain injuries above the minimum often included in the core CIT training curriculum.
* Note: As the Department of Criminal Justice Services updates law enforcement training standards the potential overlaps in mental health related topics are as yet unknown.

Mental Health Professional

Recommended Minimum: Has met all of the requirements for appropriate licensure and/or certification required by state and local law, guidelines, and policy to conduct mental health crisis work with a Community Services Board

Recommended Best Practice: The level of certification and licensure of the mental health professional will provide guidance for additional training and education needs. Many master's degree programs in this field contain content specific to defined need populations (e.g. children and youth, developmental disabilities, etc.). When those content areas have not previously been part of an education program for the team's mental health worker, the best practice would include additional focused training and/or education that supports crisis intervention for all populations of need that are likely to be encountered in the worker's response area.

Peer Recovery Specialist

Recommended Minimum: Certification as a Certified Peer Recovery Specialist through DBHDS.

Recommended Best Practice: Previous experience employed or volunteering and/or partnering with mental health jail diversion programs and having direct experience and knowledge of the Virginia emergency commitment process.

Emergency Medical Service Provider

Recommended Minimum: Certification as an Emergency Medical Technician through the Virginia Department of Health

Recommended Best Practice: Previous field experience responding to active mental health crisis calls. Existing partnerships with police and mental health stakeholders in the local community.

After selection to participate on the Community Care Team

Law Enforcement Officer

Recommended Minimum: Any law enforcement officer who is assigned to a community care team as a full-time duty position would be expected to maintain updated knowledge and training of special topics to include but not limited to: advanced CIT training modules (youth, geriatrics, etc.), refresher training in

ID/DD and acquired brain injury skills and techniques, and any refresher training as indicated by the MARCUS ALERT program manager to remain in compliance with the mandates of the legislation.

Recommended Best Practice: In addition to meeting the recommended minimums, law enforcement officers would continue to seek specialized training in recognition and de-escalation for all previously listed topics and would seek to become a trainer (when applicable) and create opportunities for cross-discipline training in their locality.

Mental Health Professional

Recommended Minimum: Meets requirements for appropriate licensure or registration, as required by state and local law, guidelines, and policy, for the purpose of behavioral health crisis response as a Community Services Board employee.

Recommended Best Practice: A professional's licensure status or registration as a QMHP provides guidance for additional training needs. Licensed or licensure-eligible professionals possess Master's-level education in an appropriate field that includes formal education and training on a wide range of populations, including child and adolescent development and developmental disabilities. For professionals who lack a Master's-level education, best practice dictates the addition of focused training on identified populations of need that are likely to be encountered in the providers' community

Peer Recovery Specialist

Recommended Minimum: *get suggestions from workgroup here*

Recommended Best Practice:

Emergency Medical Service Provider

Recommended Minimum: Maintaining continuing education for certification. Active participation in the local crisis response stakeholder group.

Recommended Best Practice: Participation in advanced mental health awareness and response training at least annually. Focused training on the identified needs for underserved populations within that team's service area.

Community Care Team Members with Other Specialties

The number of specialties in behavioral healthcare and crisis response make it impossible to provide minimum recommendations for every possible classification of response team members. A minimum recommendation for *any* member regardless of specialty however, would be for current licensure (where applicable), consistent active participation within the stakeholder group, and seeking additional specialized

training and experience related to mental health crisis response and any identified needs of the local population. In any case, the requirements and processes for additional specialties team members should be included in policies and memorandums of agreements between team partner agencies.

All Team Personnel

To meet the minimum standards identified in the Code of Virginia for SB5038 and HB5043 of the Virginia Special Session I, all full-time assigned co-responder team personnel must complete implicit bias, anti-racism, cultural competency, and disability justice awareness training (through a state-sanctioned "Advanced Marcus Alert" training or other advanced trainings that integrate these topics into crisis response training. This education and training may be accomplished at the local level or alternatively may require collaboration amongst regional resources and/or require additional support from state agencies. Additionally, personnel assigned to the team may receive facets of these training topics under standards currently in development by DCJS or through formalized education to achieve a social work degree, as two examples. Any need to verify acceptance of knowledge and training to meet minimum standards may be addressed with the DBHDS program staff. Every member of a Team must have completed training in the listed topics within a length of time agreed upon following assignment to the crisis response team.
A best practice for members of co-response teams is to include cross-discipline familiarization to include data sharing and security, scene safety, common language protocols, and cross-discipline policies and procedures for field activities and responsibilities.

3. Presentation, Response, & Intervention for Community Care Teams

Recommended Minimum

Response: all available team members will arrive at the scene at or about the same time. The arrival of team members may be affected by the composition of the team, current availability of team members, and local choice of response team transportation vehicle. Local variations and choices will determine the ability to arrive on scene together.

Presentation: There are various viewpoints regarding the modification of uniforms for law enforcement officers responding to behavioral health crises. Some research and feedback indicate that a "soft" uniform that is less formal than a typical duty uniform may provide easier initial communications while still allowing officers access to all necessary safety equipment. Because of the resources in some communities and the team assignment (full time duty vs. available backup responder), it is not feasible to make a soft uniform a

minimum requirement or standard, however it should be considered when feasible. It is a minimum recommendation for mental health professionals on community care teams to be easily identifiable as team members both for the professional purpose of identification to persons in crisis as well as any potential additional law enforcement resources that could respond to crises of high acuity.

Intervention: Depending on local team composition and transportation choices it is impossible to determine who may arrive on scene first. If there is a law enforcement officer on the team they may begin to assess scene safety, and if safety allows, may choose to not engage with the person(s) in crisis until the arrival of a mental health worker or Peer specialist.

Once a scene is safe a mental health professional or Peer specialist should lead the communication and intervention with the person in crisis as dictated by local protocols and/or policies. The circumstances of the call for service, the tenure of each team member in crisis work, the experience level of team members, and other variables may influence the amount of time it take to make a "safe scene" determination that is acceptable to all responders.

In those cases when a team contains a law enforcement officer and the team members travel separately, the law enforcement officer may arrive on scene prior to mental health or Peer specialists. Although the preference is for a mental health professional or Peer specialist to lead interventions, a law enforcement officer is not likely to remain distant from a scene when they can begin to assess for scene safety prior to the arrival of the remaining team members. In the cases when officers observe a situation that requires immediate intervention, it is reasonable that the officer will begin a dialogue and, if safe and possible, pass the lead of the intervention to another team member. This possibility must be discussed among team stakeholders and addressed in team protocols when feasible.

<u>Recommended Best Practice:</u>

Response: All team members arrive together in an unmarked vehicle. Staffing for any positions on the team is done in a full-time capacity, thus ensuring that all parts of a team are available together for service calls. It is understood that resources may not allow this practice in some communities therefore it is suggested as a best practice guidelines and not a minimum.

Presentation: Law enforcement officers assigned to the community care team as a full-time duty assignment wear a modified uniform that takes into account the authority displayed by a traditional uniform and how that may affect the ability to create rapport and support de-escalation for the person in crisis. There are many variations of this including inner vs. outer vest carriers, "class A" shirts and pants vs. polo

(or other) shirts and more casual style duty pants. Nothing in this section however, should be construed to indicate that the best practice suggests removing any necessary safety equipment from any law enforcement officer. Decisions to alter equipment or uniforms will be a local responsibility and all team members must abide by the policies and direction of their agencies.

It is recommended that mental health workers assigned to a co-response program wear clothing indicating they are a co-responder to provide for quick identification by other first responders in the instance that a life-threatening emergency while the clinician is on scene with law enforcement.

Intervention: Every reasonable effort will be taken to ensure that the mental health worker or Peer specialist leads the communication and intervention with the person in crisis as soon as the scene is safe to do so. The circumstances of the call for service, the tenure of the responder working relationships, level of experience, and other variables may influence the amount of time it take to make a "safe scene" determination that is acceptable to all responders.

In those cases when a team contains a law enforcement officer and the team members travel separately, the law enforcement officer may arrive on scene prior to mental health or Peer specialists. Although the preference is for a mental health professional or Peer specialist to lead interventions, a law enforcement officer is not likely to remain distant from a scene when they can begin to assess for scene safety prior to the arrival of the remaining team members. In the cases when officers observe a situation that requires immediate intervention, it is reasonable that the officer will begin a dialogue and, if safe and possible, pass the lead of the intervention to another team member. This possibility must be discussed among team stakeholders and addressed in team protocols when feasible.

Safety & Equipment

The variability of response teams, especially Community Care Teams, brings with it the reality that various types of equipment will be utilized depending on the members of each locality's team choices.

The best practice recommendation from this workgroup is for mental health professionals to have ballistic protection available and at minimum to establish a policy governing wearing of such equipment. Each locality must however, create and abide by their own policies and procedures that address safety equipment for team members.

Commented [LJS21]: Concerns were raised during the presentation of the workstream. There is not agreement this has support to be considered best practice.

Law enforcement officers are trained to assess for safety and equipped with tools that are intended to respond to physical aggression in the protection of others. This group strongly suggests that any responder team that has law enforcement as a team member consider the wisdom of providing familiarization of law enforcement equipment for team members. This group believes this training may provide team members

with an understanding of responses by officers in critical situations and also help them remain safe should any of the tools need to be used during a crisis call. Additionally, the law enforcement officer sees it as his or her job to maintain the safety of the team, and in dire situations may become incapacitated. It is strongly urged that ALL teams that include law enforcement require training on using a police radio so that help may be sought expeditiously in the event an officer is incapacitated.

Additional Considerations for Response Teams

The intent of this document is to provide a set of minimum guidelines that help communities create localized response programs that meet certain consistent benchmarks while also best serving the needs of their local community. It is important to realize that neither every potential situation nor possible combination of personnel can or even should be outlined in this initial set of guidelines. A recurring theme shared by members of the larger workgroup for this project is the disparity between communities in Virginia and how those difference highlight very different challenges which can also be exacerbated by a wide spectrum of resource availability.

