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

Second Draft: 5/7/2021

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By July 1, 2021, the Department, in collaboration with the Department of Criminal Justice Services and law-enforcement, mental health, behavioral health, developmental services, emergency management, brain injury, and racial equity stakeholders, shall develop a written plan for the development of a Marcus alert system. Such plan shall (i) inventory past and current crisis intervention teams established pursuant to Article 13 (§ 9.1-187 et seq.) of Chapter 1 of Title 9.1 throughout the Commonwealth that have received state funding; (ii) inventory the existence, status, and experiences of community services board mobile crisis teams and crisis stabilization units; (iii) identify any other existing cooperative relationships between community services boards and law-enforcement agencies; (iv) review the prevalence of crisis situations involving 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; (v) identify state and local funding of emergency and crisis services; (vi) include protocols to divert calls from the 9-1-1 dispatch and response system to a crisis call center for risk assessment and engagement, including assessment for mobile crisis or community care team dispatch; (vii) include protocols for local law-enforcement agencies to enter into memorandums of agreement with mobile crisis response providers regarding requests for law-enforcement backup during a mobile crisis or community care team response; (viii) develop minimum standards, best practices, and a system for the review and approval of protocols for law-enforcement participation in the Marcus alert system set forth in § 9.1-193; (ix) assign specific responsibilities, duties, and authorities among responsible state and local entities; and (x) assess the effectiveness of a locality's or area's plan for community involvement, including engaging with and providing services to historically economically disadvantaged communities, training, and therapeutic response alternatives.

Summary and Overview of State Plan

The state plan for the development of the Marcus Alert system is the result of a collaborative process between Virginia Department of Behavioral Health and Developmental Services, Virginia Department of Criminal Justice Services, other state agency partners, and the Marcus Alert State Planning Stakeholder Group. The group was comprised of 45 stakeholders from across Virginia, representing local government, non-profit, private, community, lived experience, and advocacy in the areas of mental health, law enforcement, crisis intervention teams (CIT), developmental disabilities, substance use disorder, social justice and racial equity, as well as 20 state government representatives and other *ex officio* group members.

The state plan includes four broad sections. The first section provides a vision for Virginia's behavioral health crisis system, a summary of the planning group and process, and a current landscape analysis. The landscape analysis includes, as required, a catalog of existing CIT programs, crisis stabilization programs, cooperative agreements between law enforcement and behavioral health, a review of the prevalence and estimates of crisis situations across Virginia, and current funding for crisis and emergency services. The second section describes components of the state plan that are primarily at the state level (i.e., relatively standard across the state or components administered or overseen directly by state agencies), and includes a four-level framework for categorizing crisis situations, regional coverage by STEP-VA mobile crisis teams and associated Medicaid rates, requirements for diversion of calls from 9-1-1 to 9-8-8, requirements for agreements between mobile crisis response providers and law enforcement back-up, a statewide Equity at Intercept 0 Initiative, and statewide training standards. The third section includes components of the implementation plan that are primarily at the local level, which include the local planning process, minimum standards and best practices for local law enforcement involvement in the Marcus Alert system, descriptions of different ways to achieve local community coverage, and the system for review and approval of protocols. Finally, the fourth section provides frameworks for accountability and responsibility across state and local entities and how the success of the Marcus Alert system will be evaluated.

Summary of Section I: Vision, Process, and Current Landscape Analysis

The existing behavioral health crisis system in Virginia has multiple, disparate ways for people in crisis to access care, and multiple ways for the people who are staffing the crisis system to receive, assess, triage, record these calls for care. Local community services boards/behavioral health authorities receive calls through more than 40 distinct telephone numbers bifurcated by disability, age, and even specific crisis situation (for example, there are four separate National Suicide Prevention Lifeline crisis call centers in the Commonwealth). This "patchwork" of access points is often confusing to the person in need of crisis services and creates multiple hurdles to access help and get appropriate care instead of a single point of entry that is outside of 911. This has contributed to an over-reliance on 911, law enforcement, and high-acuity, high cost services such as inpatient hospitalization.

There is significant momentum to address Virginia's long standing challenges and overutilization of high-acuity, high-cost crisis services and to build an evidence-based continuum of care that features high quality services, including comprehensive crisis services and a crisis access line. The vision for Virginia's future crisis system is to keep Virginians well and thriving in their communities, meet people's needs in environments where they already seek support, and optimize taxpayer dollars by investing in crisis prevention and crisis early intervention of mental health problems and crises. This includes a system that:

- Aligns with national best practices to serve people in the least restrictive setting possible and build on their natural supports
- Is centered on principles of trauma-informed care and the belief that people can and do recover
- Serves people regardless of disability or diagnosis, and across the life span
- Reduces the use of hospital emergency departments, jail bookings, and unnecessary hospitalizations
- Supports crisis-trained first responders to support individuals in crisis and link them to the crisis system, decreasing reliance on law enforcement as the *de facto* crisis response

The review of existing programs indicated that some key components of this system are present in Virginia, but there are significant gaps in access, availability, and coordinating infrastructure. A number of simultaneous investments will be leveraged to support the implementation of the Marcus Alert, as both state and national attention has converged on the importance of a robust, health-focused, accessible crisis response. The vision for Virginia is to align these initiatives broadly with the Crisis Now model, with Virginia specific adaptations and a focus on equity considerations.

Estimating the prevalence of crisis situations across Virginia is difficult, but estimates across levels of acuity are provided for CSB catchment areas and localities. Currently, between 4,300 (April) and 7,400 (October) crisis evaluations are completed monthly through CSB emergency services. Thirty percent of these occur under an Emergency Custody Order (ECO). Thirty one percent of these result in a TDO, and there are approximately 2,000 TDOs statewide per month.

When considering the broader range of crisis situations, including those who can be managed with phone support and linkage to services, the Crisis Now tools would estimate that there are 17,000 Virginians in crisis statewide per month. Of these, it is estimated that 5% would require call center intervention only, 6% would need mobile crisis only, 76% would need a combination of mobile crisis and a stabilization service such as 23-hour observation or crisis stabilization, and 14% would require inpatient hospitalization. In summary, there is currently approximately 30-40% penetration of emergency services evaluations into the spectrum of crisis situations, and those crises which are being evaluated are skewed dramatically towards the severe end of the crisis spectrum. This highlights two things: first, the critical role of an accessible, statewide phone line (9-8-8) to connect to the crisis system, and second, the extent to which mobile crisis services and stabilization services must be built statewide to achieve the desired statewide behavioral health response system. As one example, the Crisis Now assessment suggests that Virginia would need 346 short term beds (e.g., crisis stabilization unit beds), 406 chairs for 23-hour observation statewide, and at least 68 mobile crisis teams each responding to 4 crises per day.

The Marcus-David Peters Act is a critical step in the direction of building a continuum of community based crisis supports, particularly as it relates to mobile crisis response, availability of trained first responders, expectations that a behavioral health crisis be met with a behavioral health

response, and that these expectations are assessed in general and with a specific focus on racial/ethnic disparities in access and response type. Combined with further local, state, and federal investments in the specifics of the Marcus Alert and the other aspects of the crisis continuum, some of which are currently underway (for example, the implementation of 9-8-8 and associated tax), it is expected that the implementation of the Marcus Alert will improve outcomes for all Virginians, and will provide specific protections and increased access to Black Virginians, Indigenous Virginians, and Virginians of Color experiencing a behavioral health crisis.

