Virginia Department of Behavioral Health & Developmental Services

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

Last Revised: 6/30/2021

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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.

View the full Act here.

Abbreviations

The following abbreviations are used throughout the state plan for the implementation of the Marcus Alert system.

APA	American Psychological Association
APCO	Association of Public-Safety Communications Officials
ARPA	American Rescue Plan Act of 2021
BIPOC	Black, Indigenous, and People of Color
BJA	Bureau of Justice Assistance
CAD	Computer-Aided Dispatch
CIT	Crisis Intervention Team
CITAC	Crisis Intervention Team Assessment Center
CMS	Centers for Medicare & Medicaid Services
CRT	Co-Response Team
CSB	Community Services Board
CSG	Council of State Governments
CSU	Crisis Stabilization Unit
DBHDS	Department of Behavioral Health & Developmental Services
DCJS	Department of Criminal Justice Services
DHP	Department of Health Professionals
DMAS	Department of Medical Assistance Services
ECO	Emergency Custody Order
ED	Emergency Department
EMS	Emergency Medical Services
ES	Emergency Services (within a CSB)
FMAP	Federal Medical Assistance Percentage
IACP	International Association of Chiefs of Police
LE	Law Enforcement
MCT	Mobile Crisis Team
MHBG	Mental Health Block Grant
NASMHPD	National Association of State Mental Health Program Directors

NENA	National Emergency Number Association
NGS	911 & Geospatial Services Bureau (within VDEM)
OEMS	Office of Emergency Medical Services (within VDH)
OJP	Office of Justice Programs
PSAP	Public Safety Answering Point
REACH	Regional Education Assessment Crisis Services Habilitation
RMS	Record Management System
SAMHSA	Substance Abuse and Mental Health Services Administration
TDO	Temporary Detention Order
VDEM	Virginia Department of Emergency Management
VDH	Virginia Department of Health

Glossary

23-hour observation center: a home-like atmosphere in which individuals can receive crisis stabilization services for up to 23 hours. A variety of services may be offered, including peer services and medical services. Individuals may be referred to a 23-hour observation center from a CITAC. Such centers may also be referred to an **enhanced CITAC**, a **crisis receiving center (CRC)** or a **psychiatric emergency center (PEC)**. Use of the terms CRC or PEC generally indicate a more robust array of services.

Co-response team (CRT): an interdisciplinary team of first responders and behavioral health professionals that presents when an emergency situation necessitates a behavioral health response. The first responders could be police, fire, or paramedics/emergency medical technicians (EMTs). The behavioral health professionals could be peer recovery specialists, master's-level clinicians, etc.

Crisis Intervention Team Assessment Center (CITAC): a site where individuals can receive pre-admission screening to determine the level of care required to manage their behavioral health emergency. This is a site where law enforcement can bring individuals who are under an Emergency Custody Order (ECO) to be evaluated instead of jail and/or a hospital emergency room. These sites may also provide additional services, in which case they might also be referred to as crisis receiving centers.

Crisis Now Model. The Crisis Now Model is a national model for a comprehensive community based crisis continuum. The components include high-technology regional or statewide call centers, mobile crisis response that can respond 24/7 in the community, crisis receiving centers or other "place based" supports that do not turn people in crisis away, and essential principles and policies including a recovery orientation, trauma-informed care, suicide safer care, coordination with law enforcement, and others. Virginia has been aligning community based crisis investments with the Crisis Now model recently through STEP-VA and Project BRAVO.

Crisis stabilization unit (CSU): a home-like, residential crisis stabilization unit that allows individuals who are experiencing a behavioral health crisis to stay short-term (generally, three to ten days). This can also be a step-down level of care for individuals being discharged from an inpatient psychiatric facility.

Hazard list: a list of information that may be relevant to first responders. For example, a note may be recorded indicating that there is an individual who uses a wheelchair living in a fourth-floor apartment. This may also be referenced to as a special needs list or a list of flagged residences.

Intercept 0: community based behavioral health services, including the crisis continuum. Intercept 0 was added to the Sequential Intercept Model to highlight that when community based behavioral health services are accessible in the community, they serve as the "ultimate intercept," because no intercept/diversion would be needed if individuals receive the care they need.

Intercept 1: the first diversion point in the Sequential Intercept Model. This intercept refers to the point at which individuals begin to interact with law enforcement (for example, by call 9-1-1). See: Sequential Intercept Model.

Law enforcement agency (LE): an umbrella term used here to refer to police departments, including college/university campus police departments, sheriff's offices, and divisions of the Virginia State Police.

Living Room Model: "The Living Room Model is a walk-in respite center for individuals in crisis. These home-like environments offer a courteous and calming surrounding for immediate relief of crisis symptoms and to avert psychiatric hospitalization…The Living Room Model is distinctly different from the 23-hour crisis stabilization units. The Living Room Model provides crisis resolution and treatment for those who need more than 24 hours to resolve the issues that brought them into crisis, are short term and provide intensive treatment (CITAC Expansion Plan, 2020)."

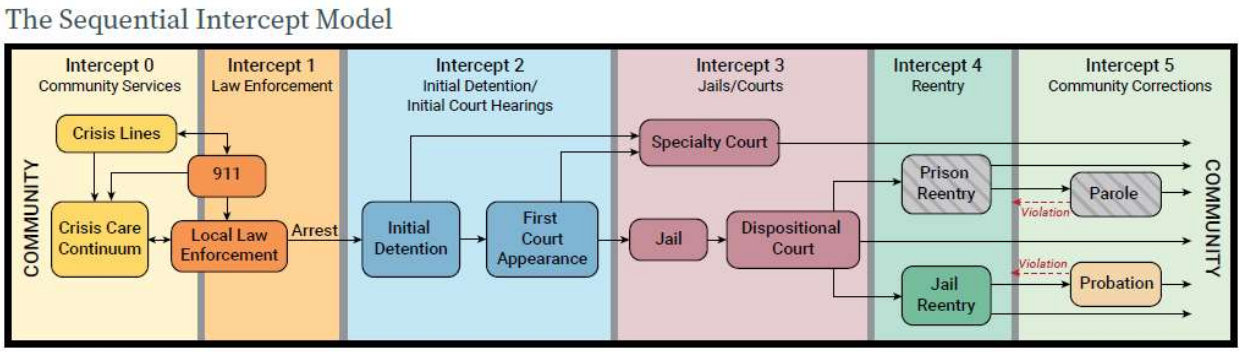
Mobile crisis team (MCT): a team of behavioral health professionals that deliver services to individuals wherever they are located. The behavioral health professionals could be peer recovery specialists, master's-level clinicians, etc.