This group has discussed the potential need for guidelines for very specialized response teams with capabilities to address focused needs (e.g. adolescents, autism, etc.) and mental health diagnoses. While this subgroup understands and supports the inclusion of team members with knowledge and abilities to suit focused needs, the vast differences in resources do not make such specialization by entire response teams significantly likely at the outset. For this reason, additional training and education are discussed within this document but it is expected that the response teams discussed herein will likely be general practitioners within their discipline. The last pertinent point is that many general practitioners receive training in many areas and, although not precisely focused specialists, have above average professional knowledge and skills that allow successful intervention with many population sub-groups.

Long-standing behavioral health crisis response systems as well as research on crisis response indicates that law enforcement response (whether as back-up or primary response) is not needed to ensure safety during approximately 90-93% of behavioral health crises. Yet, it is well known that the current Virginia landscape includes an over-representation of "deep end" or emergent calls due to lack of access to crisis care in the community. In other words, the crises that are observed by our current emergency services and law enforcement first responders are often emergent and mental health clinicians perceive a need for a safety related support. We understand that for people on the front lines, hearing about research statistics does not increase feelings of safety and security. Through this implementation, we plan to invest in workforce training to ensure that all behavioral health mobile crisis workers have significant training in

crisis response, and recognize that safety related supports are an important part of the mobile crisis response we build. We approach this flexibly, and acknowledge that safety-related supports are not synonymous with law enforcement, and believe that a safe and secure environment is achieved when *all* individuals involved feel protected from harm and do not feel that they are being threatened or intimidated. Thus, the safety related supports needed may ultimately include level of care screening, operationalization as civilian supports, therapeutic alternatives, or, a law-enforcement based safety-related support such as ability to use non-lethal force (i.e., a plain clothed officer with a taser). Over the course of implementation as we build a strong civilian mobile crisis workforce and begin to build community trust that a call for help will be met with a therapeutic approach with low risk of arrest or detention, calls for crisis response will begin to occur earlier in the crisis cycle and the overall ratio of emergent crisis calls will stabilize and become more predictable.

This section has a lot of information in it. I think we need to work as a group and make a holistic best practice or summary recommendation at the end of what a layered approach would ultimately look like.

Equity at Intercept 0 Initiative

Equity issues in both behavioral health crisis care and law enforcement must be centered and addressed through the implementation process. Intercept 0 is considered the "ultimate intercept," in that there is no "intercept" required at all. When individuals receive appropriate behavioral health services in their communities without any law enforcement involvement, the end point of the interaction will not include some of the key Marcus Alert outcomes (use of force by police, particularly lethal force, being jailed). Projecting out further, if individuals had access to preventive and early intervention behavioral health services, including crisis planning, WRAP planning, and other arrangements to identify and intervene in crises proactively, even processes such as ECOs and TDOs would be expected to significantly decrease in frequency. Unfortunately, there are verified health disparities in access to behavioral health care and the behavioral health system, including racial disparities. Although the Marcus Alert protocols are expected (and will be assessed to evaluate) to make positive impacts on interactions between law enforcement and individuals in behavioral health crisis, there will be variability in these programs across the state, and many officers will likely be armed with lethal means. Thus, the success of the implementation of the Act relies on significant effort to increase access to behavioral health crisis supports and ensure that

those behavioral health crisis supports are culturally informed and providing crisis services that are responsive to individual and family context.

The crisis continuum is being built with attention to public infrastructure, CSB code mandates, and the need for private providers and reimbursement rates to cover costs to achieve 24/7 coverage statewide. Additionally, the workgroup and listening session participants noted that some marginalized communities, particularly those who have had past negative experiences, perceive CSB emergency services and other government-based responses to be an "extension of the system" and indistinguishable from law enforcement when it comes to the fear, uncertainty, and lack of control that is felt when a governmental crisis response is provided. Further, governmental structures are large and bureaucratic, and there are also significant concerns for systemic racism. Ensuring that community-based, even to the level of neighborhood, crisis teams are available is a key aspect of a timely response as well as a culturally competent response. With new crisis definitions and rates beginning December, 2021, it is imperative that structures and partnerships are explicitly defined and supported that focus on equity at Intercept 0 and ensure that small private providers, particularly those already underrepresented in the behavioral health care system, remain viable and increase in number. The Equity at Intercept 0 initiative focuses on:

1) the development of partnerships between Black owned/led, BIPOC owned/led, and peer owned/led crisis service businesses and the public regional mobile crisis hubs,
2) professional development and supports for crisis service training with a focus on anti-racism, disability justice, and language access, and
3) analysis and reporting of race-based and other health disparities in crisis services in Virginia and ensuring that equity is a central consideration in planning, oversight, and evaluation of the success of the Marcus Alert system.

Such third sector activities and structures, which are considered an integral piece of a polycentric arrangement, must be adequately supported, through public and private funding with reasonable protections to ensure that initiatives have autonomy and influence (i.e., are not funded based on their support of special interests). Recently, additional mental health block grant (MHBG) funding was provided to Virginia to support behavioral health system development, with a noted emphasis on the development of crisis services. This provides a funding source for the first 18 months of this initiative. There are two components of the initiative. One component is a network of private and public providers, non-profit agencies, and academic partners. Leads can be clinical service providers, non-profit agencies (including those that do not provide direct clinical services), or academic partners, with a focus on those involved in

the training of behavioral health professionals. All selected will be Black-led, BIPOC led, and/or peer led. Networks are open to other providers and partners committed to anti-racism, disability justice, and addressing disparities in behavioral health. Approximately 5-7 leads will be identified across Virginia will receive approximately $175,000 to support the initiative (can be structured to cover staff time, interns, or other arrangements). Successful proposals will detail the plans for these leads, but goals are to build capacity, support training and development, and assist with building standard relations/MOUs between the regional mobile crisis hub and interested providers. All or a subset of leads, those with academic or analytic capacity, will provide evaluation planning and analysis support as well as ongoing research and development support regarding equitable crisis service development. The second component is a statewide Black-led crisis coalition. This coalition will have opportunities for broad membership, and will have responsibility for reviewing data and outcomes and providing input (including written response included in the General Assembly yearly report). A key difference between the Equity at Intercept 0 leads and the coalition is that the coalition has broader responsibility regarding Marcus Alert performance and development, including Intercept 0/1 components and Intercept 1 components. More details about the crisis coalition's accountability responsibilities are in the accountability section. The coalition will also set its own goals for further development and work with the Equity at Intercept 0 leads. One priority area for further development across the network and the coalition is creating a strong workforce pipeline between training programs for behavioral health providers and the crisis care continuum, with a focus on increasing diversity in the behavioral health workforce and increasing incentives for work such as crisis care.

Describe leadership structure of coalition here- has some board like characteristics.

Training Standards

NOTE- will add the equity at intercept 0 training recs here

This section outlines additional details related to training across the Marcus Alert system. Standards are provided for behavioral health participants, law enforcement participants, and dispatch participants.

Behavioral Health Training Standards

These requirements are in addition to any DBHDS licensing, DMAS regulatory, Department of Health Professions (DHP) regulatory expectations, that may apply to the services being provided. All required core competencies for behavioral health mobile crisis response will be integrated into the statewide training requirements on an annual basis. Because of the statewide training structure which is being implemented,

Commented [LJS22]: Recognizing that PSAP dispatchers will play a greater role in determining the immediate need for services in a behavioral health emergency, the need for minimum training standards in behavioral health, acuity levels, and interventions will be needed for all PSAP dispatchers in the commonwealth. The recommendation will be for the Department of Criminal Justice Services (DCJS) and the office of Emergency Management Services to work together with input from Virginia Department of Behavioral Health and Developmental Services to set minimum training standards as it relates to answering calls for behavioral health emergencies.

Commented [OT(23R22]: I have extended an invite to Rich Troshak at the VDH Office of Emergency Medical Services (OEMS) to join the next Triage subgroup meeting on 4/27 to discuss the mandatory EMD training.

Commented [OT(24R22]: More information is needed about which PSAPs must comply with the DCJS dispatcher certification process. I did include a question about dispatching LE in the PSAP section of the locality inventory survey, so that will provide some information about which PSAPs are subject to this DCJS training requirement. However, I worry that it will not be a complete list since it may not capture 'secondary' PSAPs.

https://www.dcjs.virginia.gov/law-enforcement/certification-process-dispatchers

https://www.dcjs.virginia.gov/law-enforcement/manual/standards-performance-outcomes/dispatchers-effective-march-30-2019

those training requirements are considered the most up-to-date source of information on core competencies for behavioral health participants in the crisis system. An overview of core competencies is provided here.

1) Training plans are updated regularly and have monitoring mechanisms in place to ensure that all participants have initial training, booster trainings, annual refresher training, and updated training when requirements change on an annual basis, and that compliance is monitored.
2) Supervisory staff have the same knowledge as line staff and use that knowledge to impact and evaluate performance.
3) There is a mechanism for ongoing clinical review and supervision.
4) There is training in empowerment and engagement, including recovery principles, harm reduction, and trauma-informed and trauma-sensitive practices
5) There is training in assessment, including trauma-sensitive assessment, collateral information, substance use, cognitive impairment, risk assessment, and level of care assessment.
6) There is training in intervention including treatment of acute agitation, safety planning, motivational interviewing, treatment of intoxication and withdrawal, crisis resolution.
7) All behavioral health providers providing mobile crisis services or any other behavioral health participants in the Marcus Alert system complete the Advanced Marcus Alert training.