Summary of Section II: State Level Plan Components

There are approximately six components of the implementation plan that are primarily defined at the state level. First, a four-level cross-sector framework for assessing risk level and communicating across entities was developed. These four levels (Marcus Alert level 1, 2, 3, and 4) are used throughout the state plan to support shared communication across sectors, to provide a framework for planning different responses at the local level, communicating local plans to DBHDS and DCJS in a fashion that can be understood across the state, and for reporting and evaluation purposes. There are also some components of the required local protocols that are defined at the state level, and these include the diversion of calls from 9-1-1 to 9-8-8 and requirements for agreements between the regional mobile crisis hubs and calling for law enforcement back up. The third state component of the implementation plan is coverage by STEP-VA mobile crisis teams that are employed by the regional crisis hubs. These teams do not have law enforcement members but can call for law enforcement back up, and are characterized by a one hour response time and consideration of law enforcement referrals as "preferred customers" with quicker response times. Private providers of mobile crisis services will also be under agreement with the regional crisis hubs so that they can be dispatched through the 9-8-8 system. The fourth state component of the implementation plan is a statewide Equity at Intercept 0 Initiative, which is focused on building supports for public-private collaboration in Virginia's publicly funded crisis services, and seeks to develop infrastructure for training and development to ensure small, community focused providers (with a focus on Black-led, BIPOC led, and peer led providers) are integrated into the crisis services system, including training and academic partnerships. The Equity at Intercept 0 Initiative also supports the development of a Black-led state crisis coalition which will work with the network

leads but also play a role in review and ongoing development of the Marcus Alert implementation. The fifth state level component refers to statewide training standards across behavioral health, law enforcement, PSAP, and other participants in the Marcus Alert system. Finally, there is a statewide component regarding a public service campaign that focuses on raising community awareness for the use of 9-8-8 as a way to access behavioral health supports in times of stress and crisis.

Summary of Section III: Local Minimum Standards and Best Practices

There are approximately eight components of the implementation plan that are defined at the local level. First, there are guidelines for local planning group formation and initial planning activities. Second, there is a description of the voluntary database which is required for each 9-1-1 center. Third, there are guidelines for how a locality can define the specifics of their four-level triage framework (based on the state framework). At the local level, there are three required protocols (required statewide by July 1, 2022) and a requirement of community coverage to be achieved by a phased in implementation date. Thus, this section provides a description of each protocol and different team types and response options to achieve community coverage at each level. These local teams and additional response options (e.g., telehealth options) are layered on top of the statewide STEP-VA mobile crisis coverage, for example, with additional mobile crisis coverage to respond quicker than one hour, community care teams of peers, EMTs, and/or social workers that provide an immediate response and connection to the crisis continuum, or co-responder units including law enforcement and clinicians responding to high acuity situations. It is important to note that coverage can be achieved without forming specific local teams, particularly in areas of low population density, where protocols and collaborations across agencies, use of telehealth, poison control models and coordinated responses can be layered with STEP-VA mobile crisis teams to achieve community coverage. Finally, there is information provided regarding the minimum required components for a plan submission, the minimum standards for the different components of the plan (e.g., minimum standards for each protocol), and a description of the review and approval process.

Summary of Section IV: Accountability and Evaluation

Finally, Section IV provides the state plan for evaluation and accountability. Cross-sector data sharing at the local and state level is one of the key challenges of evaluating the success of crisis response systems. Recently, the General Assembly allowed for a $5 million investment in the development of a crisis call center data platform to support the coordination of crisis services across Virginia. This was put to competitive bid and the vendor will be selected in May, 2021, with the work progressing over the following six months. Thus, the technical details of the Marcus Alert reporting requirements will be developed in collaboration with the development of the broader platform. There are also a number of other considerations, such as workgroups associated with improved data sharing, and variation in PSAP technical operations, which support the development of a Marcus Alert Evaluation Task Force to meet for the remainder of state fiscal year 2022 to ensure that high quality data reporting is integrated into the call center platform and that this platform is accessible to all system users, including law enforcement. Although these technical details will be under development over the next six months, some initial details are as follows. Local reporting will be required on a quarterly basis. There will be an entity accountable for each of these three areas: the reporting of PSAP requirements, mobile crisis response team requirements, and law enforcement reporting requirements. A framework for local accountability is described which includes quarterly cross-sector meetings where critical incident reviews and local system development and issues will be considered. Twice yearly, a local stakeholder/community group should be convened and provided with data and reporting on the performance of the system, including racial disparities in access or outcomes, and feedback should be collected from this group for the ongoing development of the local system. State accountability framework builds on existing structures between DBHDS, CSBs, DCJS, law enforcement, OEMS, and PSAPs. In addition to existing structures, the stakeholder group will continue to meet twice yearly through 2027 to review statewide data and ongoing system development. The Equity at Intercept 0 Initiative will support the development of a Black-led Crisis Coalition as well as network leads who will also attend these twice yearly meetings and will continue to be involved in oversight processes beyond 2027. DBHDS and DCJS will enter into a written agreement regarding shared oversight and input

on training materials for modules relevant to the success of the Marcus Alert, and will include the described entities in the review of training materials. Both of these entities (Equity at Intercept 0 leads and Crisis Coalition) will provide a written statement with feedback and recommendations for the yearly report on the implementation of the Marcus Alert that is required to the Joint Commission on Health Care.

Section I: Vision, Process, and Current Landscape Analysis

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

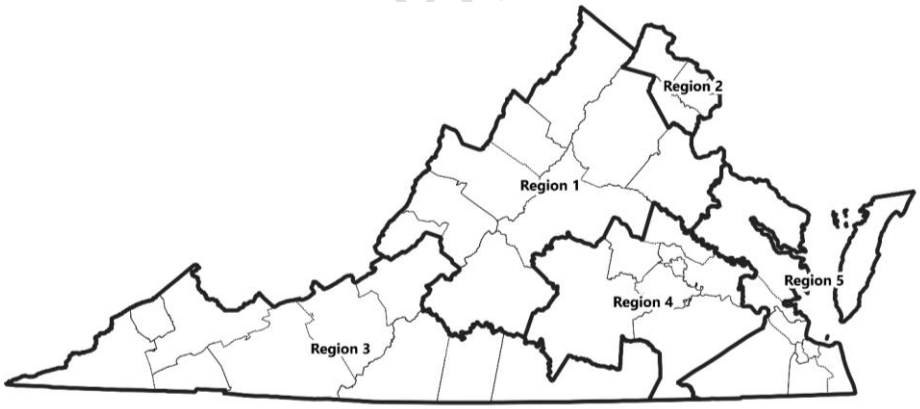
workstream focused on identifying minimum standards and policies and procedures for law enforcement responses and co-responder models. The Equity at Intercept 0 workstream focused on addressing racial and other bias at Intercept 0 (i.e., behavioral health crisis services) and developed a framework to 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.

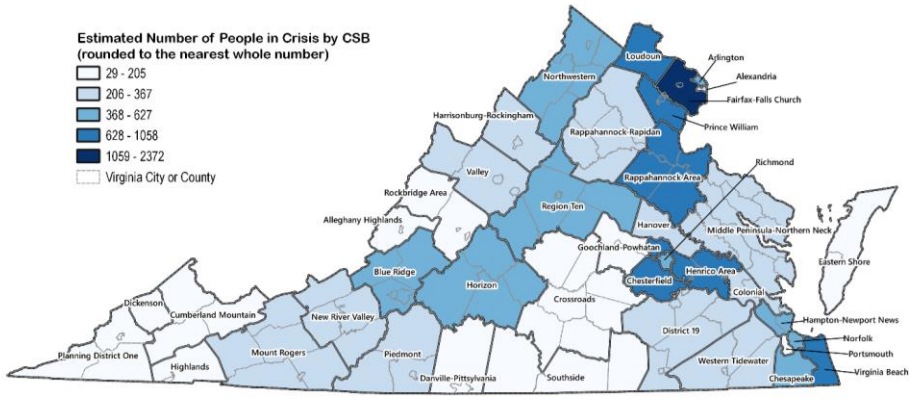
Commented [J(2]: Catalog CIT programs.* note: this section will be written by Stephen Craver and Toyin Ola using existing reports and the locality survey.
Catalog mobile crisis and CSUs.* note: this section will be written by Toyin Ola with input from Heather Norton, Mary Begor, and Nina Marino using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