Peer support professional: an umbrella term that includes peer recovery specialists and family support partners.

Public Safety Answering Point (PSAP): a call center where calls to 911 from mobile and landline subscribers are answered. It may also be referred to as a **department of emergency communications (DEC)** or a public safety access point.

Qualified mental health professional (QMHP): an individual with a degree in human services or a related field (e.g., social work, marriage and family counseling, art therapy, etc.) and upwards of 500 hours of direct, supervised experience working with individuals with mental illness within the last five years. A QMHP must be registered with the Board of Counseling. See the Board of Counseling's webpage for a full list of requirements.

Sequential Intercept Model (SIM). The Sequential Intercept Model demonstrates how individuals with mental health disorders and substance use can be diverted from the criminal justice system at different intercept points (e.g., arrest, initial court hearings, re-entry). The model was expanded to include **Intercept 0: Community Services** after previously beginning with **Intercept 1: Law Enforcement** to highlight the role of community services in diverting from law enforcement interactions.



Overview of State Plan

The Marcus-David Peters Act is 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 Ralph Northam. The Act modifies the Code of Virginia to add ***§ 9.1-193. Mental health awareness response and community understanding services (Marcus) alert system, law-enforcement protocols***, which outlines the role of DCJS and local law enforcement in the development of three protocols for behavioral health crisis situations, sets seventeen goals for law enforcement participation in the Marcus Alert system, assigns purview between DCJS and DBHDS, and requires localities to develop a voluntary database. The Act also modifies the Code of Virginia to add ***§ 37.2-311.1. Comprehensive crisis system, Marcus alert system, powers and duties of the Department related to comprehensive mental health, substance abuse, and developmental disability crisis services.*** This requires DBHDS to develop a comprehensive crisis system based on national best practice models and composed of a crisis call center, community care and mobile crisis teams, crisis stabilization centers, and the Marcus Alert system. It also requires DBHDS, in collaboration with DCJS and a range of stakeholders, to develop a written plan for the development of the Marcus Alert system, which is represented in this document.

It is important to note that the implementation of the Marcus-David Peters Act refers to the Act in its entirety, including state components of the comprehensive crisis system (e.g., regional call centers, STEP-VA mobile crisis).
A local Marcus Alert system, which is the responsibility of localities to implement, is primarily defined as a voluntary database, three protocols, and the plan for law enforcement engagement with the system and how community coverage will be achieved leveraging both state and local crisis supports. Protocols and plans must meet the minimum standards described in Section III of this plan and be approved.

The state implementation plan is the result of a collaborative process between Virginia DBHDS, Virginia DCJS, 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 implementation plan that are statewide (including the comprehensive crisis system as well as statewide aspects of the Marcus Alert system); it includes a four-level framework for categorizing crisis situations, regional coverage by STEP-VA mobile crisis teams and associated Medicaid rates, 988/regional call centers, a statewide Equity at Intercept 0 Initiative, and statewide training standards. The third section describes the requirements for localities to implement their local Marcus Alert system, which include the local planning process, minimum standards and best practices for local law enforcement involvement in the Marcus Alert system across the three protocols, 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 implementation will be assessed.

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. 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 as possible from the individuals themselves. 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; furthermore, 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).

The envisioned, robust crisis response system serves Virginians in the community with their natural supports. All interventions are trauma-informed and 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. A robust crisis response system is a collaborative effort across not only governmental agencies but also all healthcare payers, including those providing support for the uninsured, to ensure that an appropriate, health-focused response is available to *anyone*, *anywhere*, *anytime*.

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 911. 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 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, providing 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. Building a crisis system that is effective and accessible includes consideration of indirect, systemic influences on the emergence and stabilization of law enforcement as the *de facto* crisis response. These influences include historical 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. 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. 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. In the envisioned system, we seek to 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).

The vision for Virginia's crisis system is a shift away from today's *de facto* reliance on law enforcement and emergency room settings 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 in which 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., traditional first responders) who know how to triage behavioral health crises, have basic/general skills for interacting with individuals in behavioral health crisis, and have up-to-date 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 they are not a