Law Enforcement Training Standards

As outlined in Protocol #3 requirements, there will be a need for both Basic and Advanced Marcus Alert training. Basic Marcus Alert training is required of all officers and prerequisites are de-escalation training and implicit bias training. Trainings will be developed by DBHDS in collaboration with DCJS and will be developed alongside ongoing work to develop the behavioral health crisis training programs. Basic Marcus Alert training will be integrated into DCJS training standards to ensure that all officers receive this basic training. The key learning objective of the *basic* training is for officers to understand that their role in responding to behavioral health crises is to connect the individual in crisis to behavioral health services in a safe, behavioral-health informed, and timely manner. Other aspects include clarifying governmental functions and responsibilities across sectors for responding to individuals in behavioral health crisis, reasonable accommodations and least restrictive environments, and basic intersections between the skills and tactics learned in de-escalation training, mental health training, and implicit bias training, and how to integrate these skills in a basic way when connecting an individual in crisis to behavioral health services (whether that is awaiting a mobile crisis response or transporting to an assessment site).

An advanced Marcus Alert training will also be developed in partnership between DBHDS and DCJS, and DBHDS will maintain purview of the content and responsibility for updating the content and implementing statewide training. The advanced training is cross-sector (appropriate for behavioral health, law enforcement, and dispatch) and is not required but is a recommended part of advanced training plans. Advanced Marcus Alert training has a prerequisite of being a CIT trained officer (including voluntary, supervisor approved, and aptitude/interest). In addition to meeting these requirements, candidates for the Advanced Marcus Alert training should have demonstrated aptitude in community policing, cultural humility, and/or the identification and mitigation of race-based discrimination. Advanced Marcus Alert training teaches a philosophy, approach, and set of shared "No Force First" skills that are consistent with both behavioral health governmental interest and law enforcement governmental interest. The approach includes a focus on disability justice, historical trauma, and cultural humility. Skills included are empowerment and engagement, advanced de-escalation, time as a tactic, governmental interest assessment and roles, and intersectional training that addresses tensions between key aspects (do no harm, implicit bias, guardian/warrior, protect/serve, dignity of risk, treatment before tragedy), as well as intersections with wellness, burnout, and secondary trauma.

Commented [O(25]: Is there still a plan to include indicators about this training in the evaluation plan?

Dispatch Training Standards

Recognizing that PSAP dispatchers will play a greater role in determining the immediate need for services in a behavioral health emergency, the need for minimum training standards in behavioral health, acuity levels, and interventions will be needed for all PSAP dispatchers in the commonwealth. Department of Criminal Justice Services (DCJS) and the office of Emergency Management Services will work together with input from Virginia Department of Behavioral Health and Developmental Services to set minimum training standards as it relates to answering calls for behavioral health emergencies. In general, this training will mirror the Basic Marcus Alert training which will be integrated into LE training academy training.

Reporting Requirements

There are three required components for reporting. Each component is required quarterly, but those that are entered directly into the crisis data platform should be entered on scene (or within 48 hours of response) unless there are technological reasons why the data cannot be captured directly in this way. In the local plans that are submitted for approval, an accountable entity for each of the three components must be

provided. For data that are not entered directly into the data platform, quarterly data should be submitted within 15 days of the end of the quarter. The three components are referred to as core mobile crisis response reporting (all team types), CAD and disposition reporting, and event resolution reporting. Below is a heuristic illustrating the data capture points from calls, disposition (dispatch), team responses in the field, and event resolutions.

All mobile crisis response teams (including mobile crisis, community care, co-response), even those that are not mobile crisis teams/reimburseable health services, will be provided access to report on encounters through the crisis data platform. The core report is required to be completed whenever a mobile crisis, community care, or co-responder team is dispatched in response to a Marcus Alert situation (level 1, 2, 3, or 4), regardless of funding source. Reports should be completed within 48 hours of the field response, unless there is a technological limitation which requires data to be collected outside the crisis data platform and compiled quarterly. There is overlap between the key elements required for collection to assess Marcus Alert and those that are currently required for CITAC reporting. The goal is to integrate these two reporting requirements, thus, have CITAC data reported through the crisis data platform, yet, because the data platform is still in development, we are unable to provide detailed information about the timeline for any consolidation of these reports.

Key areas for reporting include basic event information, basic information about the individual in crisis, use of restraint and force (with standard definitions), transport, and outcome (with standard definitions). Restraint and force incidents will include physical restraint used, handcuffs used, soft restraints used, shackles used, taser deployed, gun drawn, gun fired, or none of the above. Outcomes will also be "check all that apply" and include cleared on scene, evaluated on scene, provided a follow up appointment for service (including phone contact) within 24 hours, ECO, voluntary transport to CITAC or 23 hour observation for evaluation, transported to CSU, transported for voluntary inpatient psychiatric hospitalization, or transported for involuntary psychiatric hospitalization. Transport options include law enforcement, alternative transportation, response team (non law enforcement), self, family/friend, or other. A chart outlining key data elements is provided in Appendix X.

In addition to information regarding dispatched teams, reporting is also required to capture the broader pool of calls, including those to which a specific response team was not dispatched. These data are also required quarterly, and will be required to be submitted through the broader crisis data platform. This will capture data on all Marcus Alert 1, 2, 3, and 4 calls even if a Marcus Alert response team is not

dispatched. This information is required to assess compliance as well as outcomes associated with the implementation of Marcus Alert Protocol #1. Because of the vast variation in how calls are classified and how that information is captured, we rely on a state-standard crosswalk to compile data. This completed crosswalk is required to be submitted with your plan.

Please identify which computer-aided dispatch (CAD) call types/incident codes align with the following event types for each of the primary public safety answering points (PSAPs) in the localities that comprise your catchment area. There may be more than one CAD call type/incident code for each event type. Note that a college or university campus police department may qualify as a primary PSAP if the campus' telephone system is configured such that dialing 9-1-1 will ring directly to the campus police.

	PSAP:	**PSAP:**	**PSAP:**	**PSAP:**
Event Type	**CAD Code**	**CAD Code**	**CAD Code**	**CAD Code**
Assist *definition*				
Suspicious Person *definition*				
Intoxicated Person *definition*				
Trespass *definition*				
Welfare Check *definition*				
Distressed Caller *definition*				
Suicide *definition*				

In order to track outcomes uniformly statewide, there will need to be CAD disposition codes associated with transfers to 988, co-responses with behavioral health professionals (BH) and first responders, and behavioral health-only responses. In the chart below, record the CAD disposition codes associated with each of these types of dispositions. Marcus Alert-related disposition codes are required for any PSAP or call center that dispatches behavioral health teams or other first responders.

	PSAP:	**PSAP:**	**PSAP:**	**PSAP:**

Disposition	CAD Code	CAD Code	CAD Code	CAD Code
Transfer to 988 *definition*				
BH Only *definition*				
BH + Police Co-Response *definition*				
BH + Fire Co-Response *definition*				
BH + EMS Co-Response *definition*				
LE Only *definition*				
LE + BH Back-Up *definition*				

The third reporting requirement is regarding event resolution data, specifically, to capture data on Marcus Alert 1,2,3, and 4 situations that do not result in a Marcus Alert response team response. There are two ways to consider gathering this data, depending on the operations and communication mechanisms of the PSAP and communications between PSAP and law enforcement. The point of data capture should be considered the point at which the call is cleared by law enforcement in the field. If there is a reporting mechanism from this point back to the PSAP linked to the specific call, it would be best to integrate this reporting requirement into the supplemental CAD call/disposition data submission. If there is not an easy way to facilitate a report back to the PSAP to link the data, then respondents will need to create data records which can ultimately be reported to the crisis data platform. The questions are similar to those regarding the general team reporting requirements, but focus the role of law enforcement in linking the individual to the behavioral health system (vs. providing a behavioral health intervention itself) safely and efficiently (time variables, use of force and restraint, etc).

Local Roadmap, Documentation, and Tools for Local Planning

The local roadmapping document can be found in Appendix X. There are five components of the local planning process. These components are:

1. **Form a local team.** The roadmap includes supports for identifying and engaging stakeholders, including those who have not historically been at the planning table, and setting a shared vision for the future.
2. **Conduct research and discovery.** The roadmap requires a guided analysis of key aspects of your community relevant to the implementation of the Marcus Alert. This process will result in four profiles that are submitted as part of your plan: population profile, policy profile, funding profile, and service profile.
3. **Gather community input.** The roadmap provides a framework for sharing information with community members and eliciting the input of community members, particularly those with lived experience related to mental illness, substance use, developmental disability, TDO, ECO, law enforcement, use of force, or racial discrimination.
4. **Assess fit of options with goals and capacity.** The roadmap includes templates for assessing the fit of different approaches to Marcus Alert implementation (e.g., the different team types, other crisis supports and services) with your system capabilities and community vision and goals.
5. **Add resources and action; submit plan**. The roadmap includes the template for the four level triage definitions for the local system, template for the CAD call type plan, template for CAD call disposition, the required logic model, guidelines for each of the three protocols, requirements for plan submission, and guidance for setting up local accountability, state reporting, and continuous quality improvement structures.

Voluntary Database

The Act requires each locality establish a voluntary database (§ 9.1-193. Mental health awareness response and community understanding services (Marcus) alert system; law-enforcement protocols.

F. By July 1, 2021, every locality shall establish a voluntary database to be made available to the 9-1-1 alert system and the Marcus alert system to provide relevant mental health information and emergency contact information for appropriate response to an emergency or crisis. Identifying and health information concerning behavioral health illness, mental health illness, developmental or intellectual disability, or brain injury may be voluntarily provided to the database by the individual with the behavioral health illness, mental health illness, developmental or intellectual disability, or brain injury; the parent or legal guardian of such individual if the individual is under the age of 18; or a person appointed the guardian of such person as defined in § 64.2-2000. An individual shall be removed from the database when he reaches the age of 18, unless he or his guardian, as defined in § 64.2-2000, requests that the individual remain in the database. Information provided to the database shall not be used for any other purpose except as set forth in this subsection.