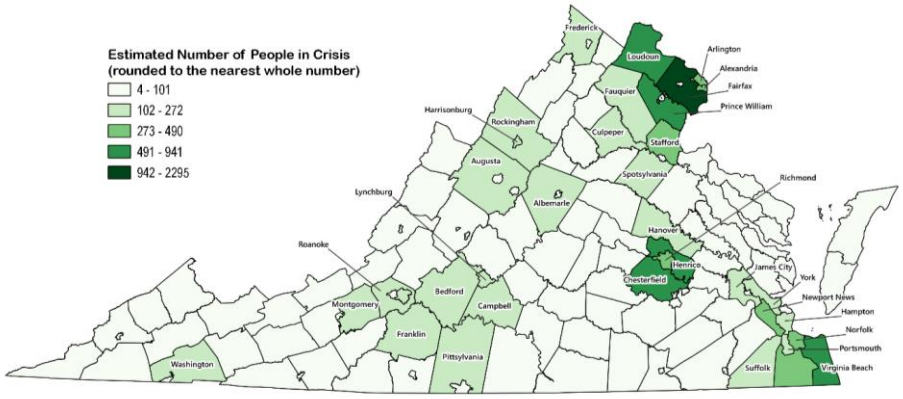
This map depicts the estimated monthly number of people in each CSB who will experience a behavioral health crisis.



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.

FY 2020 Month: 7/01/2019-6/30/2020	Total ECOs, Crisis Evaluations, Executed TDOs and Reportable Events					
	ECOs	Crisis Evals	TDOs	% Total Evals	Total Events	% Total TDOs
July	1963	6927	2042	29.5%	13	0.64%
August	2166	7100	2196	30.9%	9	0.41%
September	2047	7131	2179	30.6%	12	0.55%
October	1989	7426	2062	27.8%	20	0.97%

November	1754	6432	1833	28.5%	11	0.60%
December	1852	6301	1868	29.6%	15	0.80%
January	1956	6764	1954	28.9%	14	0.72%
February	1816	6590	1907	28.9%	18	0.94%
March	1800	5582	1831	32.8%	1	0.05%
April	1714	4360	1757	40.3%	9	0.51%
May	1827	4805	1873	39.0%	12	0.64%
June	1917	5387	2010	37.3%	10	0.50%
Totals	**22801**	**74805**	**23512**	**31.4%**	**144**	**0.61%**

Section II: State-level Plan Components

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.

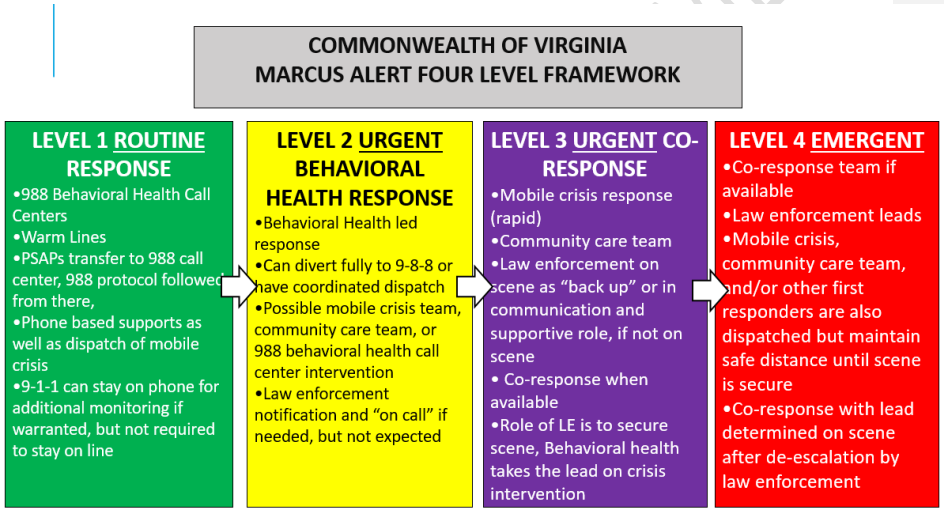
The four level triage serves multiple purposes in the state plan. First, the four level triage system provides guidelines for evaluating and classifying the risk of harm associated with behavioral health emergency situations, to ensure that the details of the situation are evaluated directly (vs. relying 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

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.

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-
...

discuss levels of risk, potential harm, 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. Each level does not have to be characterized by a single response, rather, there are some minimum standards/required aspects at some levels and local plans will likely include a range of responses designated to be dispatched at each level.

The four levels are outlined briefly here. Additional details about how localities should define the levels in the context of their CAD systems are provided in the Local Triage Planning section.



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 local 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, thus, behavioral health only responses (including immediate phone support, telehealth, and dispatch of mobile crisis) are likely

appropriate for Level 3 situations involving youth, even if the same situation involving an adult may be determined to need law enforcement presence. Clearly, this is an intersectional issue where implicit racial bias and adultification compound one another, with negative impacts accumulating on children of color.

Regional coverage by STEP-VA/BRAVO mobile crisis teams

STEP-VA is a large scale investment in the public mental health system with a goal of increasing access, consistency, quality, and accountability in behavioral health services. One STEP, crisis services, focuses on building a statewide mobile crisis response system, with dispatch of mobile crisis teams coordinated through regional hubs. Funding for children's mobile crisis was first appropriated in state fiscal year 2020, and additional funding for adult mobile crisis was appropriated in state fiscal year 2021, then frozen due to COVID-19 budget impacts, and then reallocated during Special Session 2020 in conjunction with the passage of the Marcus-David Peters Act to begin July, 2021 (state fiscal year 2022). Although STEP-VA teams are being developed regionally, the associated call center data platform, associated Medicaid rates, and training programs will be developed statewide, thus, they are considered a state component for the purposes of this plan.

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.

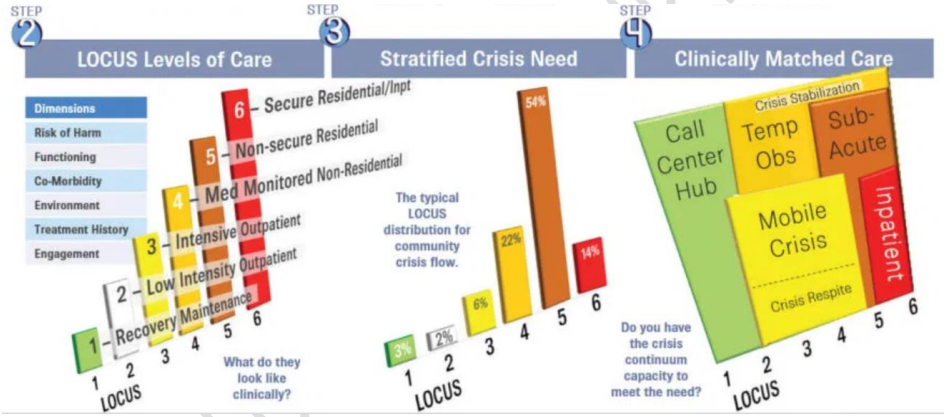
State general funds to build mobile crisis services on a regional basis were appropriated in state fiscal year 2019 (operationalized as children's mobile crisis in FY 2020) and state general funds to support adult mobile crisis teams are appropriated for state fiscal year 2022 (initially appropriated 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. Triage procedures for the call centers are still under development, but will likely follow this process: 1) risk of harm assessment, with Marcus Alert Level 4

situations being directed for 911 coordinated response, 2) the additional five domains of the Levels of Care Utilization Standards (LOCUS), which provides an estimation for the appropriate response and whether an in person response such as mobile crisis is needed. 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 key difference is that risk/acuity triage is used to determine the overall system response and responsibility to respond (and divert calls between 9-1-1 and 9-8-8), 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.

