Virginia Department of Behavioral Health & Developmental Services

Marcus Alert

State Stakeholder Planning Meeting #1

January 25, 2021

DBHDS Vision: A life of possibilities for all Virginians

Agenda

- Welcome and Opening Remarks, DBHDS and DCJS (3:05-3:15)
- Meeting Information (3:15-3:25)
- Stakeholder Introductions and Priorities (3:25-4:25)
- Initial Context (4:25-4:40)
- Next Steps (4:40-4:50)
- Public Comment (4:50-5:00)

Welcome and Opening Remarks

Meeting Information

- We will meet 12 times as currently scheduled, on Mondays and some Wednesdays
- All open meetings with brief comment period at end
- Three public forums/meetings focused on community input (these will be held in addition to the stakeholder meetings)
- Plan is due to the General Assembly by July 1, 2021, and we will need to be circulating a final draft for a number of reviews approximately one month before that

Group Process

- We expect you to advocate for the needs of your stakeholder group, and engage across stakeholder groups to create proposals, ideas, and solutions
- We will often proceed using "rounds" where everyone is asked to weigh in, even if very briefly

1 Understand

- Understand context
- Get all system "needs" on table
- Understand trends and drivers

2 Explore

- Identify and evaluate opportunities
- Understand scope and dimensions
- Create proposals
- Synthesize proposals

3 Decide

- Modify proposals and ensure everyone understands proposals
- Make a decision
- Publish a decision
- Add action and resources!

Introductions & Priorities

- Please share your name, pronouns, and any other general details such as the stakeholder group you represent, if you are with an agency, and whether you are with a specific area or geographical region
- Please share what you would like based on the following prompts:
  - What matters to you or your stakeholder group most about the Marcus Alert?
  - Why does being a part of the planning matter to you, your stakeholder group, or your community?
- I will call your name

Initial Areas

- We are honored to have the following partnerships for initial implementation:
  - Region 1: Orange, Madison, Culpeper, Fauquier and Rappahannock Counties (Rappahannock-Rapidan Community Services)
  - Region 2: Prince William County (Prince William County Community Services)
  - Region 3: City of Bristol and Washington County including the Towns of Abingdon, Damascus, and Glade Spring (Highlands CSB)
  - Region 4: City of Richmond (Richmond Behavioral Health Authority)
  - Region 5: City of Virginia Beach (Virginia Beach Human Services)

Initial Context: Marcus-David Peters Act

- The Act and required Plan
- Behavioral Health Emergency Care
- Racial Justice Intersection
- Systems Approach

Marcus-David Peters Act

- The **Marcus-David Peters Act** aims to provide behavioral health responses to behavioral health emergencies and reduce negative outcomes involving use of force in law enforcement interactions when an individual is experiencing a behavior health crisis related to a mental health, substance use, or developmental disability.
- The bill was largely the result of an advocacy effort led by the family of Marcus-David Peters, a young, Black, biology teacher who was shot by Richmond police in 2018 in the midst of a mental health crisis.