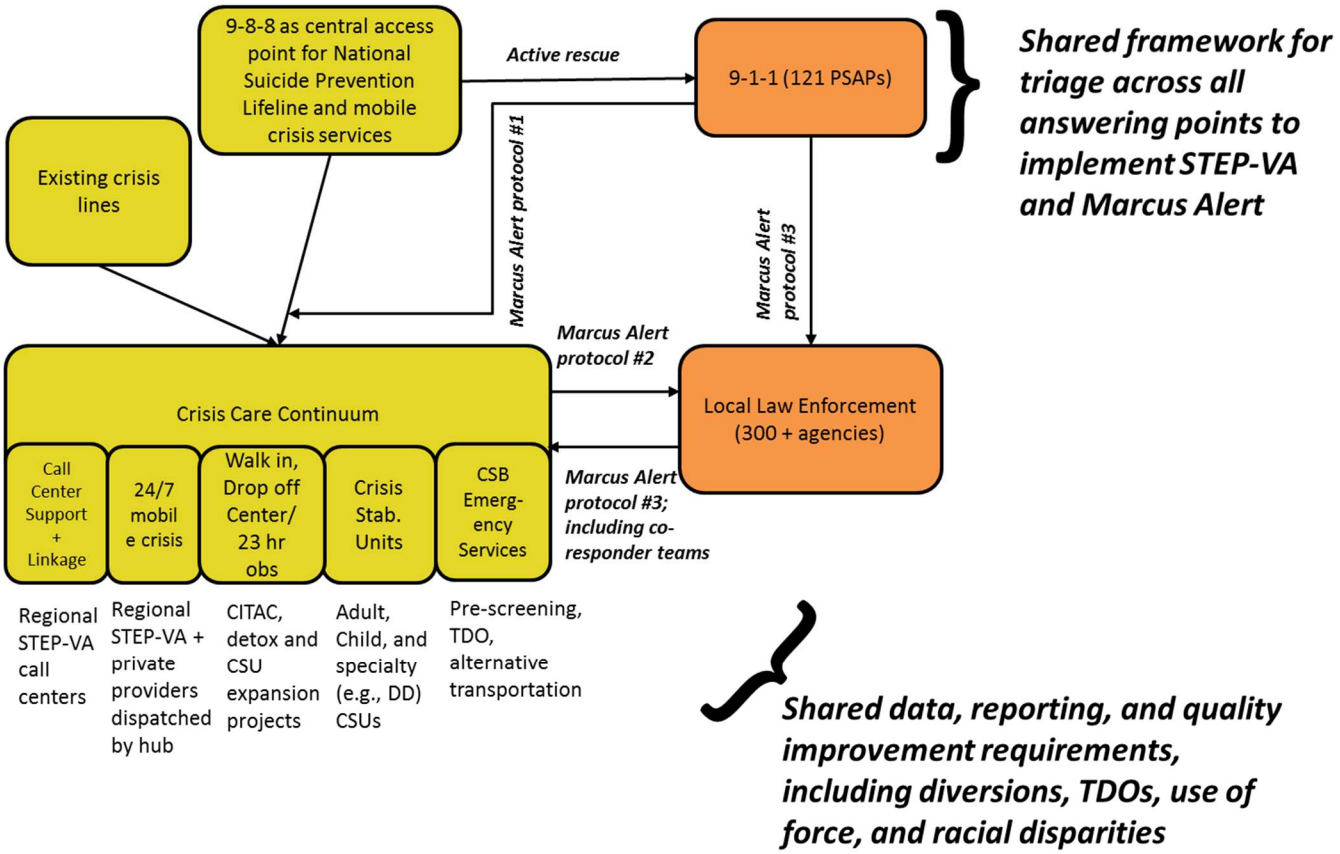
substitute for the behavioral health crisis care itself. LE and EMS are partners for triage as well as the coordination of any safety and health needs that go beyond the skills and abilities of the behavioral health crisis system.

We 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 responsibility within 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 that 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. We acknowledge that there are costs associated with supporting law enforcement in shifting 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 recognize the potentially under-identified costs for 911 PSAPs to implement this legislation. We make fiscally efficient and collaborative plans to ensure the health-focused supports are built as a priority, avoiding blanket assumptions about any agency's ability to absorb costs and working 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 and acknowledge a range of system pressures on the public behavioral health service system. 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 setbacks or stalemates, and an inclusive approach to ensure that Virginians, particularly those who have experienced harms under the existing system, provide meaningful input into the implementation and ongoing development of the crisis continuum.

Figure 1 provides a heuristic of the vision for Virginia's comprehensive crisis system, including a community based crisis continuum and a number of Marcus Alert-related supports for diversion from law enforcement involvement (Intercept 1, depicted in Orange) to the community based crisis continuum (Intercept 0, depicted in Yellow).

Figure 1. Components of a Comprehensive Crisis System

This is a visual heuristic of component of comprehensive crisis system, including a community-based crisis service continuum and pathways for diversion and coordination between law enforcement and behavioral health.



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 A. The full workgroup met 12 times between January, 2021 and May, 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. Other states have had separate initiatives to build out the crisis services continuum and/or to define and implement law enforcement reforms; therefore, 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 911 dispatch and co-responder models, implicit bias, peer roles throughout the continuum, considerations for youth, community accountability, 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. A complex adaptive system is a system where there are many elements at play, elements are heterogeneous, and internal dynamics are difficult to predict and describe. 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. 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. In total, a convenience sample of 681 individuals responded to the survey. Responses were received by individuals with family experience (61%), personal experience (35%), professional experience (24%), and no experience/potential experience (11%). Note that percentages do not add to one hundred, these groups overlap because respondents could identify with more than one group. Also, respondents were not required to answer questions: They were permitted to skip any questions that they preferred not to answer. Survey results are included throughout the report and in Appendix D, and sample characteristics are provided here:

Subpopulation	Count	Percentage
Family Experience with Behavioral Health Crisis	418	61%
Personal Experience with Behavioral Health Crisis	235	35%
Professional Experience with Behavioral Health Crisis	165	24%
Potential Experience with Behavioral Health Crisis	74	11%

Race	Count	Percentage
Asian	6	1%
Black or African American	76	11%
Native American or American Indian or Alaska Native	13	2%
Native Hawaiian or Pacific Islander	3	0%
White or Caucasian	371	54%
Other	28	4%

Ethnicity	Count	Percentage
Hispanic/Latino/Latina/Latinx	30	4%
Not Hispanic/Latino/Latina/Latinx	430	63%
Declined to Answer	221	32%

The Triage workstream focused on the role of 911/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, 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

To catalog the current crisis system, a survey was disseminated to CSBs, CIT programs, LE agencies, and PSAPs. Lists of potential respondents were compiled with the aid of DCJS, the Virginia CIT

Coalition, and the Virginia Department of Emergency Management 911 & Geospatial Services Bureau (VDEM NGS). Of the 40 CSBs, 28 (70%) completed the survey. Of the 124 primary[1] PSAPs that were contacted, 59 (48%) completed the survey. Additionally, two non-primary PSAPs completed the survey. Of the 404 law enforcement agencies that were contacted[2], 95 (24%) completed the survey. Seventeen (45%) of the 38 CIT programs that were contacted completed the survey. Finally, nineteen of the 37 CIT assessment centers (CITAC) were represented among the responses. A list of all entities to which the inventory survey was disseminated is available in Appendix C.