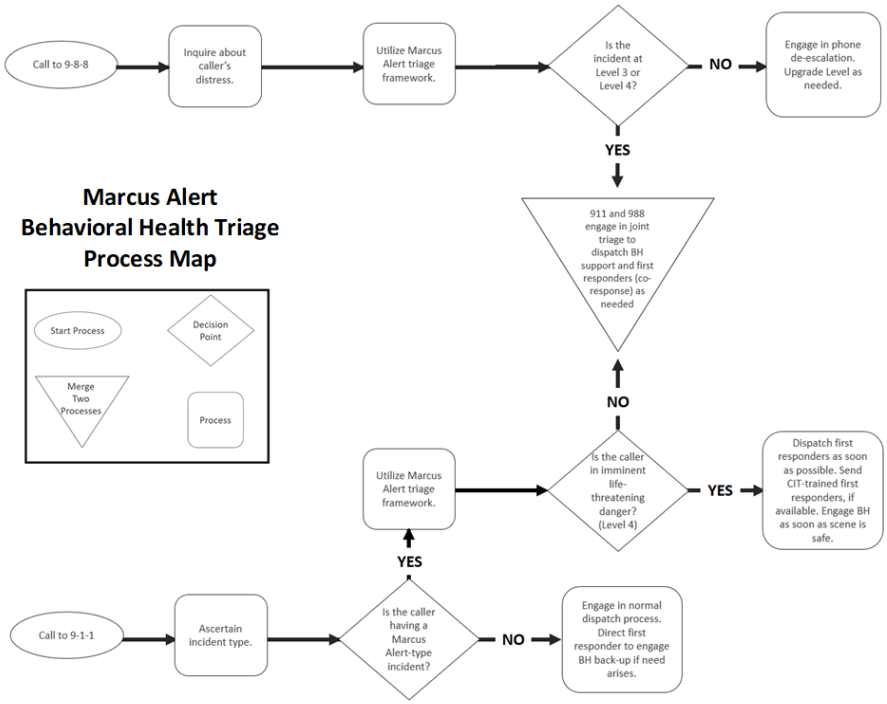


All draft rates were defined for 15 minute intervals. The two person team types included: LMHP (including LMHP-E) and CPRS, LMHP and QMHP, 2 QMHP, and QMHP and Peer. One person response type is defined as LMHP response. Provisions for other response patterns as well as allowances for telehealth availability 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.

Diversion of calls from 9-1-1 to 9-8-8

Protocol #1 focuses on the ability of PSAPs to transfer designated calls to the 988 regional centers. 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 the 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 Protocol #1 of the Marcus Alert, rather, this is the overarching /guiding heuristic.



Agreements between mobile crisis response providers and law enforcement back-up

Protocol #2 requires an agreement between each regional mobile crisis hub and any law enforcement agency that will be providing back-up assistance. 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.

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 in what governmental interest. 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. The same requirements will be required in these agreements statewide, although there may be additional details or differences in these relationships. Marcus Alert Protocol #2 will ensure that there are clear expectations between the mobile crisis regional hub and any law enforcement back-up. The regional mobile crisis hubs are as follows:

Agreements must include the four following components at a minimum.

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. It is recommended, but not required, that agreements include provisions that back-up officers sent will be voluntarily CIT trained and have received the advanced Marcus Alert training.

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 outcomes twice yearly 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.

Statewide Training Standards

Training standards will be managed at the state level and integrated into existing training and oversight processes to ensure appropriate accountability. This includes simultaneously developing requirements, such as new behavioral health crisis trainings associated with STEP-VA and new oversight requirements for DCJS to review and approve training academy lesson plans (beginning 2022). Additional best practices and training recommendations are provided for local implementation consideration. State partners will also work within existing resources and/or seek additional resources to offer best practice trainings of a voluntary nature whenever possible as the implementation continues, leveraging resources from all involved sectors to ensure that the minimum standards are feasible across the state and that opportunities for additional training are not limited only to well-resourced localities.

Behavioral Health Required Competencies and Trainings

These requirements are in addition to any DBHDS licensing, DMAS regulatory, or 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, those training requirements are considered the most up-to-date source of information on core competencies for behavioral health participants in the crisis system. All crisis providers under agreement with the regional hubs will be held accountable for these competencies, and compliance with these requirements will be managed through DBHDS oversight of the regional crisis hubs. 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. Supervisory staff have the same knowledge as line staff and use that knowledge to impact and evaluate performance; and there is a mechanism for ongoing clinical review and supervision. An overview of core behavioral health competencies is provided here:

Empowerment and Engagement	recovery principles, harm reduction, and trauma-informed and trauma-sensitive practices
Assessment	trauma-sensitive assessment, collateral information, substance use assessment, cognitive impairment, risk assessment, and level of care assessment
Clinical Interventions	treatment of acute agitation, safety planning, de-escalation, motivational interviewing, treatment of intoxication and withdrawal, crisis resolution
Cultural Competency	Racial identity development, cultural humility, implicit bias, historical trauma, family dynamics and working with natural supports, anti-racism, health disparities in behavioral health
Disability Justice	Federal and state structures and protections, ableism, dignity of risk, intersection of disability justice and criminal justice
Basic MA training	Basics of MA requirements, laws, triage levels, local implementations, evaluation and required data collection
Intersectional MA training	Advanced intersectional training regarding risk assessment, race, implicit bias, clinical diagnosis,

	criminalization of behavioral health disorders, perceptions of family support and wellness, advanced empowerment techniques, and mitigating implicit bias in the context of behavioral health crisis response

Law Enforcement Required Competencies and Trainings

Law enforcement required competencies and trainings were developed in consideration with broader criminal justice reforms also passed during Special Session 2020. Specifically, the addition of 59. And 60. Under 9.1.102 and 9.1-112.1 (italics indicate text added during Special Session):

§ **9.1-102**. Powers and duties of the Board and the Department.

The Department, under the direction of the Board, which shall be the policy-making body for carrying out the duties and powers hereunder, shall have the power and duty to:

*59. Establish compulsory in-service training standards for law-enforcement officers in the following subjects: (i) relevant state and federal laws; (ii) awareness of cultural diversity and the potential for bias-based profiling as defined in § **52-30.1**; (iii) de-escalation techniques; (iv) working with individuals with disabilities, mental health needs, or substance use disorders; and (v) the lawful use of force, including the use of deadly force only when necessary to protect the law-enforcement officer or another person;*

60. Develop a uniform curriculum and lesson plans for the compulsory minimum entry-level, in-service, and advanced training standards to be employed by criminal justice training academies approved by the Department when conducting training; and

additionally from the Special Session:

*§ **9.1-112.1**. Criminal justice training academies; curriculum.*

*A. Any criminal justice training academy approved by the Department shall employ the uniform curriculum and lesson plans developed by the Department pursuant to § **9.1-102** for all training offered at the academy intended to meet the compulsory minimum entry-level, in-service, and advanced training standards established by the Board pursuant to § **9.1-102**. No credit shall be given toward the completion of the compulsory minimum training standards for any training that does not employ the uniform curriculum and lesson plans.*

Given these parameters, the following are identified as core competencies for law enforcement. Because DCJS is required to collaborate with DBHDS on Marcus Alert development and training, and also has recently enhanced purview over the review of academy curriculum and lesson plans, the most logical

course of action is for DBHDS and DCJS to enter into an agreement regarding DBHDS, Equity at Intercept 0, and Black-led coalition input onto Marcus Alert training requirements. This agreement will be pursued during the first year of implementation.