July 1, 2021 Plan

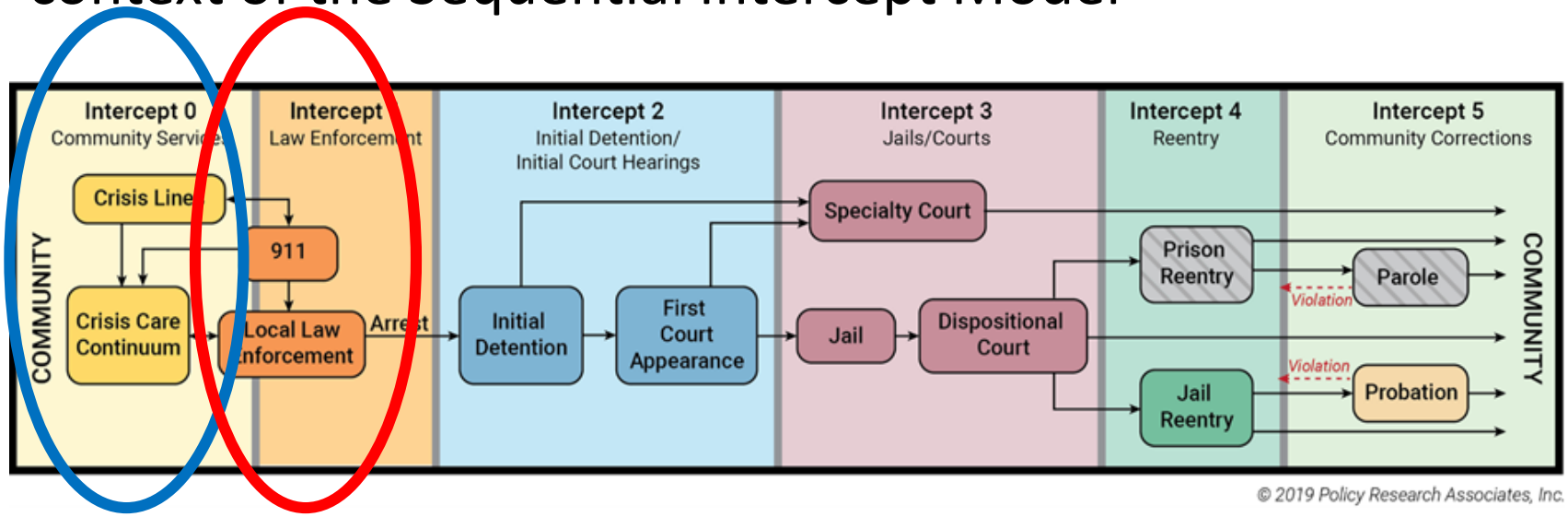
- Report focuses on the state framework (i.e., not each local implementation)
- Collaborative report between DBHDS, DCJS, and stakeholders
- Has 10 components:

5 components ("catalog")	5 components ("protocols and process")
Past and current crisis intervention teams	Protocol/framework for 9-1-1 diversion to behavioral health system
Current mobile crisis teams and crisis stabilization units	Protocol/framework for relation between mobile crisis hubs (regional) and local law enforcement
Other cooperative arrangements between mental health and law enforcement	Minimum standards/best practices for law enforcement engagement in system
Prevalence of crisis situations and any Virginia data	Assignment of duties, responsibilities, and authorities across state and local entities
Catalog state and local funding of crisis and emergency services	Process for review and approval and evaluation of localities' plans

Initial Context: Behavioral Health Emergency Care

Sequential Intercept Model

- The intersection between a behavioral health mobile crisis system and law enforcement is best understood in the context of the Sequential Intercept Model



Blue = STEP-VA/Behavioral Health Mobile Crisis

Red = Marcus Alert

Crisis Now Model

- Virginia is aligning investments with the Crisis Now model, including call center, mobile crisis, and crisis stabilization centers (www.crisisnow.com)
- Marcus Alert is also consistent with the Crisis Now model, because one of the "Essential Principles and Practices" is collaboration with law enforcement, and CITACs have crisis stabilization components
- Marcus Alert adds *additional* requirements to the best practice of collaboration with law enforcement, including changes to law enforcement presentation when responding to a behavioral health crisis

HIGH-TECH CRISIS CALL CENTERS

These programs use technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems. At the same time, they provide high-touch support to individuals and families in crisis.

24/7 MOBILE CRISIS

Mobile crisis offers outreach and support where people in crisis are. Programs should include contractually required response times and medical backup.

CRISIS STABILIZATION PROGRAMS

These programs offer short-term "sub-acute" care for individuals who need support and observation, but not ED holds or medical inpatient stay, at lower costs and without the overhead of hospital-based acute care.

ESSENTIAL PRINCIPLES & PRACTICES

These must include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

Initial Context: Systems Approach and Systemic Racism

Racial Equity Lens onto Ongoing and New Efforts

Why is this a racial justice issue?

Race and Circumstances as predictors of fatal police shootings (2015-2018)	In a Mental Health Crisis 20-25%	Not in a Mental Health Crisis 75-80%
Unarmed	52, 1.5% • **Black Civilian (3.4x)** • **Police killed in line of duty (county)**	209, 6% • **Black Civilian (3.8x)** • **Fleeing** • **Threat Level** • **Police killed in line of duty (county)**
Armed	860, 24% **No racial differences**	2,423, 68% • **Black Civilian (2.3x)** • **Latinx Civilian (1.6x)** • **Asian/PI/NA Civilian (1.6x)** • **Fleeing** • **Threat Level**

Virginia Department of Behavioral Health & Developmental Services

Analysis of 3,933 fatal police shootings between 2015-2018. Access Boston University Law Review report here: https://scholarship.law.columbia.edu/faculty_scholarship/2656

Taking a Systems Approach

What is a complex systems approach?