Localities can determine solutions based on consultation between 9-1-1, behavioral health, and law enforcement. Localities may consider software solutions which allow for individuals to provide information to 9-1-1 dispatch, or can build a database related to existing lists (e.g., hazard lists or information associated with addresses), or create a new database that meets the requirements state in the Act.

The state planning group as well as a number of additional stakeholders described interest in a statewide database that would be available across the state and include linkages to phone numbers, addresses, and/or names.

Local Plan Submission, Review, and Approval

Plan submission details can be found in the roadmapping document (Appendix X). Plans to seek full initial compliance require l2 components to be submitted via the application web portal. Plans seeking compliance with statewide July 1, 2021 code requirements must submit #4, 5, 6, 7, 8, and 12. Plan review will take between 4 and 6 weeks.

1	Documentation of Sections 1-4 of the roadmap	Full compliance date
2	List of stakeholder group members	Full compliance date
3	Description of plan for community coverage	Full compliance date
4	Triage crosswalk	July 1, 2021 statewide
5	Copy of Protocol #1	July 1, 2021 statewide
6	Copy of Protocol #2	July 1, 2021 statewide
7	Copy of Protocol #3	July 1, 2021 statewide
8	Data and reporting crosswalks and responsible parties	July 1, 2021 statewide
9	Logic Model	Full compliance date
10	Plan for local accountability and quality improvement	Full compliance date
11	Budget	Full compliance date
12	Contact information	July 1, 2021 statewide

Reporting requirements are in effect October 1, 2021 (quarter 1 of implementation). Data system testing period will occur through approximately March, 2022. When testing period ends, data are interpreted as valid representation of activities occurring under the Marcus Alert.

Marcus Alert Accountability Framework

Marcus Alert accountability structures are three fold. The framework outlines how the Marcus Alert requirements intersect with existing accountability structures between local agencies, state agencies, and the general assembly. The framework also outlines cross-sector accountability (local/regional and state) and community accountability (local/regional and state).

Key outcomes will include meeting basic requirements, progress towards local goals, and a series of state performance measures. A table of currently planned state performance measures are in Appendix X.

Some examples include rate of diversion and increased behavioral health only response (e.g., # of calls diverted to 988 from 911 during the reporting period / # of calls received by 988 call center during the reporting period, # of times regional mobile crisis is dispatched by 988 call center during the reporting period); growth in the crisis continuum statewide (e.g., # of CSUs open and operational as of the end of the reporting period; # of CSUs open and operational as of the end of the reporting period that are outfitted with aspects of the Living Room Model / # of CSU open and operational as of the end of the reporting period; # of CRCs open and operational as of the end of the reporting period; # of CRCs open and operational as of the end of the reporting period that are outfitted with aspects of the Living Room Model / # of CRCs open and operational as of the end of the reporting period; # of dispositions from CITAC to CSU during the reporting period / # of individuals screened at the CITAC during the reporting period) and decreased use of force, restraint, and decreases in efficiency/time to transfer for law enforcement during drop offs.

The most basic (e.g., meeting basic requirements, such as MOUs in place and completing required reporting) compliance and accountability measures will be layered into existing mechanisms. DBHDS communicates and enforces requirements through a Performance Contract with CSBs. Local law enforcement has accountability to DCJS. It is important to note that the relationship between the CSBs and DBHDS (contractual in addition to codified) is different than the relationship between DCJS and local law enforcement, primarily due to the contractual relationship and funding relationship between DBHDS and the CSBs. Both CSBs and law enforcement agencies have a high level of accountability to their local governments.

PSAPs existing accountability structures are more complex. On the state level, the 9-1-1 Services Board (c.f., Code of Virginia § 56-484.14) and the 9-1-1 & Geospatial Services Bureau within the Virginia Department of Emergency Management are charged with oversight of the statewide transition to Next Generation 9-1-1 (NG9-1-1). Meanwhile, the Office of Emergency Medical Services within the Virginia Department of Health has purview over the existing Emergency Medical Dispatch (EMD) accreditation process and the implementation of the new telecommunicator cardiopulmonary resuscitation (T-CPR) and EMD training requirements for all telecommunicators that must be implemented by July 1, 2022 and January 1, 2024, respectively (c.f., Code of Virginia § 56-484.16:1). DCJS also has a role in state-level oversight as it administers the compulsory minimum training standards for law enforcement dispatcher certification. On the federal level, PSAP requirements are promulgated by the National 911 Program

within the National Highway Traffic Safety Administration as well as the Federal Communications Commission. Additionally, the Department of Homeland Security Science and Technology Directorate has been charged with managing automated language translation solutions for Text-to-9-1-1. It is important to note that the technology used by PSAPs to handle calls and data also come with training requirements and certifications mandated by commercial vendors. Moreover, there are several professional organizations (e.g., Association of Public-Safety Communications Officials-International, APCO; International Academies of Emergency Medical Dispatch, IAED; National Emergency Number Association, NENA; etc.) that are constantly striving to improve consistency and interoperability among PSAPs through the issuance of best practices.

Shared system (cross-sector) accountability is required at the local and state level, in addition to existing accountability between local governmental structures and state agencies. Local cross-sector accountability is likely to be the key factor in the development of the most successful Marcus Alert programs. Local cross-sector accountability should be structured around quarterly multidisciplinary team meetings. The level of organization is suggested as CSB catchment area embedded within DBHDS region, unless otherwise indicated by the structure of the Marcus Alert area. Regional meetings for full DBHDS region should be integrated into the local/area quarterly meeting schedule. For example, Q1 local, Q2 regional, Q3 local, Q4 regional. Due to the high level of coordination required, a suggestion would be to hold two part meetings when a regional component is included, particularly if meetings are held via web-based teleconferencing (i.e., Q2 meeting may be 60 minutes local business and 60 minutes regional business). The coordinator position will arrange these meetings, ensure data is available to review, etc. Currently, there is one coordinator position funded per region. As additional coordinator positions are funded, regional responsibilities can be shared or delegated in the way most supportive of the collaboration. If additional coordinators are not brought into the system, then the initial coordinator position will have a regional responsibility for coordination. The quarterly meeting group should have peer representation (peer providers and/or community member lived experience). This group is not the full stakeholder group, but can have repetition in representation. Any local structures described here can be combined with existing, related structures, so long as all objectives and requirements are met. Cross-sector accountability at the state level will be managed with a MOU between DBHDS, DCJS, and DMAS and quarterly cross-sector meetings.

Critical incident reviews of cases should be required to occur at the program level. Immediate critical incident reviews required per existing oversight (e.g., if use of force always has to be reviewed, then when used in Marcus Alert, that would still trigger the same process). The state plan should have specific requirements for the quarterly meetings without being overly proscriptive (i.e., we do not need to explicitly say it must be within 48 hours but we can copy/paste the suggestions from the recent report).

Quarterly local meetings and critical incident reviews would be the avenue to do quality improvement at a local level. Examples of review activities to undertake include:

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

The third accountability structure relates to community accountability. Because civilian oversight and general accountability in law enforcement is in flux/under some changes right now, the Marcus Alert system needs to be responsive to these changes and integrate when it makes sense. At the local level, the primary difference between civilian review boards (CRBs) and the accountability structures we describe here is that the Marcus Alert accountability structures are based on de-identified data (aggregated personal health information) and reviewed in aggregate but also including racial and ethnic disparities as required. Disability types will also be disaggregated when possible. All CRBs that are developed should be briefed on the local Marcus Alert plan, approved protocols, and expectations for informational purposes. If any cases regarding Marcus Alert go to the CRB, CRB processes will be followed.

Twice yearly, the larger area stakeholder group (must continue to meet the composition requirements as members leave and are replaced) must be reconvened by the coordinator. Any regional

Equity at Intercept 0 leads should also be invited to these meetings to provide updates on the Equity at Intercept 0 initiative. The purpose of these meetings is to report on the performance of the Marcus Alert system, including aggregated outcomes and race-based disparities, to the stakeholder group. Once a year, a stakeholder group liaison should provide written comments from the stakeholder group regarding recommended improvements to the system. The coordinator must forward these written comments as well as a written response and any associated action plans from the cross-sector quarterly meeting group. These comments and response must be received by DBHDS by September 1, of each year. It is recommended that all community stakeholders who are not participating in a paid capacity should be compensated for their time, including the additional time for the role of the liaison.

Once yearly, the state stakeholder group (i.e., the planning group) must be reconvened by DBHDS. The purpose of these meetings is to report on the performance of the Marcus Alert system, including aggregated outcomes, race-based health disparities, and variations and models being used across the state. Following this meeting, the state stakeholder liaison should provide written comments to DBHDS and DCJS regarding recommended improvements to the system (within 4 weeks of the meeting). DBHDS must include these comments as well as a response and any associated action plans as part of the yearly report to the General Assembly (due each December). All community stakeholders who are not participating in a paid capacity should be compensated for their time, including the additional time for the role of the liaison.

State Accountability Framework

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

9.1 (Criminal Justice) Requirements:

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

37.2 (Behavioral Health) Requirements:

D. The Department (DBHDS) shall assess and report on the impact and effectiveness of the comprehensive crisis system in meeting its goals. The assessment shall include the number of calls to the crisis call center, number of mobile crisis responses, number of crisis responses that involved law-enforcement backup, and overall function of the comprehensive crisis system. A portion of the report, focused on the function of the Marcus alert system and local protocols for law-enforcement participation in the Marcus alert system, shall be written in collaboration with the Department of Criminal Justice Services and shall include the number and description of approved local programs and how the programs interface comprehensive crisis system and mobile crisis response; the number of crisis incidents and injuries to any parties involved;

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

To meet these goals of providing comprehensive reporting on the Marcus Alert, the local accountability framework will need to be replicated to a certain extent at the state level. The plan is for the initial state planning group to meet twice per year, at least through 2026, to review data and make quality improvement recommendations. The Black-led coalition developed through the Equity at Intercept 0 initiative will also play a role in these twice yearly meetings, and all participants will receive the data to review, including data which would indicate race-based health disparities, prior to the meeting. Both groups will have a chair who will be responsible for compiling responses and recommendations on a yearly basis to provide direct written input into the comprehensive annual report. Any concerns or recommendations raised by the planning group or coalition must be addressed in the implementation plan for the following year and reported back on in the following year's comprehensive report.