Core law enforcement competencies are as follows. Whether they would be met through basic, inservice, or advanced academy training, or CIT training, is indicated:

Basic de-escalation (basic and inservice)	
Basic mental health, including empowerment and engagement skills (basic and inservice)	
Implicit bias (basic and inservice)	
Basic MA training (integrated into legal basic and in service training)	Basics of MA requirements, laws, triage levels, local implementations, evaluation and required data collection
Intermediate de-escalation (inservice and advanced, or CIT)	Intersection of de-escalation, implicit bias, and behavioral health response (e.g., time as a tactic)
Cultural Competency and Disability Justice (inservice and advanced or CIT)	cultural humility, anti-racism, Federal and state structures and protections, ableism, dignity of risk, intersection of disability justice and criminal justice
Intersectional MA training (advanced or CIT)	Advanced intersectional training regarding risk assessment, guardian vs. warrior, race, implicit bias, explicit racism, criminalization of behavioral health disorders, and mitigating implicit bias in the context of behavioral health crisis response

For law enforcement, 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. Because any trainings beyond what can be integrated into the basic and inservice trainings are ultimately discretionary at the local level, partnerships will be formed with regional training academies to ensure that these trainings are at a minimum available across the state. The future considerations segment of the report describes the connection between accreditation and the setting of specific local standards for law enforcement as part of the Marcus Alert implementation.

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.

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, making the public service campaign a critical state-level component of the plan. 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. Further, throughout the planning process and when receiving input from stakeholders, it was evident that a primary concern and reason for not reaching out for help is due to a fear of involuntary hospitalization, being handcuffed, and a lack of control over the outcome once help has been called. Although there is momentum for broader changes to our system, at this time, the best way to ensure that behavioral health needs are met in a preventive manner is to call for help early in the crisis cycle. A parallel is made between public service campaigns for stroke awareness, which focus on identifying the first/earliest signs of the condition and

reaching out quickly. This approach, combined with targeted outreach and community engagement, may deserve consideration for the details of the public service campaign for the launch of 9-8-8.

Local Plan Components

Guidelines for local planning group formation and initial planning

There are five components of the local planning process. There is a local roadmap document in Appendix X, which provides additional details about these five initial planning steps. 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.

Description of the voluntary database requirement for each 9-1-1 center

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. Yet, the Act authorizes this as a local requirement that is housed at the local level.

Guidelines for development of 4-level triage framework

Each implementation area must develop a local version of the 4-level triage framework (described initially in the State components section). This will provide the local framework for classifying situations as Level 1, Level 2, Level 3, and Level 4 Marcus Alert situations. Here, additional details about how localities can conceptualize their definitions of each level are provided. The four levels correspond specifically to risk of harm, and are also the framework for determining which response is appropriate per the local plan.

Level 1 (Routine Behavioral Health)	
Risk Considerations	**Response Considerations**
Lowest acuity 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. When individuals reach out	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 trained behavioral health

through non-emergency lines and describe a need for behavioral health support, these calls may be appropriate to transfer to 9-8-8 additionally.	supports 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. Whether or not PSAP staff will remain on the line for any amount of time will be determined at the local planning level. 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.
Level 2 (Urgent Behavioral Health Response)	
Risk Considerations	**Response Considerations**
The appropriate acuity level for the second level response include situations where clinical intervention is needed to reduce the advancement of greater risk. Individuals with suicidal thoughts but no intent, plan, means, capability or weapons would be appropriate for a level two urgent behavioral health response. Only very vague or low-level expressions of homicidal ideation (e.g., developmentally expected and in absence of means, such as a child stating "I want to kill you!" to parents, but without means) would be appropriate for a level 2; most situations involving	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

homicidal intent would likely be characterized as a level 3. 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.	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 responding to individuals where they are located in the community in hopes of avoiding hospitalizations and escalation of symptoms. 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)	
Risk Considerations	**Response Considerations**
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 and a specified plan, but no lethal weapons present also fall under a level three response. Individuals engaging in self-injurious behavior related to a behavioral health	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 local PSAP. Co-response will look different from jurisdiction to jurisdiction, and the term "co-response" is used here to indicate coordination and multiple-sector involvement, not a "co-response

Commented [MR9]: Local PSAP

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 be considered for utilizing 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.	team or unit" specifically as a required response. Urgent co-response can include phone or telehealth coordination, EMS involvement, etc. 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 scene safety while working with co-responders. 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 response model 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 are considered key partners in the response, utilizing de-escalation skills and other trainings. Based on response time and available co-response assets, law enforcement may be on the scene much quicker than behavioral

Commented [N(6]: 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(7R6]: Can we add something about the levels being reassessed at some point by the call center in coordination with PSAPs

Commented [LJS8]: 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"

Commented [MR10]: scene safety

	health co-responders and may 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. Over time, as additional teams are developed, it is expected that more and more Level 3 situations will be handled by a behavioral health only response, or that Level 3 situations will come through the 9-8-8 line and behavioral health response would then follow their procedures to determine whether law enforcement back up would be requested. Although Level 3 is characterized by a coordinated response broadly, it is important to note developmental considerations in planning for response. All potential team types and other options for local planning considerations at Level 3 are provided in the local requirements section of this report.
Level 4 (Emergent Response)	
Risk Considerations	**Response Considerations**
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 and possess the means to cause life threatening harm to others or themselves. Individual who have made active suicide attempts	The fourth level of response is emergent, and is termed an "active rescue" in other states. Although each plan will create a definition for Level 4 based on their internal coding, processes, and definitions, Level 4 situations are those situations that require an immediate response and no delay in responding is appropriate. When originating from a 9-1-1 call, Level 4 situations send first responders (law enforcement, EMS) immediately, and the

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 or suicidal intent and without expressed ambiguity or significant barriers to acting on the intent or plan.	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.

Protocol for a specialized law enforcement response for behavioral health crisis (Marcus Alert Protocol #3)

Regarding 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, here we provide 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. Additional details about how localities should approach the development of Protocol #3 are in the local guidelines section of the report.

The Marcus Alert state approach 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."

Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf **(Balfour, 2020)**

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. Protocol #3 is required by July 1, 2022 statewide. Thus, a specialized response must be available by that date, even if additional community coverage by teams is expected to be developed beyond that date (e.g., if an area has a full implementation date of 2024 or 2026). It is assumed that most agencies will integrate this protocol into existing policies, for example, "Response to Persons with Mental Illness" policies. Minimum standards for defining this

specialized law enforcement response are provided below in the Minimum Standards and Best Practices for Law Enforcement Involvement in the Development of the Marcus Alert system.

Guidelines for planning for community coverage

In addition to regionally dispatched mobile crisis teams described as a State component of the plan, it is expected that a range of mobile response teams will also be developed at the local level. "Community coverage" can be achieved across the 4 risk levels in a range of ways, and the local approach should be designed with community input, cross-sector collaboration, and local government leadership involvement (beyond law enforcement, behavioral health, and PSAP leadership).

The base, minimum standard is that a plan is submitted for community coverage by the locality's "phased in community coverage" date, which can range from 2022 through 2026. There is nothing precluding localities from achieving community coverage by an earlier date, and feasibility of this may be based on the approach taken by the locality and when STEP-VA mobile crisis coverage is achieved. Each level must be covered with a plan considered appropriate at that level. Minimum standards and best practices in general are listed first, and then team types are described and example coverage plans are provided.

Minimum standards include:

1) Level 1 calls must be diverted to 9-8-8
2) Level 2 approaches must be behavioral health led (options include warm hand off to 9-8-8, poison control model with 9-8-8, mobile crisis team, or community care team without law enforcement). Some specialty or low-acuity community care teams with law enforcement may be appropriate at level 2 depending on the specialization (e.g., to respond to "frequent callers" or programs that provide a case management function)
3) Level 3 approaches must include coordination, which can include a poison control model with 9-8-8 with simultaneous dispatch of mobile crisis and/or other team types, co-responses to include behavioral health, EMS, fire, CIT trained law enforcement officers with telehealth capabilities or providing a liaison role with behavioral health responders (e.g., law enforcement securing the scene and behavioral health supporting the officer or individual over the phone)
4) Level 4 approaches must receive an emergent response, where the response is not delayed.

Best Practices for Community Coverage are as follows. These best practices are provided for guidance only, as there are no established best practices when choosing among these approaches.