- Focuses on emergent behaviors, or outcomes that are difficult to predict
- Looks at outcomes of the system moreso than behaviors of a single individual (and applies when outcomes are difficult to predict using individual behavior)
- Applies when there are multiple elements at play, elements interact in a non-linear way, or elements are high in number or different from one another

Why does it make sense to apply?

- There are many elements involved (behavioral health, law enforcement, emergency management) and all have different perspectives and policies
- Antiblack bias and stigma and stigma against people with disabilities have been found systemically across the involved elements, and all are more sensitive to bias and stigma in chaotic or stressful situations where there are not clear policies
- In addressing racism as a public health concern high stakes domains have garnered the most attention (e.g., maternal mortality), but systems approaches show promise

Next Steps

- Consider goals for state planning process
- (Vision and goals for Marcus Alert system will emerge after "understand" phase)

1	2	3	4	5
Health focused	Empowerment and Recovery oriented	Equitable Access	Polycentric Governance	Transparent and Data-driven

Next Steps

- Gathering “inputs” for first phase
  - If you have an input you want considered for next week’s meeting, please send to Lisa or marcusalert@dbhds.Virginia.gov by Thursday close of business
  - Members of the public can send inputs you would like the group to consider to marcusalert@dbhds.Virginia.gov
  - Lisa will send about 3 inputs to review on Friday
  - Next meeting we will review all domains of the bill and discuss inputs
- Both DBHDS and DCJS have been approved for a staff position and we will introduce then as soon as they are on board

Closing Round/Public Comment

- Next meeting: Wednesday, February 3, 3-5 pm

Recently released Federal Toolkit (February, 2020): **National Guidelines for Behavioral Health Crisis Care (SAMHSA)** highlights:

"With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care…In too many communities, the "crisis system" has been unofficially handed over to law enforcement; sometimes with devastating outcomes. The current approach to crisis care is patchwork and delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks; resulting in multiple hospital readmissions, life in the criminal justice system, homelessness, early death and suicide."

"A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach."

Reference Slides

All meeting dates

- Monday Jan 25 3-5pm
- Wednesday Feb 3 3-5pm
- Monday Feb 8 3-5 pm
- Monday Feb 22 3-5pm
- Monday March 8 3-5pm
- Wednesday March 17 3-5 pm
- Monday March 22 3-5 pm
- Monday April 5 3-5 pm
- Monday April 19 3-5pm
- Wednesday April 28 3-5pm
- Monday May 3 3-5pm
- Monday May 17 3-5pm

Best Practice in Crisis System Transformation

Recently released Federal Toolkit (February, 2020): **National Guidelines for Behavioral Health Crisis Care (SAMHSA)** highlights:

"With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care…In too many communities, the "crisis system" has been unofficially handed over to law enforcement; sometimes with devastating outcomes. The current approach to crisis care is patchwork and delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks; resulting in multiple hospital readmissions, life in the criminal justice system, homelessness, early death and suicide."

"A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach."

Marcus Alert Budget Information

- Call center staff $4.7 million (STEP VA) (790)
- Adult mobile crisis $6.1 million (STEP VA) (790)
- $3 million for teams/Marcus Alerts ($600,000 for each region) (790)
- 1 FTE at Central Office for Marcus Alert implementation (720); 1 at DCJS
- This pattern of investments is consistent with national recommendations, in that the crisis care continuum ***must*** be present in order for law enforcement to successfully divert and decrease involvement

Race, Behavioral Health Crises, and Fatal Shootings

- National models evaluating race and other situational characteristics as predictors across 4 groups: killed experiencing a mental health crisis unarmed, killed while armed, neither, and both
- Black civilians were more likely to be killed in three of the four groups (no racial differences observed when armed and in a mental health crisis)

Jeffrey A. Fagan & Alexis D. Campbell, Race and Reasonableness in Police Killings, BOSTON UNIVERSITY LAW REVIEW, VOL. 100, P. 951, 2020; COLUMBIA PUBLIC LAW RESEARCH PAPER NO. 14-655 (2020). Available at: https://scholarship.law.columbia.edu/faculty_scholarship/2656