Summary of Accountability Framework

As emphasized throughout the plan, a polycentric governance approach was taken. In 2019, Virginian (and other) experts describe a brief history and overview eloquently:

"The idea of polycentricity was introduced and theorized in the field of public administration by Vincent Ostrom, who developed it along the lines of argument first advanced by the classical-liberal author Michael Polanyi. Polanyi distinguished between two kinds of order. The first order is directed by an ultimate authority exercising control through a unified command structure. The second kind of order is a relatively spontaneous one of overlapping, competing, and cooperating centers of power and decision making that make mutual adjustments to each other in a general system of rules.

Thus, urban issues, environmental crises, and race problems seemed without solution, or at least it seemed that administrative and policy theory had no solutions to offer. The cause, Ostrom argues, was the fact that the political science and administrative theory were excessively shaped by a state-centric, monocentric vision." (Aligica, Boettke, & Taro, 2019, pg. 68)

At the local and regional level, regional mobile crisis hubs, local CSBs, local law enforcement, PSAPs, local governments, private crisis providers, cross-sector quarterly meeting attendees (which may overlap with CIT stakeholder groups), Equity at Intercept 0 leads in the area/surrounding area, and twice yearly meetings of the original local Marcus Stakeholder group, play a role in accountability for the local Marcus Alert system. Local plans will include information regarding specific accountability for data and reporting for each of the three reporting requirements. The Marcus Alert coordinator position will convene the meetings. The local group will include a written statement for the local annual report.

At the state level, Virginia DBHDS and DCJS share responsibility for reporting the status of the Marcus Alert to the Joint Commissioner on Healthcare, the Secretary of Health and Human Services, the Secretary of Public Safety and Homeland Security, the Governor's office, the General Assembly, and Virginians in general. Per this state plan, we identify VDH (OEMS), Equity at Intercept 0 leads, the Crisis Coalition, the original Marcus Alert stakeholder group and regional mobile crisis hubs as additional entities playing a key role in the success of the Marcus Alert system and the reporting of an accurate and detailed assessment of the success of the system on a yearly basis. The yearly report will include data regarding the performance of the system, including race-based health disparities, as well as written responses from the Crisis Coalition and original stakeholder group.

Public Service Campaign

A collaborative public service campaign during state fiscal year 2022 is required per the Act. The planning group determined that the primary information which needs to be provided to the public is the 9-8-8 number as an access point to the behavioral health crisis continuum. Due to the variability in Marcus Alert protocols across localities, there is not a cohesive statewide message to share from a public service campaign perspective regarding the protocols themselves, but by directing more individuals to utilize the 9-8-8 number as an access point, the goals of the Act can be supported from a public information perspective. At the local level, more individual outreach will be necessary depending on the details of the local plan. For example, localities may need to provide public service campaigning around their voluntary database, or, localities may need to work directly with other entities to share any changes to protocol. Thus, the statewide component of the public service campaign will be to direct individuals to dial 9-8-8 when in need of support for a behavioral health crisis, and the local component will be tailored to the most pertinent information needed to provide to the local community.

Summary of State Framework

Commented [LJS26]: •This could be potential information: An identified, multidisciplinary accountable entity at the local level (i.e., "Marcus Alert system" level) that meets quarterly and is convened by an identifiable system coordinator position.

- •An ongoing, local community stakeholder group that meets twice per year and is convened by the coordinator that receives data reports of system performance, including any racial disparities; has a role in the annual planning process (including goal setting); and completes a section in the annual report from the local implementation to DBHDS and DCJS (which will then be consolidated for the annual report to the General Assembly).
- •An ongoing state stakeholder group that meets twice per year and is convened by DBHDS, that receives data reports of system performance, including any racial disparities; receives information about each local implementation plan and performance across areas; has a role in the annual planning process (including setting goals at the state level and identifying opportunities for quality improvement initiatives at the state level); and completes a section in the annual report to the General Assembly.
- •Local leadership engagement at Intercept 0, 0/1, and 1, in system development and improvement, as indicated by engagement with Marcus Alert local leadership trainings.
- •Data sharing agreements to facilitate the work of the accountable entity and ongoing community stakeholder group.
- •Facilitated involvement of Equity at Intercept 0 initiatives with quarterly and twice yearly meetings described above, as well as data sharing agreements to facilitate the work of Equity at Intercept 0 initiatives.
- •Shared messaging around access to the crisis system with a focus on highlighting 9-8-8 as a resource for community members to access the full continuum of behavioral health emergency supports.
- •Enactment of the shared values of the state implementation as well as the ongoing identification and refinement of values at the local level.
- •Monthly core data reporting requirements for Marcus Alert response teams (accountability structures to DBHDS) and quarterly data reporting requirements for supplementary 9-1-1 call data (CAD classification and call disposition) and outcome (Marcus Alert resolution; accountability structures to DCJS).
- •Participation of state-level quality improvement initiatives and development and execution of local-level continuous quality improvement.
- •Shared triage definitions for Level 1, 2, 3, and 4 Marcus Alert to guide development of the local system as well as facilitate communication and evaluation with public stakeholders as well as accountable entities at the state level.

Wait until plan is complete to write summary section

Broader Systems Considerations

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

1) Currently, Marcus Alert code requires a "mental health service provider" as part of a community care team. It states that a peer support specialist may be a team member. This may be interpreted in two ways, due to lack of clarity regarding whether a peer support specialist is a type of mental health service provider. There are a number of models that may be an appropriate linkage to care (e.g., "street triage" models) that do not include a clinician. For example, a requirement that a community care team include a human services professional including peer professionals, and clinician being optional, would allow for additional team types.
2) A key issue regards 37.2, (requirement of LE in ECO process). It may deserve consideration that the presence of law enforcement be based on risk of harm, versus a blanket requirement. Other areas where custody is established without law enforcement involvement as a blanket requirement include alternative transportation and DSS custody. Additional support for non-law enforcement custody processes would allow for law enforcement to be available for those crises that require law enforcement requirement.
3) Similarly, 23 hour observation is a critical aspect of a crisis continuum. Currently, code would prohibit individuals under ECO to be sent to this level of care as a hospital diversion or simple further observation (e.g., under the influence)- unless LE stay with them until the 8 hour point and then "release" them. 23 hour observation does not mean that people are observed for exactly 23 hours. The average length is between 6-8 hours. But, it can be up to 23 hours and this is a clinical decision. Thus, if custody could be passed to the 23 hour obs facility upon drop off and the ECO be extended until clinically released. Would still need a procedure for if the ECO needed to become a TDO. But, clarify that we are NOT talking about extending the ECO period as it currently stands, we are talking about aligning it with our services and it will result in LE being out of the situation much earlier unless there is a specific risk of harm
4) Funding considerations.
    a. Need for ALL payers (not just Medicaid)
    b. Rural vs. urban LE considerations for cost
    c. Social justice position re: further investment in LE
    d. ES considerations
    e. 988 tax revenue
    f. General welfare funding trends (e.g., basic needs scaling linear; crime scales superlinear- how do we break the funding cycle to meet needs?)
    g. Incentive structures more broadly- re: bed days

I. Potential Areas of Concern or Issues With Implementation- these are from the triage subgroup. They can be used for this section in broader system considerations. (the training concern from that workstream is in the training section)

A. Funding

Through multiple conversations in the triage subcommittee, the common theme is the recurring need for new funding sources. This is true for new training of law enforcement, behavioral health, and all levels of co-response. Statewide standardized 911 systems would be another large cost should it ever be considered. The four levels of response can and will change the way behavioral health

Commented [LJS27]: Best Practice Considerations

Present best practices for law enforcement engagement in system.*

Present minimum standards/best practices for behavioral health crisis services
Basic Crisis System Capacities (from the National Council 2021 Report):

•The system has welcoming and safe access for all populations, all levels of acuity and for those who are both voluntary and involuntary.
• Family members and other natural supports, first responders and community service providers are priority customers and partners.
• Crisis response begins as early as possible, well before 911 (or 988) and continues until stability is regained.
• There is capacity for sharing information, managing flow and keeping track of people through the continuum.
• There is a service continuum for all ages and people of all cultural backgrounds.
• All services respond to the expectation of comorbidity and complexity.
• Welcome all individuals with active substance use in all settings in the continuum.
• Medical screening is widely available and is not burdensome.
• There is a full continuum of crisis components, including a crisis call center, mobile crisis, walk-in urgent care, secure crisis center, 23-hour observation, residential crisis services, hospitalization and intensive crisis outpatient services.
• Telehealth is provided for needed services not available in the local community.
• Program components are adequately staffed by multidisciplinary teams, including peer support providers.
• There is clinical/medical supervision, consultation and leadership available commensurate with provisions for emergency medical care.
Clinical standards:
The system has expectations of universal competencies based on values. Welcoming, hope and safety come first.
• Engagement and information sharing with collaterals is an essential competency.
• Staff must know how to develop and utilize advance directives and crisis plans.
• Essential competencies include formal suicide and violence risk screening and intervention.
• "No force first" is a required standard of practice.
• Risk screening guidelines for medical and substance use disorder (SUD)-related issues must ...

emergencies are responded to in Virginia, but coverage comes with a tremendous cost. Behavioral health trained responders for a consistent coverage towards a 24-hour response will come at a great cost at a point where no current funding stream is in place to support it. The lack of funding is greater is some areas of the diverse state than others, but a four level, behavioral health led response looks much different than a law enforcement response where 24-hour coverage is already in place. The lack of funding that will slow the implementation and not allow for a consistent coverage window for behavioral health led responses is a concern.