1) Include community stakeholders in the planning process for community coverage, with a focus on stakeholders who have been impacted by the current system (such as those in a jail re-entry program, families who have lost loved ones to a mental health crisis or a police encounter, and individuals who have lived experience and are from a racial or ethnic minority background)
2) Take a systems view and, when resources are constrained, build behavioral health focused supports as a priority over other investments
3) Build on and integrate with other existing and emerging services and supports, such as the STEP-VA mobile crisis teams, current CIT programs and initiatives, Assertive Community Treatment or homeless outreach providers in the area
4) Consider partnerships across jurisdictional boundaries, particularly when it increases efficiency (e.g., for any telehealth based coverage)
5) Consider a "layered" approach, with investments aligning with community values vs. the selection of one specific team type only

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.

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.

First, we provide a description of different team members to be considered for community care team composition. Workforce challenges are understood and may impact the ability of to staff either or both of these personnel at the level of recommended best practice, but this should not be viewed as a barrier to or recommendation against implementing a co-response program. Next, we provide definitions for the approach taken by both co-responder team models and non co-responder models, both of which meet the definition for community care team. Finally, we provide examples and further references regarding these different approaches to coresponder and community care teams.

Community Care Team Composition: Team Members
Law enforcement officer. A law enforcement officer assigned to a community care 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 training. A recommended best practice is the law enforcement officer is self-selected (or even chosen through competitive process), supervisor approved for the assignment, posses a minimum of two (2) years as a sworn law enforcement officer, and a minimum of one (1) year experience following completion of CIT training. Law enforcement officers serving on a community care team should 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. A recommended best practice is for law enforcement officers is 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. A mental health professional assigned to a community care team should have at least one year of clinical experience. Best practice recommendation would include experience with crisis response and/or assessment and an established working relationship with local law enforcement agencies. Prior to inclusion on a co-response team, mental health professionals must meet all requirements for appropriate licensure and/or certification, as required by state and local law, guidelines, and policy to

conduct mental health crisis work through a Community Service Board in the Commonwealth of Virginia. 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. Certified Peer Recovery Specialists must have a consistent period of recovery commensurate with the human resources policy of the employing stakeholder. Recommended best practice is at least one (1) year experience, post-certification, with crisis response in a career or volunteer capacity. Completion of CIT core training, preferably with the local CIT program. Peers serving on a community care team shall be Certified Peer Recovery Specialist through DBHDS. Recommended best practice will include 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. Peer Recovery Specialists will maintain all requirements necessary to maintain their Certification in the Commonwealth of Virginia.

Emergency Medical Service Provider. Emergency Medical Service providers shall have a current certification as an emergency medical technician through the Virginia Department of Health and recommended best practice includes previous field experience responding to active mental health crisis calls and existing partnerships with police and mental health stakeholders in the local community. Emergency medical providers, if part of a community care team will be expected to maintain their certification through the Virginia Department of Health and will have active agency representation on the local crisis response stakeholder group. Best practice recommendations include participation in advanced mental health awareness and response training, at least annually, and 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 community care 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.

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.

Different Community Care Team Approaches

Co-responder team. Co-responder 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. In addition to general team member descriptions above, for law enforcement officers working as part of a co-response team, 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. Additionally, any officer assigned as a full-time co-responder should have access to additional training for recognition and de-escalation of individuals who have intellectual and developmental disabilities or acquired brain injuries, beyond the minimum often included in the core CIT training.

Co-Responder Team: Team Approach
Response: it is recommended that 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 along co-responder team. Recommended best practice is for law enforcement and mental health to 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: 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 nature of 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 recommended that mental health professionals on co-responder teams 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.

Recommended best practice is that 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 when working as part of a high-acuity team that responds to Level 4 situations, mental health professionals should be fitted for ballistic protection, and there should be a policy governing wearing of such equipment when part of a high risk response.

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-responders' 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 policies and/or protocols that make the clinical lead a priority for co-responder teams.

Community Care Teams (with or without law enforcement)

Community Care Teams outside of the "coresponder team model" are an option for communities to choose as their crisis response model and may be comprised of any combination of professionals listed above 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 individuals. 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 level 2 (community care teams without law enforcement members, unless a specialized team), level 3 (any configuration) and level 4 (any configuration).

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), but the enabling legislation requires mental health professional participation on a community care team.

Community Care Team (non Co-responder team) Approach
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. The recommended best practice is for all team members to arrive together in an unmarked vehicle, and if possible, a van or other vehicle that can allow for supplies, transport, etc. Best practice recommendation is that 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.
Presentation: The composition of the team plays a significant role on how the team "presents" itself. For non-law enforcement participants, street clothes or a very basic uniform are common. Some programs

present in a way that allows for comfort, mobility, and a level of relatability or casual dress, such as screen printed hoodies. EMT members may wear existing uniforms. For law enforcement participants, 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. Therefore, it is recommended that 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.

Best practice recommendation is for 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 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.

Intervention: Depending on local team composition and transportation choices it is impossible to determine who may arrive on scene first. Community care interventions focus on linking individuals to the appropriate supports and services. Some countries refer to teams similar to this as "street triage" teams. This could involve attending to minor injuries if an EMT is part of the team, supporting a transport to a crisis receiving or assessment center, or supporting the individual while assessing for safety and awaiting a mobile crisis response. 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.

Recommended best practice is that 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. 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. 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.

Additional Considerations for Response Teams

Many crisis response philosophies aim to decrease or remove law enforcement from crisis response. 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. The intent of these team descriptions are to provide a set of considerations 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.

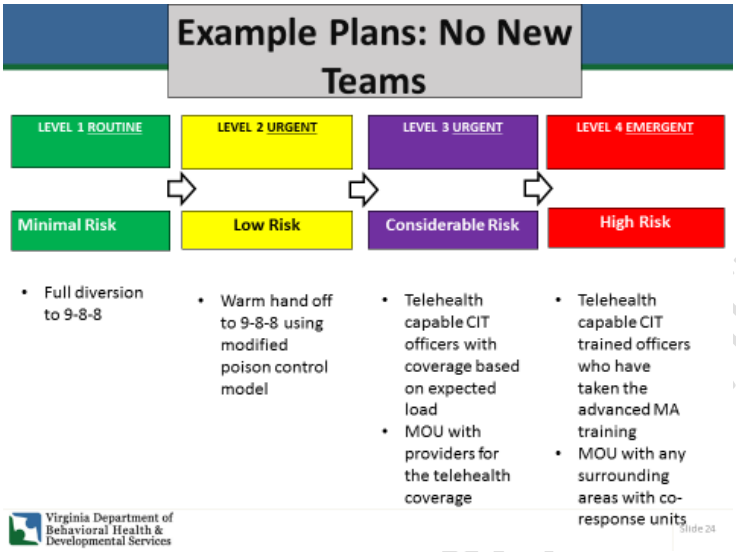
This group has discussed the potential need for guidelines for very specialized response teams with capabilities to address focused needs (e.g. adolescents, autism, etc.) and mental health diagnoses. While this subgroup understands and supports the inclusion of team members with knowledge and abilities 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.

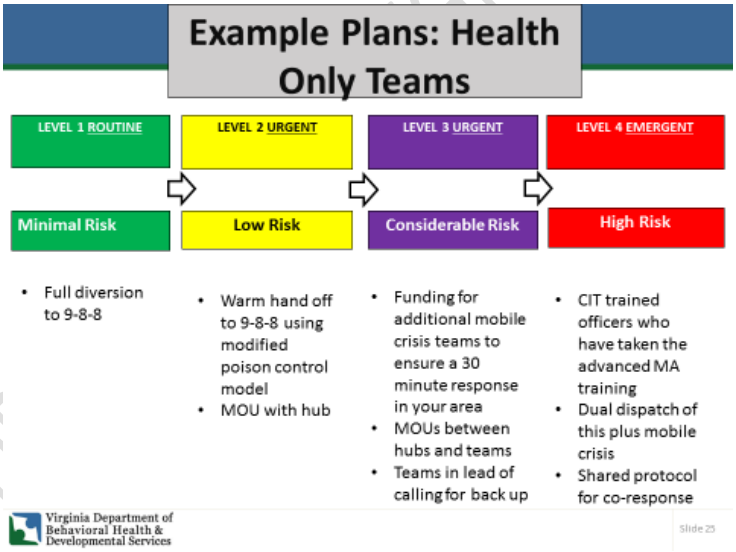
Research on crisis response indicates that law enforcement response (whether as back-up or primary response) is not needed to ensure safety during approximately 90-93% of behavioral health crises (www.crisisnow.com). Yet, it is well known that the current Virginia landscape includes an over-representation 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—much beyond 7-10% of the time. 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.