	Risk Ratio	Std. Error	p	95% CI	
Neither					
Black Civilian	3.772	(.960)	***	2.358	6.373
Latinx Civilian	1.508	(.387)		.931	2.538
Asian/NA/PI/Other Civilian	1.970	(.925)		.814	5.082
Flee	3.791	(1.727)	**	1.344	8.721
Threat Level	.460	(.123)	**	.281	.823
Officers Killed in the Line of Duty	1.067	(.030)	*	1.005	1.13
Police Killings	1.003	(.005)		.996	1.008
Constant	.003	(.010)		.001	12.908
Armed Only					
Black Civilian	2.378	(.385)	***	1.757	3.337
Latinx Civilian	1.560	(.196)	***	1.238	2.012
Asian/NA/PI/Other Civilian	1.602	(.349)	*	1.058	2.478
Flee	3.565	(1.122)	***	1.908	6.526
Threat Level	1.422	(.190)	**	1.099	1.851
Officers Killed in the Line of Duty	1.036	(.052)		.943	1.146
Police Killings	1.000	(.004)		.999	1.008
Constant	1.088	(2.019)		.060	39.807
Mental Health Only					
Black Civilian	3.366	(1.318)	***	1.629	7.33
Latinx Civilian	.786	(.366)		.318	1.926
Asian/NA/PI/Other Civilian	2.482	(1.697)		.512	6.967
Flee	.674	(.613)		.147	6.019
Threat Level	.978	(.416)		.387	2.144
Officers Killed in the Line of Duty	1.115	(.049)	**	1.115	2.305
Police Killings	.995	(.008)		.989	1.007
Constant	.279	(1.590)		.000	1143.05
Model Statistics					
AIC	4436.71				
Pseudo R2	.076				
Pseudo LL	-2170.36				

Significance: * = p <.05, ** p < .01, *** p < .001

Notes: N=3239 Reference groups include Both (armed and mental health) circumstances and White victims. Models estimated with year fixed effects, and

Marcus Alert and Best Practices in Crisis Care

- Marcus Alert requires communities to complete detailed planning for providing a crisis response that conforms to these modern principles ***across*** governmental responses/responders including behavioral health and law enforcement

- Marcus Alert requires communities to complete detailed planning for system integration and diversion to behavioral health mobile crisis as mobile crisis capacity is built across Virginia

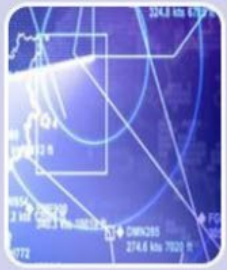
- Marcus Alert protocols are expected to clarify procedures and plans to ensure that therapeutic crisis care is equally accessible, safe, and least restrictive for all Virginians regardless of race, ethnicity, or disability

Marcus Alert and Best Practices in Crisis Care

How Does Your Crisis System Rate?

A Framework for State/Regional Self-Assessment

For more info see http://crisisnow.com





What makes Level 5 different?	① Call Center Hub Real Time Access Valve Mgmt	② Mobile Outreach Meets Person at Home/Apt/Street	③ Sub-acute Stabilization Direct LE Drop Off <10 Min	Crisis Now System Equal Partners 1st Responders	Level 5 System Also Conforms to 4 Modern Principles
Level 5: FULLY INTEGRATED	Air Traffic Control Connectivity	Adequate Access Statewide	Adequate Access Statewide	Adequate Access Statewide Plus →	① Priority Focus on Safety/Security
Level 4: CLOSE	Data Sharing (Not 24/7 or Real Time)	Statewide Access but Reliant on ED	Statewide Access but Reliant on ED	Integrated System w/ Diversion Power	② **Suicide Care Best Practices**, e.g. Systematic Screening, Safety Planning and Follow-up
Level 3: PROGRESSING	Formal Partnerships	Adequate Access **<1 Hr Response**	Adequate Access **>50% Bed Available**	Adequate Access Major Payers Included	
Level 2: BASIC	Shared MOU/ Protocols	Some Availability Limited to Urban	Some Availability Limited to Urban	Limited State/ County Support	③ Trauma-Informed, Recovery Model
Level 1: MINIMAL	Agency Relationships	None or Very Limited Availability	None or Very Limited Availability	Fragmented Status Quo	④ Significant Role for Peers

Levels of Crisis Analysis and Crisis Care

Call center only intervention; mobile crisis may be appropriate as determined by behavioral health triage procedures

Mobile crisis response needed, shared procedures and plans across 9-1-1 (for diversion) and 9-8-8