B. Coverage

An area of concern was the amount of coverage time available in different regions of the state as personnel and funding are available. With a positive view that a four level response framework is a great start, the concern is still present that there will be gaps in the capacity to provide a behavioral health response or co-response consistently across the various localities. In the initial implementation phase, trained law enforcement will continue to respond to 911 calls a majority of the time. Additionally, behavioral health provider training standards to include behavioral health emergency triage and de-escalation for law enforcement is important as they will still be responding to level three and level four responses, as well as all calls for service when the behavioral health co-response, mobile crisis teams, or community care teams are not available or on another call. The concern is the large gaps of time without behavioral health and co-response available will lead to behavioral health options not being available in a situation that ultimately leads to force being used or a life is taken during a behavioral health emergency. The committee was clear that it was hopeful provide expectations to avoid one bad incident from undermining the efforts to change the overall behavioral health emergency response. The committee recommends robust advertisement and public information sessions geared toward using the 988 regional call centers versus 911 as well as explaining this is a long term process of enhancing the crisis continuum for behavioral health could help educate the citizens and individuals with mental illness having emergencies. Informative messaging on the intent and timeline of the MARCUS alert bill needs to be clear that this is not an immediate discontinuation of law enforcement from responding to behavioral health emergencies and is the initial step of a long-term process.

Appendix A: Background and Context for Marcus Alert

Background

The Commonwealth of Virginia, along with the rest of the United States of America, was faced with mass protests and calls for inquiry into racial disparities in the use of force, particularly lethal force, against Black Americans in Summer, 2020, immediately precipitated by the death of George Floyd. In response to these protests and calls for reform, Governor Ralph Northam expanded the purpose of the 2020 Special Session (originally a budget meeting to address COVID-19 budget impacts) to address state budget as well as health and criminal justice and police reforms. To this end, the House and Senate passed a number of measures including a bill enabling local governments to create civilian review boards with subpoena power to investigate police misconduct, a bill enabling the state's Attorney General to investigate allegations of systemic racism in local law enforcement agencies, a bill to ban no-knock search warrants, a bill to ban chokeholds, a bill establishing minimum training standards for law enforcement officers, a bill addressing the decertification of police officers, a bill requiring officers who witness a colleague using excessive force to intervene, a bill outlawing sexual relations between law enforcement and people in their custody, and a bill prohibiting officers from stopping cars for minor infractions such as an alleged scent of marijuana or a broken taillight.

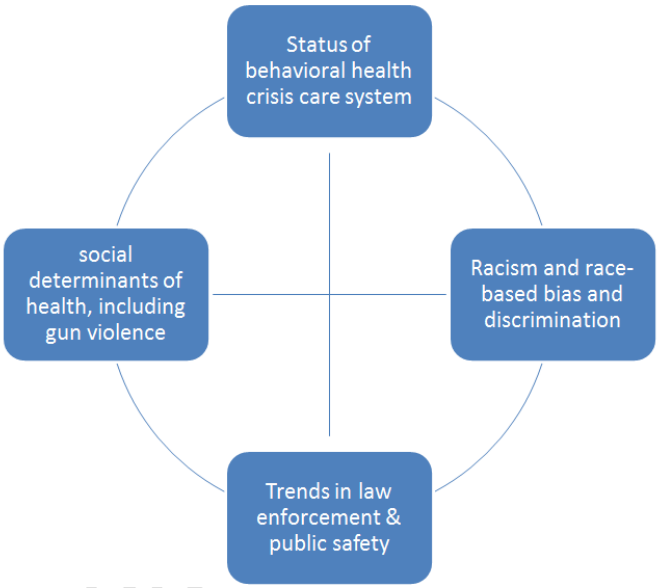
Additionally, the Virginia General Assembly passed the Marcus-David Peters Act, named in honor of Marcus-David Peters, a young, Black, biology teacher and VCU graduate who was fatally shot by Richmond Police in 2018 in the midst of a behavioral health crisis; it was signed into law in November 2020 by Governor Northam. This act, under the umbrella of the "Marcus Alert," requires localities to establish policies and protocols for law enforcement involvement with behavioral health crises, including diversion to the behavioral health system from 9-1-1 and law enforcement whenever feasible as well as specialized requirements for law enforcement encounters (e.g., police presentation and behavior) with individuals experiencing a behavioral health crisis, whether called there as back-up to a mobile crisis team or responding as a law enforcement response. A hallmark of the bill is the use of mobile crisis and "community care teams" and other provisions that authorize the behavioral health system as the first responder for behavioral health crises and required diversion to the behavioral health system whenever feasible. There is flexibility regarding whether police officers are members of the community care team or not, consistent with the broad variation that currently exists regarding local roles and responsibilities regarding the provision of safety and welfare of individuals unable to care for themselves, or at risk of hurting themselves, and how that intersects with law enforcement responsibility to protect other individuals from harm if an individual is at risk of hurting someone else due to a behavioral health crisis. There is language prohibiting law enforcement as members of mobile crisis teams. The Act includes law enforcement goals for engagement including decreased use of force, decreased hospitalizations, increased diversions, and other indicators of a specialized response to individuals in behavioral health crisis.

The primary authority for the implementation of the Marcus-David Peters Act (hereafter, "The Act") has been placed with the Department of Behavioral Health and Developmental Services, signaling that, in the broadest sense, Virginia values a health-centered response to behavioral health crises (as opposed to a law-enforcement centered response) that builds on recent investments in public behavioral health services such as STEP-Virginia mobile crisis, DOJ Settlement Agreement, and Behavioral Health Medicaid Enhancements. Yet, close coordination and specific responsibilities have also been required of Department of Criminal Justice Services (consistent with their regulatory authority over law enforcement), and the requirement of implementing the standards developed by DBHDS and DCJS is placed on localities. Localities may implement alone or implement as part of an "area" such as a CSB catchment area or a DBHDS region. The plan must be developed by July 1, 2021 and five pilot programs implemented by December, 2021. All localities must then implement protocols by July, 2022, and be served by mobile crisis or community care teams by 2026.

Systems Approach Overview

A complex adaptive system is a system where there are many elements at play, elements are heterogenous, and internal dynamics are difficult to predict and describe. Complex adaptive systems can be characterized by non-linear

and chaotic system behaviors, which are difficult to predict based on individual system players or the behaviors of a single agent within the system. "Emergent behaviors" refer to behaviors of a complex adaptive system that are observed from outside the system and are more difficult to observe when observing from within the system or observing the behaviors of a single agent within the system. Emergent systems behaviors are often observed through the analysis of group differences or trends over time (i.e., social trends, funding trends, racial disparities, rural vs. urban outcomes). From a systems framework, the intersection of behavioral health crisis care, trends in law enforcement, public safety, social determinants of health, and racial discrimination represents a complex adaptive system that has attributes and outcomes not attributable to one aspect of the system or the behavior of one agent within the system.



A systems approach was adopted for the development of the Marcus Alert state plan, including an acknowledgment that the most appropriate response to a behavioral health crisis is a behavioral health response, and that law enforcement does not (and should not) be the preferred first responder to behavioral health emergencies. This also included acknowledgement that law enforcement generally became the *de facto* responders to behavioral health crises due to the lack of an alternative response, and that law enforcement had been serving as a "gap fill" for appropriate behavioral health crisis care. Finally, this included an acknowledgement of complex influences that have led to this arrangement and must be considered when designing an alternative response system.

Providing for the safety and welfare of individuals who cannot care for themselves or keep themselves safe due to a developmental disability, mental health disorder, or substance use disorder is a shared responsibility between family and loved ones, legal guardians and custodians, parents and guardians of individuals under the age of 18, and local and state agencies and authorities, with as much input from the individual themselves as possible. During an acute behavioral health crisis, individuals may experience a suicidal crisis, dissociation, elopement, a lack of contact with reality, disorganized speech and behavior, and other symptoms that could have safety implications for the individual. Individuals with mental health, substance use, or developmental disabilities may have difficulties with receptive and expressive communication, further, the acute crisis may render the individual unable to engage in

receptive or expressive communication (for example, follow commands or describe needs or internal states). In addition to these presentations and associated individual safety implications, when individuals are experiencing acute behavioral health crises, there is also a small but observable increase in risk of behaving violently towards others. Typically, families do whatever they can to keep each other safe and de-escalate individuals with mental health disorders, substance use disorder, and developmental disabilities when an acute crisis occurs, because crisis services are not easily accessible and in most states, including Virginia, a law enforcement response has become the *de facto* crisis response which is in general escalating, stressful, and unpredictable. Both behavioral health and law enforcement systems have put resources towards attempts to shift these contingencies, but large scale change has been elusive to date.

From a systems perspective, there are both direct and indirect influences on the emergence and stabilization of law enforcement as the *de facto* crisis response, all of which will require analysis and planning in the implementation of the Marcus Alert. Direct influences generally fall into two categories, and are why "coordination with law enforcement" is nationally considered an aspect of a functional, best practice behavioral health crisis response system. First, law enforcement may be involved to the extent to which there is a concern for the safety of the individual in crisis and concern that there are not options to provide for safety without using force or physical restraints (i.e., use of force to inhibit behavior that could result in the serious injury or death of the person in crisis). Laws around use of force in governmental functions are complicated and law enforcement agencies may be a primary agency allowed to use force in a governmental capacity, with regulations regarding use of force in healthcare settings also important to consider. Second, law enforcement may be involved to the extent to which there are concerns for the safety of family members, bystanders, or healthcare providers (i.e., use of force against the individual in the crisis if they are threatening or engaging in violence against another). Third, in Virginia, Department of Behavioral Health and Developmental Services has granted some civil responsibilities to law enforcement as it relates to the custody arrangements of a temporary detention order (TDO).