Survey responses that were submitted after the end of the survey administration period or via a mechanism other than the online survey (e.g., an emailed PDF) are not included here. Fewer than five responses across all respondent groups were excluded for these reasons. In the infrequent instances in which more than one response was received from the same entity, the most recent response was used for the analysis presented here. For localities where surveys were not submitted, the inventory will be a required component of the local Marcus Alert plan submission.

Community Services Board Respondents

Through STEP-VA, community services boards have been situated as the primary gateway to the public behavioral health system (see additional information in this section). Moreover, with recent STEP-VA investments in regional adult and youth mobile crisis teams, coverage for the Marcus Alert system could theoretically be achieved utilizing only DBHDS-funded mobile crisis teams, particularly for areas with low population density that will see fewer individuals in crisis seeking help each month (see Figures 26 through 33). Thus, CSBs were a key stakeholder to survey to create an inventory of the current crisis system.

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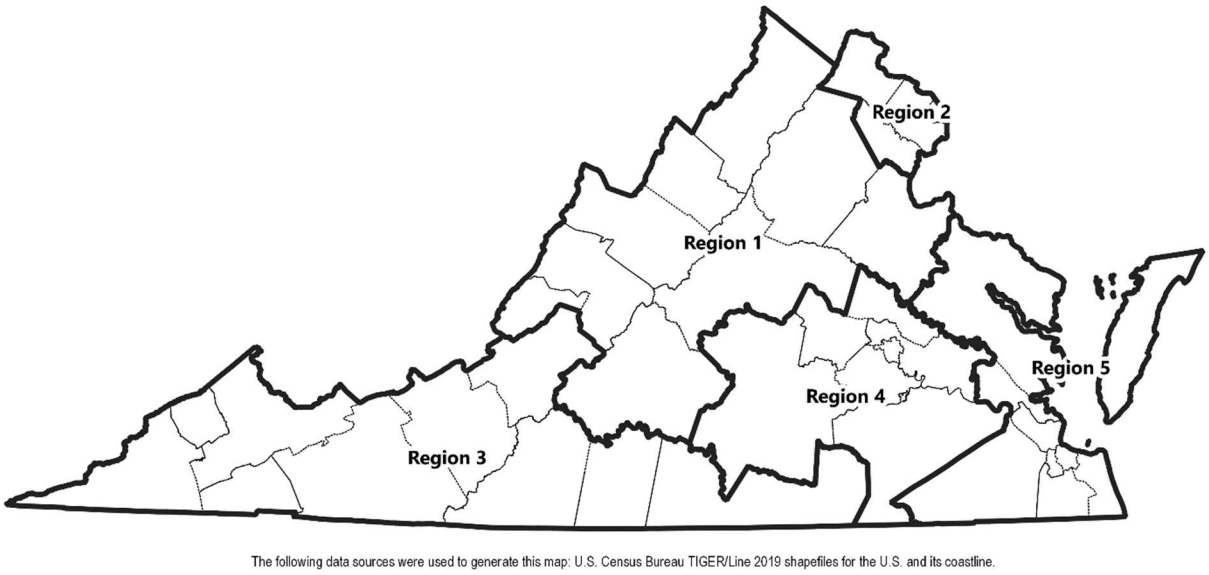
[1] Per VDEM NGS, primary PSAPs are those that received funding from VDEM NGS for the Next Generation 911 (NG911) initiative. In Virginia, the NG911 initiative is the transition from nine analog (copper wire) telephone networks to one internet protocol (IP) telephone network that is dedicated to emergency communications. For more information about Virginia's transition to NG911, see this dashboard created by VDEM NGS. Additional information about the objectives of the national NG911 initiative can be found here, a June 2019 national NG911 roadmap is available here.

[2] Ten law enforcement agencies could not be contact due to missing or inaccurate contact information; they are listed in Appendix D.

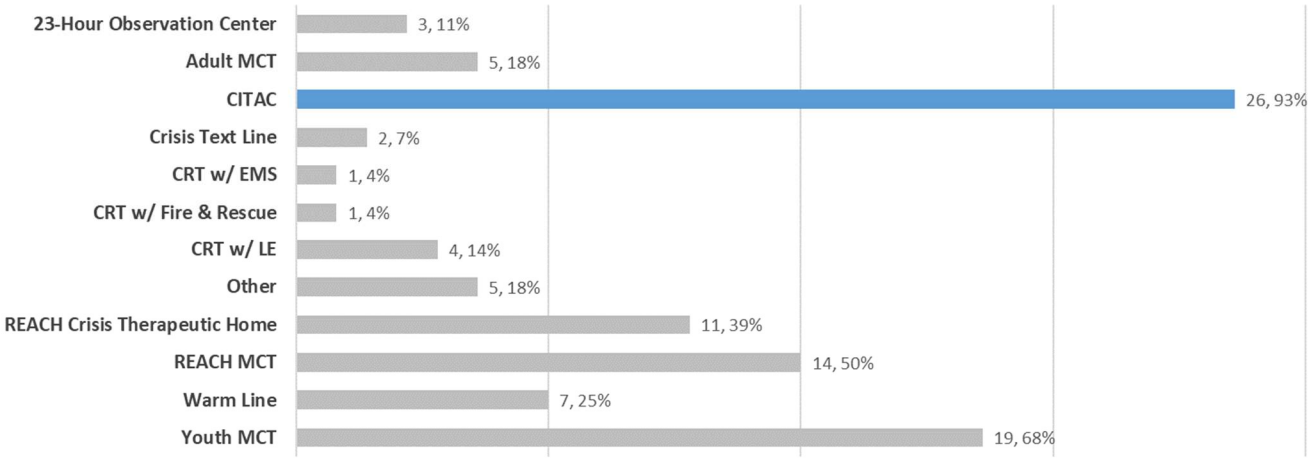
Figure 2. Map of DBHDS Regions



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.