Mobile crisis response appropriate and LE or other safety supports engaged as back up, shared procedures and plans across 9-1-1 and 9-8-8 (coordination)

High risk behavioral health-led response, via direct dispatch of co-responders or coordinated effort between mobile crisis and LE or other safety supports

Emergent situation, LE led approach with specialized protocols or co-response (but LE confirm environmental concerns first); mobile crisis called to scene but first responders respond

Marcus Alert Requirements

- Marcus Alert requirements are best understood in terms of:
  - *Three required protocols*
  - *Community coverage*
  - *Voluntary database*
  - *Data and quality improvement*

Three Required Protocols

- There are **3 required protocols**, all of which will have a statewide framework provided in the July 1, 2021 report
  - Communities will then take these frameworks and write their protocols, which will need to go through an approval process. Initial areas must have protocols in place by Dec, 2021, and all other communities by July 1, 2022

Is Marcus Alert a Co-Responder Model?

- Although some versions of the bill emphasized a co-response model only, the General Assembly-approved Act allows for coverage by mobile crisis teams or community care teams. Co-response teams fit under community care team definition
- In other words, it is not required that your community set up a co-response model; although some communities may feel this is the best local support needed to meet their needs
- If your plan includes a co-response model, you will still be required to divert behavioral health calls to the behavioral health crisis line as appropriate (i.e., divert to a behavioral health only response), and the co-response team will have to be coordinated with the call center to ensure integrated care

How is this different from CIT?

- In many communities, the Marcus Alert implementation will build on existing CIT partnerships, programs, and initiatives
- Because CIT programs are local/locally defined in the context of state goals and essential elements, the path for communities to reach the state requirements will look different in each community
- Marcus Alert also increases the behavioral health *only* responses to behavioral health emergencies, which will be a new priority for CIT programs and/or triage function between law enforcement and behavioral health unless robust mobile crisis already exists in the community

STEP-VA and Marcus Alert

- STEP-VA and Marcus Alert complement one another
- A robust crisis system *requires* investment in Intercept 0 (STEP-VA), or else any Marcus Alert initiatives or law enforcement programs/reforms will not have the behavioral health care needed for diversion
- A robust behavioral health crisis system *requires* diversion from Intercept 1 to Intercept 0 and coordination with law enforcement and other first responders, and Marcus Alert provides state standards for this planning
- Statewide coverage with mobile crisis is planned via STEP-VA, and CSU/CITAC coverage is also needed; Marcus Alert investments will vary by community to coordinate between local supports and regional mobile crisis dispatch

Community Coverage

- **Coverage** means that your community has behavioral health teams (mobile crisis teams or community care teams) that can respond to behavioral health emergencies in the community within a 1 hour response time
- Communities can achieve coverage via STEP-VA mobile crisis which will be dispatched regionally through 9-8-8 (once implemented) with teams co-located throughout region for geographical coverage
- Communities may also *add* teams through their implementation of the Marcus Alert to supplement STEP-VA coverage based on community need (e.g., immediate co-response), but this is not required and not feasible everywhere
- Statewide coverage is required on a phased timeline, 5 areas by Dec 2021, 5 more the next year, and so on.

High Level Timeline *beyond* July 1 2021 Plan

- Initial five areas must implement all aspects of the plan (protocols, team coverage) by December 1, 2021
- All areas must implement protocols by July 1, 2022
- All areas must have team coverage, with more areas added yearly until statewide coverage is achieved by 2026
- Voluntary database (DCJS) required by July 1, 2021
- Public campaign required December, 2021-July, 2022

Appendix of Full Bill

Domains of the Bill

1. Code section placement/authority, and agency purview (DBHDS/DCJS)
2. Framework for comprehensive crisis system
3. Definition of Marcus Alert
4. Goals for law enforcement participation
5. Community care team / mobile crisis team definitions
6. Specificity of crisis response model
7. Population served
8. Law enforcement protocols
9. Police presentation details
10. Written plan, stakeholders, and deadline
11. Launch of Marcus alert and teams
12. Remaining phasing in of Marcus alert and teams
13. All localities have diversion protocol/Marcus alert system
14. Public service campaign
15. Voluntary database
16. Assessment and reporting

Marcus Alert Bill - Agency purview (DBHDS/DCJS)

DCJS maintains purview over monitoring requirements associated with decreased use of force and body-worn camera systems.