Indirect influences are much more diffuse and difficult to define, such as lack of mental health funding (rendering low access to behavioral health crisis care for all Virginians), criminalization of mental illness and federal and state policies associated with use of illicit substances, lack of safe and affordable housing for vulnerable Virginians (i.e., behavioral health crises are observable in public spaces due to lack of privacy), and many more. Further, when combined with disparities in police presence in low-income neighborhoods and predominately Black neighborhoods, implicit and explicit racial bias in behavioral healthcare (i.e., interpretations on who is dangerous under what behavioral circumstances, misdiagnosis of behavioral health difficulties in racial and ethnic minorities), and racial disparities in use of force against Black Americans as compared to white Americans, a complicated picture emerges. In this landscape, Black Virginians, Indigenous Virginians, and Virginians of Color experiencing a behavioral health crisis have even lower accessibility to the already difficult-to-access behavioral health crisis supports, have family and natural supports with increased hesitancy to seek emergency supports until a crisis has escalated to an unmanageable situation, and will be less likely than white counterparts to be met with a therapeutic, health-focused response when help is sought.

Emergent behaviors associated with this complex system can be seen at the national level, including evidence that individuals in behavioral health crisis represent approximately 25% of fatal police shootings and evidence that unarmed Black Americans are 2-3x more likely to be victims of fatal police shootings as compared to unarmed white Americans interacting with police. These disparities persist after accounting for indicators such as fleeing status and risk level and are not present when an individual is both armed and in a mental health crisis (I.e., the disparities exist when individuals are unarmed in a mental health crisis, unarmed not in a mental health crisis, and armed not in a mental health crisis). State-level emergent system behaviors of concern include a stable TDO rate, despite investments in community services, continued high expectations and time-commitments of law enforcement in the TDO, ECO, and transportation process, despite investments in CITACs, CIT, and Alternative Transportation, ongoing overutilization of emergency departments as locations for CSB emergency evaluations, and ongoing state hospital bed census.

Federal Context

The Americans with Disabilities Act posits that governments have a responsibility to provide reasonable accommodations to ensure equal access to governmental goods and services for individuals with disabilities. In general, access to de-escalation and support from a first responder during a behavioral health emergency can be considered a basic community service. Given that the behavioral health crisis system has been more or less handed over to law enforcement for the provision of services due to the confluence of factors described above, this puts police in an impossible position—the presence of a police officer and displays of authority via uniform and badges is considered base level, appropriate, use of force with a purpose of demonstrating professionalism and gaining compliance with the directives of the law enforcement officer. In other words, by being sent to the scene, force has been dispatched as such. It is not a surprise, given what is known about human behavior, traumatic stress, and fear, that techniques of force and control tactics are not likely to work on individuals in a behavioral health crisis, are likely to escalate a behavioral health crisis, and that any response that escalates, vs. de-escalates, the situation is contrary to the governmental interest in the scenario if the purpose of the dispatch was to assess the safety and welfare of the individual. Thus, reasonable accommodations for individuals with disabilities is a key federal contextual consideration in the design and implementation of the Marcus Alert.

In November, 2020, President Trump signed the National Suicide Hotline Designation Act of 2020 which requires all states to have 9-8-8 designated as a three-digit access point to, at the minimum, the National Suicide Prevention Lifeline (NPSL) services. This is a unique opportunity to integrate the broader crisis system of supports and services with this three-digit access code. Thus, Virginia must work towards the federal implementation mandate of July 16, 2022 which aligns generally with the requirements of the Marcus-David Peters Act and the broader crisis system transformation. As such, Virginians could access telephone supports as well as mobile crisis dispatch and service referral all by dialing 9-8-8. This is particularly important for the Marcus Alert protocol that requires full diversion to the behavioral health system when feasible, which all localities must implement by July, 2022.

State context includes STEP-VA, BRAVO (Enhancements), CSBs, TDO/code, other law enforcement reforms/training requirements coming online, NextGen 911, 2024 EMD requirement

Local context includes CIT, local authority, heterogeneity

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Appendix _

Appendix_: Monthly Crisis Estimates by Community Services Board

Below are crisis estimates by community services board (CSB) catchment area based on the Crisis Now monthly crisis flow formula.

CSB	DBHDS Region	Total 2019 Population	Total Monthly Estimate of People in Crisis (rounded)	Monthly Estimate of People in Crisis at LOCUS 1	Monthly Estimate of People in Crisis at LOCUS 2	Monthly Estimate of People in Crisis at LOCUS 3	Monthly Estimate of People in Crisis at LOCUS 4	Monthly Estimate of People in Crisis at LOCUS 5	Monthly Estimate of People in Crisis at LOCUS 6
Alexandria	2	159,428	319	10	6	19	70	172	45
Alleghany Highlands	1	20,398	41	1	1	2	9	22	6
Arlington	2	236,842	474	14	9	28	104	256	66
Blue Ridge	3	257,180	514	15	10	31	113	278	72
Chesapeake	5	244,835	490	15	10	29	108	264	69
Chesterfield	4	352,802	706	21	14	42	155	381	99
Colonial	5	172,028	344	10	7	21	76	186	48
Crossroads	4	102,335	205	6	4	12	45	111	29
Cumberland Mountain	3	88,185	176	5	4	11	39	95	25
Danville-Pittsylvania	3	100,398	201	6	4	12	44	108	28
Dickenson	3	14,318	29	1	1	2	6	15	4
District 19	4	172,405	345	10	7	21	76	186	48
Eastern Shore	5	44,026	88	3	2	5	19	48	12
Fairfax-Falls Church	2	1,186,168	2,372	71	47	142	522	1,281	332
Goochland-Powhatan	4	53,405	107	3	2	6	23	58	15
Hampton-Newport News	5	313,735	627	19	13	38	138	339	88
Hanover	4	107,766	216	6	4	13	47	116	30
Harrisonburg-Rockingham	1	134,964	270	8	5	16	59	146	38
Henrico Area	4	360,872	722	22	14	43	159	390	101
Highlands	3	70,502	141	4	3	8	31	76	20

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Horizon	1	263,566	527	16	11	32	116	285	74
Loudoun	2	413,538	827	25	17	50	182	447	116
Middle Peninsula-Northern Neck	5	141,626	283	8	6	17	62	153	40
Mount Rogers	3	116,756	234	7	5	14	51	126	33
New River Valley	3	183,280	367	11	7	22	81	198	51
Norfolk	5	242,742	485	15	10	29	107	262	68
Northwestern	1	239,692	479	14	10	29	105	259	67
Piedmont	3	136,761	274	8	5	16	60	148	38
Planning District One	3	86,353	173	5	3	10	38	93	24
Portsmouth	5	94,398	189	6	4	11	42	102	26
Prince William	2	528,898	1,058	32	21	63	233	571	148
Rappahannock Area	1	375,694	751	23	15	45	165	406	105
Rappahannock-Rapidan	1	181,509	363	11	7	22	80	196	51
Region Ten	1	256,206	512	15	10	31	113	277	72
Richmond	4	230,436	461	14	9	28	101	249	65
Rockbridge Area	1	40,644	81	2	2	5	18	44	11
Southside	3	80,729	161	5	3	10	36	87	23
Valley	1	125,310	251	8	5	15	55	135	35
Virginia Beach	5	449,974	900	27	18	54	198	486	126
Western Tidewater	5	154,815	310	9	6	19	68	167	43
Total		**8,535,519**	**17,073**	**511**	**341**	**1,023**	**3,754**	**9,219**	**2,391**

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Appendix _: Monthly Crisis Estimates by City and County

Below are crisis estimates by jurisdiction (city or county) based on the Crisis Now monthly crisis flow formula.

City/County	Total 2019 Population	Total Monthly Estimate of People in Crisis (rounded)	Monthly Estimate of People in Crisis at LOCUS 1	Monthly Estimate of People in Crisis at LOCUS 2	Monthly Estimate of People in Crisis at LOCUS 3	Monthly Estimate of People in Crisis at LOCUS 4	Monthly Estimate of People in Crisis at LOCUS 5	Monthly Estimate of People in Crisis at LOCUS 6
Accomack County	32,316	65	2	1	4	14	35	9
Albemarle County	109,330	219	7	4	13	48	118	31
Alleghany County	14,860	30	1	1	2	7	16	4
Amelia County	13,145	26	1	1	2	6	14	4
Amherst County	31,605	63	2	1	4	14	34	9
Appomattox County	15,911	32	1	1	2	7	17	4
Arlington County	236,842	474	14	9	28	104	256	66
Augusta County	75,558	151	5	3	9	33	82	21
Bath County	4,147	8	0	0	0	2	4	1
Bedford County	78,997	158	5	3	9	35	85	22
Bland County	6,280	13	0	0	1	3	7	2
Botetourt County	33,419	67	2	1	4	15	36	9
Brunswick County	16,231	32	1	1	2	7	18	5
Buchanan County	21,004	42	1	1	3	9	23	6
Buckingham County	17,148	34	1	1	2	8	19	5
Campbell County	54,885	110	3	2	7	24	59	15
Caroline County	30,725	61	2	1	4	14	33	9
Carroll County	29,791	60	2	1	4	13	32	8
Charles City County	6,963	14	0	0	1	3	8	2
Charlotte County	11,880	24	1	0	1	5	13	3
Chesterfield County	352,802	706	21	14	42	155	381	99
Clarke County	14,619	29	1	1	2	6	16	4