The distribution of the key components of a comprehensive crisis system among the 28 CSB respondents is depicted in Figure 3 on the next page. Almost all CSB respondents (26, 93%) indicated that there is at least one CITAC within their respective catchment areas. CITACs primarily serve as non-hospital locations where crisis evaluations can occur and law enforcement can transfer custody of individuals under ECO (discretionary hand-off); see the CITAC Respondents section for additional information about the services that they offer and the populations that they serve. The second most common crisis system component reported among CSB respondents was a youth MCT. This is not surprising given the recent investments in youth MCTs through STEP-VA. Similarly, the third most common crisis component, the REACH MCT, has been prioritized in recent years due to its intersection with the Department of Justice Settlement Agreement. Currently, among CSB respondents, the prevalence of co-response teams (CRTs), which partner behavioral health professional with traditional first responders like emergency medical services (EMS) or law enforcement, is low. Some localities may choose to start CRTs or enhance their CRT capacity in order to ensure community coverage for Level 3 or 4 Marcus Alert calls (see section on options to achieve community coverage). Henrico CSB reported its Services to Aid Recovery program as an "Other" component of a comprehensive crisis system, Highland CSB noted having adult ambulatory crisis stabilization. Notably, no CSB respondents reported having peer-operated respites within their respective catchment areas. There were also no novel police-mental health collaborations reported: Respondents cited CIT programs and CITACs.

Figure 3. Distribution of Crisis System Components among CSB Respondents



Crisis Stabilization Units

The CSU is an essential component of a comprehensive crisis system. Crisis stabilization units play a key role in supporting individuals who may require an extended period of out-of-home care—but not the sort of high-acuity care provided in inpatient psychiatric hospitals—to return to their pre-crisis baselines. This crisis system component is currently available throughout the Commonwealth as a regional asset, meaning that all CSBs within a given DBHDS region (see Figure 2) utilize the CSU, even though it is located within one CSBs catchment area. All DBHDS-funded CSUs that are currently available throughout the Commonwealth are depicted in Figure 4. Note that the CSU that is currently located within the Prince William CSB catchment area will be closed shortly, it will be replaced by a new CSU located within the Fairfax CSB catchment area.

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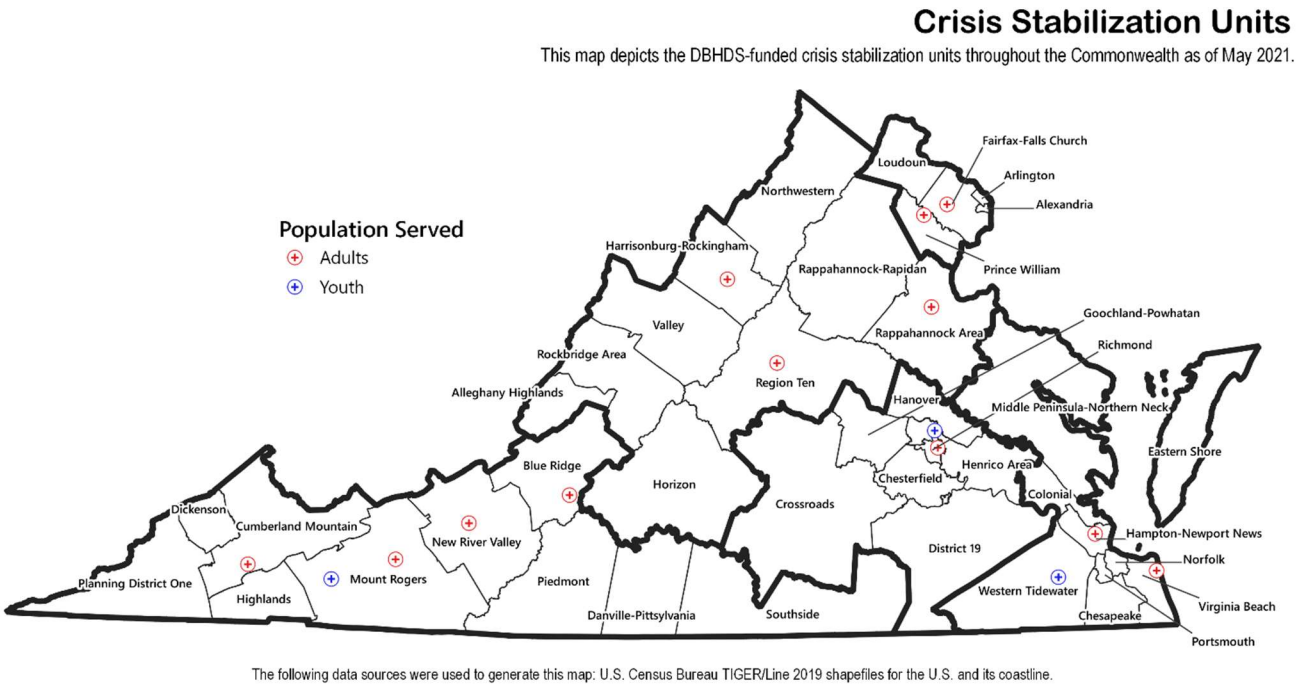
Figure 4. Map of CSUs Currently Funded by DBDHS[3]



As noted above, CSUs are designed to be therapeutic alternatives to inpatient psychiatric hospitalization. Though a Living Room Model is distinct from a CSU, comfortable, home-like elements associated with the Living Room Model can be incorporated into a CSU to promote recovery. For instance, the Mount Rogers CSB respondent reported that the youth-serving Hospital Avenue CSU within the catchment area is equipped with couches or lounge furniture, outdoor space, and a television while the adult-serving Monroe Street CSU has private bathrooms, showers, and rooms in addition to couches or lounge furniture, outdoor space, and a television. Similarly, CSB respondents reported that the Shirley Gate CSU within the Fairfax CSB catchment area private bathrooms, private showers, couches or lounge furniture, and a television.