DBHDS maintains purview over the development of a mobile crisis response system.

DBHDS and DCJS will collaborate regarding protocols for all aspects of the Marcus Alert, including protocol for law enforcement backup of a mobile crisis response when necessary.

Framework for Comprehensive System

- The bill provides a framework for a comprehensive crisis system, including establishing a new section in 37.2 called “Comprehensive crisis system”, and names DBHDS’s duties and roles related to the crisis system and Marcus alert system.
- This new section defines elements of the comprehensive crisis system including community care team, comprehensive crisis system, Marcus alert, mobile crisis response, and mobile crisis team.
- DBHDS will continue its work with stakeholders to develop the crisis call center as well as mobile crisis response infrastructure, key details of which are still being worked through.

Marcus Alert System / Definition

Mental health awareness response and community understanding services alert system = Marcus Alert system

Marcus alert is a **series of protocols** aimed to **divert to the behavioral health system** or respond with a **specialized law enforcement response**, including:

1. Protocols to divert from 911 to crisis call center
2. MOUs for law enforcement backup to a crisis response
3. Minimum standards/best practices for law enforcement response

Goals for law enforcement participation

There are 17 stated goals of law enforcement participation in comprehensive crisis services and the Marcus alert system in DCJS's purview.

1. Ensuring that individuals experiencing behavioral health crises are served by the behavioral health comprehensive crisis service system
2. Ensuring that local law-enforcement establishes standardized agreements for the provision of backup and specialized response when required
3. Providing immediate response and services when diversion to the comprehensive crisis system continuum is not feasible with a protocol that meets the minimum standards and strives for the best practices developed by DBHDS
4. Affording individuals whose behaviors are consistent with mental illness, substance abuse, intellectual or developmental disabilities, brain injury, or any combination thereof a sense of dignity
5. Reducing the likelihood of physical confrontation

Goals for law enforcement participation (Cont'd)

There are 17 stated goals of law enforcement participation in comprehensive crisis services and the Marcus alert system in DCJS's purview.

6. Decrease arrests and use-of-force incidents by law-enforcement officers;
7. Ensuring the use of unobstructed body-worn cameras
8. Identifying underserved populations in historically economically disadvantaged communities whose behaviors are consistent with mental illness, substance abuse, developmental disabilities, or any combination thereof are directed or referred to and provided with appropriate care
9. Providing support and assistance for mental health service providers and law-enforcement officers
10. Decreasing the use of arrest and detention of persons whose behaviors are consistent with mental illness, substance abuse, developmental or intellectual disabilities, brain injury, or any combination thereof by providing better access to timely treatment

Goals for law enforcement participation (Cont'd)

There are 17 stated goals of law enforcement participation in comprehensive crisis services and the Marcus alert system in DCJS's purview.

11. Providing a therapeutic location or protocol to bring individuals in crisis for assessment that is not a law-enforcement or jail facility
12. Increasing public recognition and appreciation for the mental health needs of a community
13. Decreasing injuries during crisis events
14. Decreasing the need for mental health treatment in jail
15. Accelerating access to care for individuals in crisis
16. Improving the notifications made to the comprehensive crisis system concerning an individual experiencing a mental health crisis
17. Decreasing the use of psychiatric hospitalizations as a treatment for mental health crises

Specificity of crisis response model

“Mobile crisis response" may be provided by a community care team or a mobile crisis team, and a locality may establish either or both types of teams to best meet its needs

Community Care Team / Mobile Crisis Team

Community Care Team

- A team of mental health service providers. May include peer recovery specialists and law-enforcement, with the mental health service providers leading.
- Law enforcement may provide backup support as needed in accordance with the protocols and best practices developed pursuant to § 9.1-193.
- May engage in community mental health awareness and services.

Mobile Crisis Team

- A team of one or more qualified or licensed mental health professionals. May include a peer recovery specialist or family support partner.
- A law-enforcement officer shall not be a member of a mobile crisis team, but may provide backup as needed in accordance with § 9.1-193

Population served

- Includes mental illness, substance abuse, developmental or intellectual disability, brain injury, or any combination thereof.
- Additionally, one of the listed goals for law enforcement is to identify underserved populations in historically economically disadvantaged communities whose behaviors are consistent with mental illness, substance abuse, developmental disabilities, or any combination thereof.