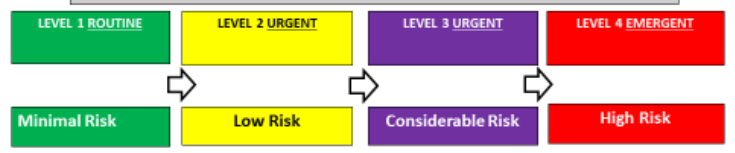
Examples of Local Plans for Community Coverage

Community coverage by a mobile crisis response can be achieved a number of ways, and all do not require the development of local-specific teams, due to the regional coverage by STEP-VA mobile crisis teams. Below are some examples of how communities may achieve community coverage across the levels of risk. As stated in the minimum standards, Level 1 is a required diversion, Level 4 is required emergent response, and there are a range of options that can be selected among or layered across all levels.


Example Plans: No New Teams
LEVEL 1 ROUTINE
LEVEL 2 URGENT
LEVEL 3 URGENT
LEVEL 4 EMERGENT
Minimal Risk
Low Risk
Considerable Risk
High Risk
• Full diversion to 9-8-8
• Warm hand off to 9-8-8 using modified poison control model
• Telehealth capable CIT officers with coverage based on expected load
• MOU with providers for the telehealth coverage
• Telehealth capable CIT trained officers who have taken the advanced MA training
• MOU with any surrounding areas with co-response units
Virginia Department of Behavioral Health & Developmental Services
Slide 24


Example Plans: Health Only Teams
LEVEL 1 ROUTINE
LEVEL 2 URGENT
LEVEL 3 URGENT
LEVEL 4 EMERGENT
Minimal Risk
Low Risk
Considerable Risk
High Risk
• Full diversion to 9-8-8
• Warm hand off to 9-8-8 using modified poison control model
• MOU with hub
• Funding for additional mobile crisis teams to ensure a 30 minute response in your area
• MOUs between hubs and teams
• Teams in lead of calling for back up
• CIT trained officers who have taken the advanced MA training
• Dual dispatch of this plus mobile crisis
• Shared protocol for co-response
Virginia Department of Behavioral Health & Developmental Services
Slide 25

Example Plans: Community Care "CAHOOTS style" Team



- Full diversion to 9-8-8
- Quality of life calls of a specific nature may go to community care team

- Warm hand off to 9-8-8 using modified poison control model

- Community Care team response
- Connection to crisis continuum

- Community care team and LE partnership protocol
- LE coverage by CIT trained officers who have taken the advanced MA training

Virginia Department of Behavioral Health & Developmental Services

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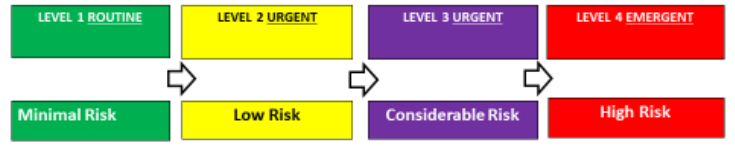
Example Plans: Community Care STAR (Henrico) team



- Full diversion to 9-8-8
- Quality of life calls of specific nature may go to STAR

- Warm hand off to 9-8-8 using modified poison control model
- STAR response for high utilizers

- STAR response
- Connection to the crisis continuum

- STAR response (with different protocols for high risk situations)

Virginia Department of Behavioral Health & Developmental Services

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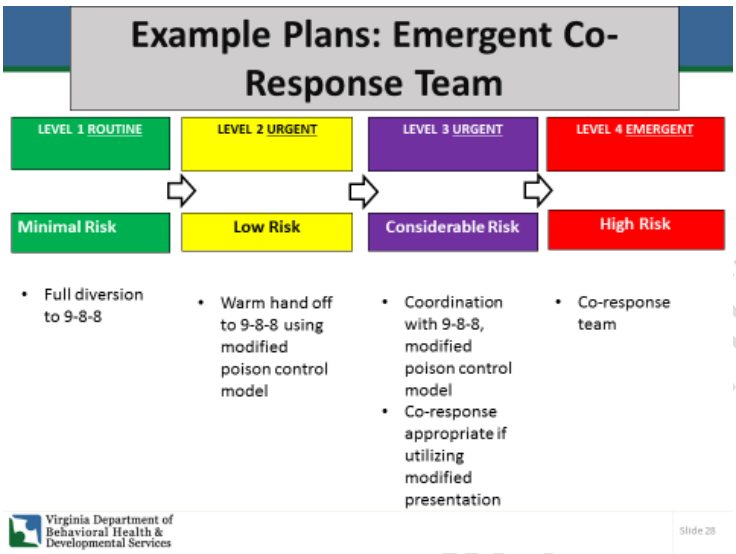


Minimum standards and best practices for local law enforcement involvement in the Marcus Alert system

Minimum standards are as follows:

- ✓ All localities comply with state training standards
- ✓ The four level framework is defined at a local level and adopted for standard communication and response planning
- ✓ Level 1 calls and situations are diverted to 9-8-8
- ✓ Level 2 calls are coordinated with 9-8-8
- ✓ Memorandums of agreement (consistent with the state requirements) are developed between the call center hub and any responding law enforcement agency
- ✓ Submission of a plan for specialized law enforcement response addressing these four areas: leadership/organizational, basic training, intermediate training, and specialized and advanced training
- ✓ Specialized response across all four levels is behavioral health focused

- ✓ Policy regarding Marcus Alert response being utilized whenever a situation is identified as a Marcus Alert 1, 2, 3, or 4 situation (even if not initially identified)
- ✓ Appropriate coverage and preferential deployment of CIT officers and officers with advanced Marcus Alert training
- ✓ Attendance at cross-sector quarterly local meetings
- ✓ Submission of quarterly data using state crosswalks

Best Practice considerations are as follows:

- ✓ Level 1 calls are fully diverted to 9-8-8
- ✓ Level 2 calls follow a poison-control model with 9-8-8
- ✓ Level 3 calls are coordinated with 9-8-8 to ensure efficient use of resources (i.e., telehealth relationships, phone-based assessment support, coordinated dispatch of teams)
- ✓ The majority of Level 3 calls involving youth are coordinated with 9-8-8 and specialized children's mobile crisis teams
- ✓ Back-up officers sent under agreements with regional hubs will be voluntarily CIT trained and have received the advanced Marcus Alert training
- ✓ 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
- ✓ 8 hour mental health first aid for all officers
- ✓ Ongoing de-escalation training for all officers, including basic and intermediate
- ✓ Interactive, scenario based de-escalation training specific to mental health scenarios, with a focus on time as a tactic, at least yearly
- ✓ Advanced workshop based trainings on cultural humility and cultural competence (examples and options are included in Appendix X)
- ✓ 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.

- ✓ Agencies have coverage each shift by an appropriate amount of officers who have completed the advanced/intersectional Marcus Alert training
- ✓ High level engagement in cross sector quarterly meetings and data driven quality improvement processes at the local level

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, 2022 code requirements must submit #4, 5, 6, 7, 8, and 12. Plan review will take between 4 and 6 weeks. Full compliance date, which includes plan for community coverage, will vary across the state. Initial 5 areas must submit all 12 components prior to implementation December 1, 2021.