Physical location of a CSU is another key factor in creating a recovery-oriented, health-focused environment in which individuals in crisis can be evaluated, stabilized, and returned to their baseline. Ideally, CSUs should not be co-located at a hospital emergency department (ED). To that end, many CSUs throughout the Commonwealth are currently co-located at CSB headquarters or located in stand-

[3] Note that the Brandon House CSU that is currently located within the Prince William CSB catchment area will be closed shortly; it will be replaced by a new CSU located within the Fairfax CSB catchment area.

alone facilities. For example, CSB respondents indicated that Brandon House CSU, Hospital Avenue CSU, Monroe Street CSU, and Shirley Gate CSU are all located in stand-alone facilities.

As noted above, CSUs that are funded by DBHDS are considered a regional asset, and, currently, there are at least two CSUs in each DBHDS region. Nonetheless, each DBHDS region does not have at least one CSU for youth: Neither DBHDS Region 1 nor DBHDS Region 2 have at least one CSU for youth. Furthermore, the maximum licensed bed capacity for each of these residential treatment locations is no greater than 16 beds (see Figure 5).

Figure 5. Adult and Youth CSU Licensed Maximum Bed Capacity

Operating CSB	Licensed Maximum Bed Capacity
Adults	
Blue Ridge	16
Cumberland Mountain	16
Fairfax-Falls Church	16
Hampton-Newport News	11
Harrisonburg-Rockingham	7
Mount Rogers	8
New River Valley	7
Prince William	6
Rappahannock Area	12
Region Ten	16
Richmond	16
Virginia Beach	16
Youth	
Mount Rogers	8
Richmond	8
Western Tidewater	5

Mobile Crisis Teams

Adults

Among the CSB respondents, five reported having a mobile crisis team (MCT) that serves adults within their respective catchment areas (see Figure 6 on the next page). The majority of these adults MCTs are staffed with certified pre-admissions screening clinicians and master's-level clinicians (80%, respectively). Slightly less than half of the CSB respondents' adult MCTs (2, 40%) have peer support professionals among their staff (see Figure 7). The hours of operation for the CSB respondents' adult MCTs varied widely (see Figure 8). Nonetheless, CSB respondents indicated that the majority of their respective adult MCTs (4, 80%) offer phone consultations outside of normal hours of operations.

Figure 6. CSB Respondents with Adult MCTs

CSB Respondent
Eastern Shore Community Services Board
Fairfax-Falls Church Community Services Board
New River Valley Community Services
Portsmouth Department of Behavioral Healthcare Services
Richmond Behavioral Health Authority

Figure 7. CSB Respondents' Adult MCT Staffing

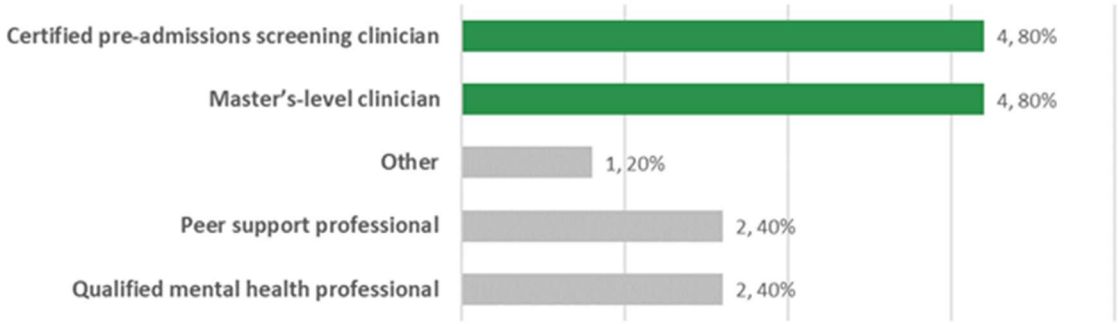


Figure 8. CSB Respondents' Adult MCT Hours of Operation

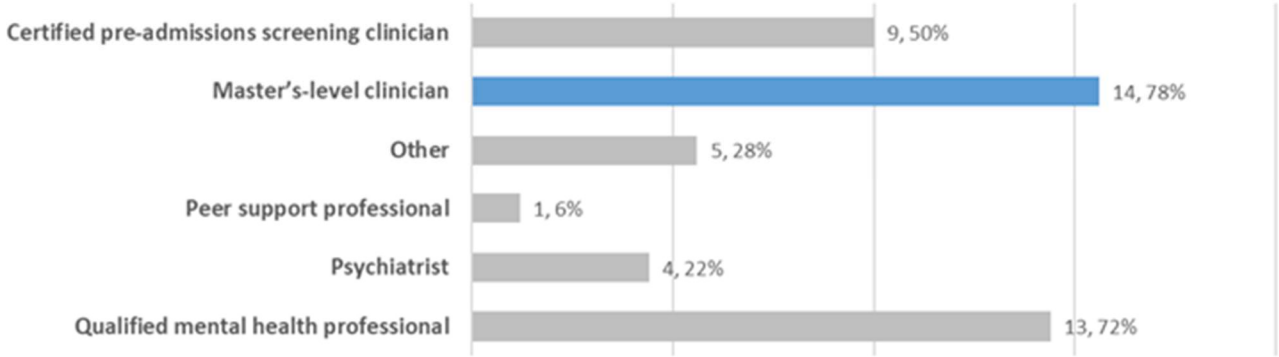
Monday		
Operating Hours	**Count of Adult MCTs**	**Percentage of Adult MCTs**
12 hours	2	40%
16 hours	1	20%
24 hours	2	40%
Tuesday		
Operating Hours	**Count of Adult MCTs**	**Percentage of Adult MCTs**
12 hours	2	40%
16 hours	1	20%
24 hours	2	40%
Wednesday		
Operating Hours	**Count of Adult MCTs**	**Percentage of Adult MCTs**
12 hours	2	40%
16 hours	1	20%
24 hours	2	40%
Thursday		
Operating Hours	**Count of Adult MCTs**	**Percentage of Adult MCTs**
12 hours	2	40%
16 hours	1	20%
24 hours	2	40%
Friday		
Operating Hours	**Count of Adult MCTs**	**Percentage of Adult MCTs**
12 hours	2	40%