Craig County	5,131	10	0	0	1	2	6	1
Culpeper County	52,605	105	3	2	6	23	57	15
Cumberland County	9,932	20	1	0	1	4	11	3
Dickenson County	14,318	29	1	1	2	6	15	4
Dinwiddie County	28,544	57	2	1	3	13	31	8
Essex County	10,953	22	1	0	1	5	12	3
Fairfax County	1,147,532	2,295	69	46	138	505	1,239	321
Fauquier County	71,222	142	4	3	9	31	77	20
Floyd County	15,749	31	1	1	2	7	17	4
Fluvanna County	27,270	55	2	1	3	12	29	8
Franklin County	56,042	112	3	2	7	25	61	16
Frederick County	89,313	179	5	4	11	39	96	25
Giles County	16,720	33	1	1	2	7	18	5
Gloucester County	37,348	75	2	1	4	16	40	10
Goochland County	23,753	48	1	1	3	10	26	7
Grayson County	15,550	31	1	1	2	7	17	4
Greene County	19,819	40	1	1	2	9	21	6
Greensville County	11,336	23	1	0	1	5	12	3
Halifax County	33,911	68	2	1	4	15	37	9
Hanover County	107,766	216	6	4	13	47	116	30
Henrico County	330,818	662	20	13	40	146	357	93
Henry County	50,557	101	3	2	6	22	55	14
Highland County	2,190	4	0	0	0	1	2	1
Isle of Wight County	37,109	74	2	1	4	16	40	10
James City County	76,523	153	5	3	9	34	83	21
King and Queen County	7,025	14	0	0	1	3	8	2
King George County	26,836	54	2	1	3	12	29	8
King William County	17,148	34	1	1	2	8	19	5
Lancaster County	10,603	21	1	0	1	5	11	3

Lee County	23,423	47	1	1	3	10	25	7
Loudoun County	413,538	827	25	17	50	182	447	116
Louisa County	37,591	75	2	2	5	17	41	11
Lunenburg County	12,196	24	1	0	1	5	13	3
Madison County	13,261	27	1	1	2	6	14	4
Mathews County	8,834	18	1	0	1	4	10	2
Mecklenburg County	30,587	61	2	1	4	13	33	9
Middlesex County	10,582	21	1	0	1	5	11	3
Montgomery County	98,535	197	6	4	12	43	106	28
Nelson County	14,930	30	1	1	2	7	16	4
New Kent County	23,091	46	1	1	3	10	25	6
Northampton County	11,710	23	1	0	1	5	13	3
Northumberland County	12,095	24	1	0	1	5	13	3
Nottoway County	15,232	30	1	1	2	7	16	4
Orange County	37,051	74	2	1	4	16	40	10
Page County	23,902	48	1	1	3	11	26	7
Patrick County	17,608	35	1	1	2	8	19	5
Pittsylvania County	60,354	121	4	2	7	27	65	17
Powhatan County	29,652	59	2	1	4	13	32	8
Prince Edward County	22,802	46	1	1	3	10	25	6
Prince George County	38,353	77	2	2	5	17	41	11
Prince William County	470,335	941	28	19	56	207	508	132
Pulaski County	34,027	68	2	1	4	15	37	10
Rappahannock County	7,370	15	0	0	1	3	8	2
Richmond County	9,023	18	1	0	1	4	10	3
Roanoke County	94,186	188	6	4	11	41	102	26
Rockbridge County	22,573	45	1	1	3	10	24	6
Rockingham County	81,948	164	5	3	10	36	89	23

Russell County	26,586	53	2	1	3	12	29	7
Scott County	21,566	43	1	1	3	9	23	6
Shenandoah County	43,616	87	3	2	5	19	47	12
Smyth County	30,104	60	2	1	4	13	33	8
Southampton County	17,631	35	1	1	2	8	19	5
Spotsylvania County	136,215	272	8	5	16	60	147	38
Stafford County	152,882	306	9	6	18	67	165	43
Surry County	6,422	13	0	0	1	3	7	2
Sussex County	11,159	22	1	0	1	5	12	3
Tazewell County	40,595	81	2	2	5	18	44	11
Warren County	40,164	80	2	2	5	18	43	11
Washington County	53,740	107	3	2	6	24	58	15
Westmoreland County	18,015	36	1	1	2	8	19	5
Wise County	37,383	75	2	1	4	16	40	10
Wythe County	28,684	57	2	1	3	13	31	8
York County	68,280	137	4	3	8	30	74	19
Alexandria City	159,428	319	10	6	19	70	172	45
Bristol City	16,762	34	1	1	2	7	18	5
Buena Vista City	6,478	13	0	0	1	3	7	2
Charlottesville City	47,266	95	3	2	6	21	51	13
Chesapeake City	244,835	490	15	10	29	108	264	69
Colonial Heights City	17,370	35	1	1	2	8	19	5
Covington City	5,538	11	0	0	1	2	6	2
Danville City	40,044	80	2	2	5	18	43	11
Emporia City	5,346	11	0	0	1	2	6	1
Fairfax City	24,019	48	1	1	3	11	26	7
Falls Church City	14,617	29	1	1	2	6	16	4
Franklin City	7,967	16	0	0	1	4	9	2
Fredericksburg City	29,036	58	2	1	3	13	31	8

Galax City	6,347	13	0	0	1	3	7	2
Hampton City	134,510	269	8	5	16	59	145	38
Harrisonburg City	53,016	106	3	2	6	23	57	15
Hopewell City	22,529	45	1	1	3	10	24	6
Lexington City	7,446	15	0	0	1	3	8	2
Lynchburg City	82,168	164	5	3	10	36	89	23
Manassas City	41,085	82	2	2	5	18	44	12
Manassas Park City	17,478	35	1	1	2	8	19	5
Martinsville City	12,554	25	1	1	2	6	14	4
Newport News City	179,225	358	11	7	22	79	194	50
Norfolk City	242,742	485	15	10	29	107	262	68
Norton City	3,981	8	0	0	0	2	4	1
Petersburg City	31,346	63	2	1	4	14	34	9
Poquoson City	12,271	25	1	0	1	5	13	3
Portsmouth City	94,398	189	6	4	11	42	102	26
Radford City	18,249	36	1	1	2	8	20	5
Richmond City	230,436	461	14	9	28	101	249	65
Roanoke City	99,143	198	6	4	12	44	107	28
Salem City	25,301	51	2	1	3	11	27	7
Staunton City	24,932	50	1	1	3	11	27	7
Suffolk City	92,108	184	6	4	11	41	99	26
Virginia Beach City	449,974	900	27	18	54	198	486	126
Waynesboro City	22,630	45	1	1	3	10	24	6
Williamsburg City	14,954	30	1	1	2	7	16	4
Winchester City	28,078	56	2	1	3	12	30	8
TOTAL	**8,535,519**	**17,071**	**511**	**337**	**1,024**	**3,758**	**9,217**	**2,389**

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Appendix X. Response Team Reporting Elements

Program	Data Element	Definition	Response Options	Associated Evaluation Category
Marcus Alert	**Response Date**	What is the date of the response?	{*calendar*}	
	Event Number	What is the call identifier supplied by the entity that dispatched the behavioral health response team?		
	Notification	Which entity notified the response team that its services were needed?	○ 988 call center ○ 911 PSAP ○ Law enforcement (call for back-up)	
	Travel Time	How much time elapsed between the response team being notified and the response team arriving on scene?		
	Response Time	At what time did the response team arrive on scene?	{*time*}	
		At what time did the response team leave the scene?	{*time*}	
	Police District		{*drop-down menu*}	
	Co-Responding Officer		{*write-in response*}	
	Citizen Presentation	How did the citizen present when the response team arrived on scene?	☐ Disoriented ☐ Homicidal ☐ Psychotic ☐ Suicidal ☐ Other (specify) ☐ None of the above	
	Citizen Age	How old (years) is the citizen?		
	Citizen Diagnosis	Which of the following diagnoses has the citizen received?	☐ ID/DD (*specify*) ☐ Mental Health (*specify*) ☐ Neither ☐ Prefer not to answer	

	Citizen Race	What is the citizen's self-identified race?	☐ Asian ☐ Black or African American ☐ Multiracial ☐ Native American or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ White or Caucasian ☐ Other (*specify*) ☐ Prefer not to answer	
	Citizen Ethnicity	What is the citizen's self-identified ethnicity?	○ Latinx ○ Not Latinx ○ Prefer not to answer	
	Mental Health Services	Is the citizen currently receiving mental health services?	○ Yes ○ No ○ Unknown	
	IF YES: Where are services being received? { *write-in response* }			
	History of Inpatient Psychiatric Hospitalization		○ Yes ○ No ○ Unknown	
	IF YES: What is the date of the most recent inpatient psychiatric hospitalization? {*calendar*}			
	History of TDO		○ Yes ○ No ○ Unknown	
	IF YES: What is the date of the most recent TDO? {*calendar*}			
	Military Status		○ None ○ Active ○ Veteran	
	Substance Use History		○ Yes ○ No ○ Unknown	

	Body-Worn Camera Use	Did co-responding law enforcement utilize an unobstructed body camera throughout the response?	☐ No ☐ Yes	
	Use of Force		☐ Physical restraint used ☐ Handcuffs used ☐ Shackles used ☐ Soft restraints used ☐ Taser deployed ☐ Gun drawn ☐ Gun fired ☐ None of the above	
	Outcome		☐ Cleared on scene ☐ Evaluated on scene ☐ Referral to outpatient resources ☐ Voluntary transport to CITAC for evaluation ☐ Involuntary transport to CITAC for evaluation ☐ Transported to 23-hour observation center or CRC ☐ Transported to CSU ☐ Transported for voluntary inpatient psychiatric hospitalization ☐ Transported for involuntary inpatient psychiatric hospitalization	
	Transportation Method	Who transported the citizen to the secondary location?	○ Law enforcement ○ Alternative Transportation ○ Response team ○ Self ○ Family/friend ○ Other (specify)	

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