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, 2022 statewide
5	Copy of Protocol #1	July 1, 2022 statewide
6	Copy of Protocol #2	July 1, 2022 statewide
7	Copy of Protocol #3	July 1, 2022 statewide
8	Data and reporting crosswalks and responsible parties	July 1, 2022 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, 2022 statewide

Reporting requirements will go into effect October 1, 2022 (quarter 1 of implementation). Data system testing period will occur through approximately March, 2023. When testing period ends, data are interpreted as valid representation of activities occurring under the Marcus Alert. Reporting is required quarterly and the activities to prepare and plan for data collection are described in the State Evaluation Plan section.

Section IV: Evaluation and Accountability Plan

Marcus Alert Evaluation Task Force

The importance of evaluation and accountability for performance of the Marcus Alert system at both the local and state level was supported across the stakeholder group. Given the complexities of the different data and reporting structures at the local and state level across behavioral health, PSAP, and law enforcement, as well as overlapping projects such as the crisis call center data platform development, ongoing work with technical experts from each sector will be required to launch the state-level evaluation of the Marcus Alert. Thus, the evaluation plan presented here should be considered a high-level overview of the framework the task force will be working towards in the design of reporting processes.

Local Reporting Requirements

In a general sense, there will be three required components for reporting. Each component is required quarterly, and any requirements that can be built directly into the crisis call center platform will be integrated in that way. In the local plans that are submitted for approval, an accountable entity for each of the three components should 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.

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. 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 but CITAC data owners and managers will be included on the data task force.

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, although the technical process will need to be developed by the data task force. 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 diversion of calls. Because of the vast variation in how calls are classified and how that information is captured, it is assumed that the process will rely on a state-standard crosswalk to compile data. This completed crosswalk will be required to be submitted with your plan. Below is an example of how this crosswalk will likely appear, for informational purposes. The data task force will finalize the crosswalk prior to December 1, 2021.

EXAMPLE CROSSWALK FOR PSAP CALL TYPE DATA

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).

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, submitting complete quarterly data, 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 or other crisis-related quarterly meetings), 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.

Summary of State Framework

This state plan provides the initial framework for the implementation of the Marcus-David Peters Act. With significant cross-sector and stakeholder input, five components were defined primarily at the state level and eight components were defined primarily at the local level. A framework for the ongoing development of a robust evaluation plan and structures for community input and accountability was also defined. The framework takes a continuous quality improvement approach to the ongoing evaluation, development, and improvement of the Marcus Alert system, including the overall performance of the system and the specific performance of the system for Black Virginians, Indigenous Virginians, and Virginians of Color. Throughout initial stages of implementation, additional community input will be needed with a focus on input from marginalized and disproportionately impacted communities, and adjustments to the plan may be needed.

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). Ability to transfer custody from law enforcement to 23 hour observation facilities may need to be considered. There are multiple viewpoints on whether, and if so, what, structural or legislative solutions would help relieve pressure on law enforcement related to the ECO process.
3) Requiring accreditation of law enforcement agencies would allow for additional standards to be set regarding Marcus Alert compliance. Currently, DBHDS and DCJS can collaborate on basic, inservice, or advanced trainings, within the existing parameters (e.g., 40 hours of inservice training every year), but if accreditation were required, additional standards could be set and then monitored as part of the accreditation process. Currently, many of the recommendations of this report are ultimately discretionary.
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

Commented [LJS11]: •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 t(...

Commented [LJS12]: 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. ...

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 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.

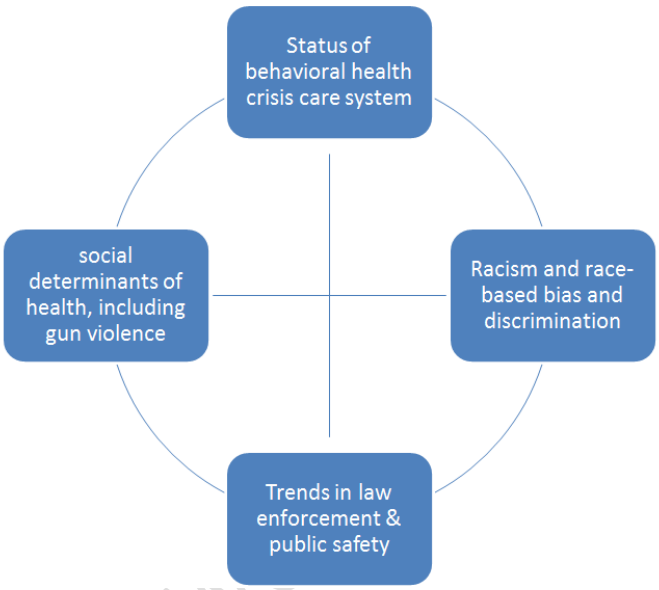
Additionally, the Virginia General Assembly passed the Marcus-David Peters Act, named in honor of Marcus-David Peters, a young, Black, biology teacher and VCU graduate who was fatally shot by Richmond Police in 2018 in the midst of a behavioral health crisis; it was signed into law in November 2020 by 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*}	
	Individual Presentation	How did the citizen present when the response team arrived on scene?	☐ Disoriented ☐ Homicidal ☐ Psychotic ☐ Suicidal ☐ Other (specify) ☐ None of the above	
	Individual Age	How old (years) is the citizen?		
	Individual Diagnosis	Which of the following diagnoses has the citizen received?	☐ ID/DD (*specify*) ☐ Mental Health (*specify*) ☐ Neither ☐ Prefer not to answer	

	Individual 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	
	Individual 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	
	Law Enforcement Actions and Controls		☐ Handcuffs used ☐ Shackles used ☐ Soft restraints used ☐ Person summonsed ☐ Person arrested	
	Use of Force		☐ Officer went hands on ☐ Pepper spray ☐ Baton ☐ 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)	

Appendix X. Draft Summary of Minimum Local Requirements for Compliance

By July 1, 2021…
Establish voluntary database
Prior to May 15, 2022 (assuming 4-6 weeks for plan approval)…
Submission of 12 required application components
By July 1, 2022…
Approved protocol 1, 2, and 3 meeting minimum standards based on 4 level triage framework
By community coverage date…
Implementation of any additional local mobile crisis or community care teams, including co-responder teams

Local Program Minimum Standards

Meet minimum statewide training law enforcement standards, including Basic, In-service, and Advanced training (requirements coordinated with DCJS)

Ensure PSAP participants have access to basic Marcus Alert training

Develop the required Marcus Alert framework regarding definitions for Level 1, 2, 3, and 4

Code/capture these event designations in CAD system

Have a policy in place to utilize MA training and protocols when responding to a MA event as soon as it is known that it is a MA event

Development of voluntary database; utilization of voluntary database when classifying calls as MA and communicating between entities

Diversion of routine and low risk behavioral health calls to 9-8-8 (protocol 1- july 1, 2022)

Agreement with mobile crisis hub in area regarding serving as back-up (protocol 2- july 1, 2022)

Specialized law enforcement response when responding to persons in behavioral health crisis, defined within the four level framework (protocol 3- july 1, 2022). The specialized response protocol must be in place July 1, 2022, and the plan should be updated yearly if specialized response includes the development of additional local teams between July 1, 2022 and required community coverage date. Options include non law enforcement community care teams, additional mobile crisis teams to support response sooner than 1 hour, community care team with law

enforcement, co-responder model, shift coverage by CIT officers, shift coverage by advanced MA trained officers, telehealth capable CIT officers and other behavioral health response from a distance as part of immediate response.

Quarterly data and reporting based on the state cross walks

Yearly reporting on program development (including a copy of your 4 level triage model, your three protocols, any developed community coverage teams, and successes and barriers)

Participation in quarterly cross-sector meetings with continuous quality improvement focus on diversion (meetings organized by CSB or Marcus Alert coordinator)

Twice yearly stakeholder group convening for data review and written input into local annual report

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