Law enforcement protocols

- DCJS has purview over –
  1. Law-enforcement agencies' roles and engagement with the development of the Marcus alert system
  2. DCJS'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
  3. Plans for the measurement of progress toward the goals for law-enforcement participation in the Marcus alert system
- Protocols for law enforcement participation in Marcus alert shall be developed in coordination with local behavioral health and developmental services stakeholders and approved by DBHDS
  - This should provide for a specialized response by law enforcement to ensure that individuals receive a specialized response when diversion to the comprehensive crisis system is not feasible
  - Must also consider the impact to care that the presence of an officer in uniform or a marked vehicle at a response has and mitigate this impact when feasible through the use of plain clothes and unmarked vehicles.
  - Finally, must set forth best practices, guidelines, and procedures regarding the role of law-enforcement during a mobile crisis response, including the provisions of backup services when requested.

Police presentation details

- Specialized response protocols and training by law enforcement shall consider the impact to care that the presence of an officer in uniform or a marked vehicle at a response has and shall mitigate such impact when feasible through the use of plain clothes and unmarked vehicles.

Written plan, stakeholders, and deadline

DBHDS, in collaboration with DCJS and law enforcement, mental health, behavioral health, emergency management, brain injury, and racial equity stakeholders, shall develop a written plan for the development of a Marcus alert system **by July 1, 2021.**

1. Inventory past and current crisis intervention teams
2. Inventory the existence, status, and experiences of CSB mobile crisis teams and crisis stabilization units
3. Identify any other existing cooperative relationships between CSBs and law-enforcement agencies
4. 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
5. Identify state and local funding of emergency and crisis services

Written plan, stakeholders, and deadline (cont'd)

DBHDS, in collaboration with DCJS and law enforcement, mental health, behavioral health, emergency management, brain injury, and racial equity stakeholders, shall develop a written plan for the development of a Marcus alert system **by July 1, 2021.**

6. 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
7. 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
8. Develop minimum standards, best practices, and a system for the review and approval of protocols for law-enforcement participation in the Marcus alert system
9. Assign specific responsibilities, duties, and authorities among responsible entities
10. 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

Launch of Marcus alerts and crisis response

No later than **December 1, 2021**

DBDHS shall establish five Marcus alert systems and community care or mobile crisis teams in each of the five Department regions.

Remaining phasing in of Marcus alert and teams

- No later than **July 1, 2023**, DBHDS shall establish five additional Marcus alert system programs and community care or mobile crisis teams, one located in each of the five Department regions.
- The Department shall establish additional Marcus alert system and community care teams in geographical areas served by a CSB/BHA authority by **July 1, 2024; July 1, 2025**; and **July 1, 2026**. No later than **July 1, 2026**, all CSB/BHA geographical areas shall have established a Marcus alert system that uses a community care or mobile crisis team.

Public service campaign

DBHDS and DCJS must coordinate a public service campaign to run from **July 1, 2021, until January 1, 2022**, announcing the development and establishment of community care teams and mental health awareness response and community understanding services (Marcus) alert systems in localities and areas throughout the Commonwealth.

Assessment and Reporting

- Finally, DBHDS must assess and report on the impact and effectiveness of the comprehensive crisis system in meeting its goals. The assessment shall include:
  - number of calls to the crisis call center
  - number of mobile crisis responses
  - number of crisis responses that involved law-enforcement backup
  - overall function of the comprehensive crisis system.
- A portion of the report, focused on the function of the Marcus alert system, shall be written in collaboration with DCJS and include:
  - number and description of approved local programs and how the programs interface comprehensive crisis system and mobile crisis response;
  - number of crisis incidents and injuries to any parties involved; a description of successes and problems encountered
  - 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 CSB or BHSA.

All localities have diversion protocol/Marcus Alert system

- By **July 1, 2022** every locality shall have established local protocols that meet the requirements set forth in the DBHDS plan (1. protocols to divert from 911 to crisis call center; 2. MOUs for LEO backup; 3. minimum standards/best practices for LEO in Marcus alert system).
- Also by **July 1, 2022**, every locality shall have established, or be part of an area that has established, protocols for law enforcement participation in the Marcus alert system that has been approved by DBHDS and DCJS.

Voluntary database

DCJS will oversee the creation of voluntary databases with information related to individuals' behavioral health illness, developmental or intellectual disability, or brain injury. Every locality must establish a database, made available to the 9-1-1 alert system and the Marcus Alert system, by July 1, 2021.