16 hours	1	20%
24 hours	2	40%
Saturday		
Operating Hours	**Count of Adult MCTs**	**Percentage of Adult MCTs**
None	1	20%
12 hours	1	20%
16 hours	1	20%
24 hours	2	40%
Sunday		
Operating Hours	**Count of Adult MCTs**	**Percentage of Adult MCTs**
None	1	20%
12 hours	1	20%
16 hours	1	20%
24 hours	2	40%

Youth

As noted above, youth MCTs were one of the most prevalence components of a comprehensive crisis system reported by CSB respondents (19, 68%). As with adult MCTs, the majority of CSB respondents' youth MCTs (14, 78%) include master's-level clinicians on their respective staffs. QMHPs are reportedly the second most common type of staff on CSB respondents' youth MCTs (see Figure 9). In their "Other" write-in responses, some CSB respondents noted that their youth MCTs are staffed by a LMHP supervisor. One CSB respondent (Richmond Behavioral Health Authority) noted that its youth MCT is in the process of adding a family support staffperson, while another CSB respondent noted that its youth MCT's peer support positions are currently vacant.

Figure 9. CSB Respondents' Youth MCT Staffing Distribution



While the CSB respondents reported twice as many youth MCTs compared to adult MCTs, the hours of operation among the youth MCTs are more variable (see Figure 10). Only one youth MCT currently operates 24 hour per day, seven days per week. Unlike adult MCTs, the CSB respondents'

reports suggest that it is more common for youth MCTs to be available on Saturdays and Sundays (see Figure 10). Nonetheless, only one CSB respondent indicated that its youth MCT is available twenty-four hour per day, seven days per week: New River Valley CSB.

Figure 10. CSB Respondents' Youth MCT Hours of Operation[4]

Monday		
Operating Hours	**Count of Youth MCTs**	**Percentage of Youth MCTs**
7 hours	1	6%
8 hours	6	33%
11 hours	1	6%
12 hours	2	11%
14 hours	3	17%
16 hours	3	17%
24 hours	1	6%
Tuesday		
Operating Hours	**Count of Youth MCTs**	**Percentage of Youth MCTs**
7 hours	1	6%
8 hours	6	33%
11 hours	1	6%
12 hours	2	11%
14 hours	3	17%
16 hours	3	17%
24 hours	1	6%
Wednesday		
Operating Hours	**Count of Youth MCTs**	**Percentage of Youth MCTs**
7 hours	1	6%
8 hours	6	33%
11 hours	1	6%
12 hours	2	11%
14 hours	3	17%
16 hours	3	17%
24 hours	1	6%
Thursday		
Operating Hours	**Count of Youth MCTs**	**Percentage of Youth MCTs**
7 hours	1	6%
8 hours	6	33%
11 hours	1	6%
12 hours	2	11%
14 hours	3	17%
16 hours	3	17%
24 hours	1	6%

[4] One CSB respondent with a youth MCT terminated the survey early so there is no data on its hours of operation.

Friday		
Operating Hours	**Count of Youth MCTs**	**Percentage of Youth MCTs**
7 hours	1	6%
8 hours	6	33%
11 hours	1	6%
12 hours	2	11%
14 hours	3	17%
16 hours	3	17%
24 hours	1	6%
Saturday		
Operating Hours	**Count of Youth MCTs**	**Percentage of Youth MCTs**
None	7	39%
8 hours	1	6%
12 hours	2	11%
14 hours	3	17%
16 hours	3	17%
24 hours	1	6%
Sunday		
Operating Hours	**Count of Youth MCTs**	**Percentage of Youth MCTs**
None	7	39%
8 hours	1	6%
12 hours	2	11%
14 hours	3	17%
16 hours	3	17%
24 hours	1	6%

Co-Response Team with Emergency Medical Services

Chesterfield CSB was the only CSB respondent that reported having a CRT with EMS. However, note that, in Fairfax County, emergency medical technicians (EMTs) within the fire department participate in a co-response team (see section below). The behavioral health staff on the Chesterfield EMS CRT is a peer support professional. The behavioral health professional does ride along with EMS in the same vehicle. Chesterfield CSB reported that the members of its EMS CRT complete the full 40-hour CIT training. This EMS CRT is only dispatched when a direct referral from EMS or LE is received in response to an overdose. This response is available for eight hours per day on Monday through Friday; it is not available on Saturdays or Sundays.

Co-Response Teams with Fire & Rescue

There was only one CSB that reported having a CRT with fire and rescue: Fairfax CSB. As noted above, in Fairfax County, the EMTs within the fire department participate in the CRT. The behavioral health members of the team include a certified pre-admissions screening clinician and a peer support professional. This CRT is available six days a week (Monday through Saturday) for eight hours per day.

The behavioral health professionals who are part of the CRT do not complete CIT training; instead, they complete Mental Health First Aid training. The behavioral health professionals do not ride along in the same vehicle. Fairfax CSB reported that this CRT is dispatched collaboratively by the CSB and emergency services.

Co -Response Teams with Law Enforcement

Among the 28 CSB respondents, only four (14%) indicated that their CSB participates in a co-response team (CRT) with LE. Note that CSB respondents were instructed to record only LE CRTs that have moved beyond a pilot phase. The CSB respondents and the LE agencies with which they partner to create CRTs are listed in Figure 11.

Figure 11. CSB and Law Enforcement Agencies Partnering in CSB Respondents' CRTs

CSB Respondent	Law Enforcement Partner
Alexandria Community Services Board	Alexandria Police Department
Harrisonburg-Rockingham Community Services Board	Rockingham Co. Sheriff's Office
New River Valley Community Services	Blacksburg Police Department
	Christiansburg Police Department
	Montgomery County Sheriff's Office
Prince William County Community Services Board	Prince William County Police Department

One concern that emerged from the state planning group was the ability of specialized teams to provide adequate coverage. To that point, CSB respondents were asked to indicate the hours that their LE CRTs currently operate. As is depicted in Figure 12, the majority of the CSB respondents' LE CRTs (3, 75%) operate for eight hours per day Monday through Friday.

Figure 12. Distribution of CSB Respondents' LE CRTs Hours of Operation

Monday		
Operating Hours	**Count of LE CRTs**	**Percentage of LE CRTs**
12 hours	1	25%
8 hours	3	75%
Tuesday		
Operating Hours	**Count of LE CRTs**	**Percentage of LE CRTs**
14 hours	1	25%
8 hours	3	75%
Wednesday		
Operating Hours	**Count of LE CRTs**	**Percentage of LE CRTs**
14 hours	1	25%
8 hours	3	75%
Thursday		
Operating Hours	**Count of LE CRTs**	**Percentage of LE CRTs**
14 hours	1	25%

8 hours	3	75%
Friday		
Operating Hours	**Count of LE CRTs**	**Percentage of LE CRTs**
10 hours	1	25%
8 hours	3	75%

All CSB respondents reported that their LE CRTs are staffed with certified pre-admissions screening clinicians; half reported that their CRTs include master's-level clinicians. The CSB respondents reported that all of their respective LE CRTs have the behavioral health members complete CIT training. Three of the four LE CRTs have the behavioral health professionals complete the full 40-hour CIT training.

Throughout the state planning process, discussions were had regarding the importance of team presentation and other factors that promote cohesion among behavioral health and law enforcement members of a LE CRT. To that end, CSB respondents were asked several questions to access the prevalence of these factors among existing LE CRTs. For the majority of the CSB respondents' LE CRTs (3, 75%), participating in a CRT is a permanent duty assignment for the law enforcement members. Furthermore, three of the four CSB respondents' LE CRTs have behavioral health clinicians and law enforcement ride together in the same vehicle. Per CSB respondents, two of their respective LE CRTs have LE members wear soft uniforms, one respondent terminated the survey early and did not respond to this question. Three of the LE CRTs' law enforcement members wear gun belts, one respondent terminated the survey early and did not respond to this question.

High-Frequency Utilizers

CSB respondents were also asked whether their boards maintain a list of individuals who frequently interface with the CSBs. Among the respondents, five (18%) indicated that their CSBs maintain such a list. Four of those five respondents noted that their CSBs have a board or committee that routinely reviews the list: Arlington County Community Services Board, Mount Rogers Community Services Board, Norfolk Community Services Board, and Prince William County Community Services Board.

Of the four high-frequency consumer committees reported by CSB respondents, two are interdisciplinary. One CSB respondent with an interdisciplinary committee reported that its high-frequency user committee included representatives from EMS, fire and rescue, social services, and state psychiatric facilities in addition to CSB staff. The second CSB respondent with an interdisciplinary high-

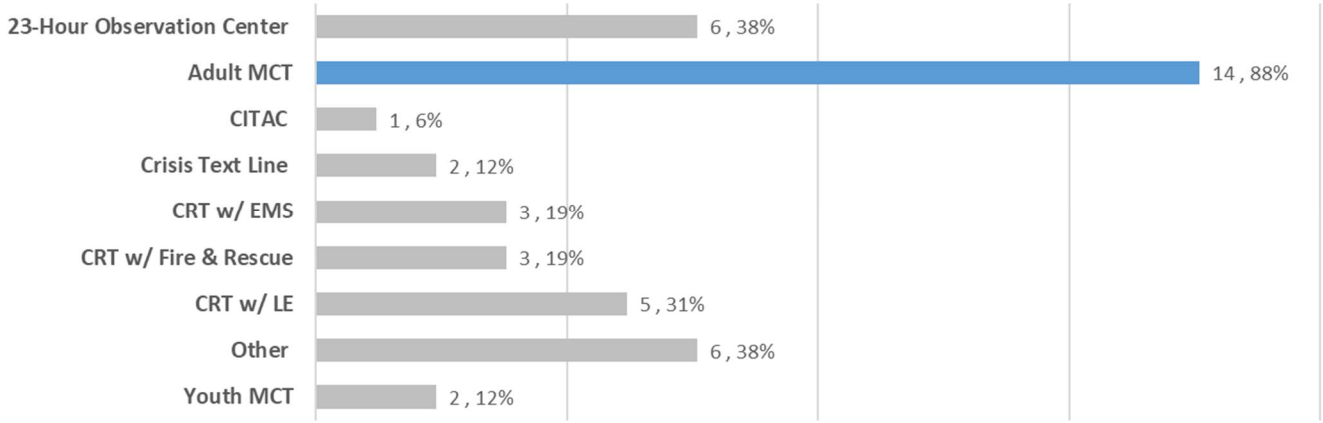
frequency user committee reported that representatives from social services, state psychiatric facilities, and consumers' guardians and parents are among the members.

Upcoming Crisis System Components

Since local plans for the Marcus Alert system are not due until July 1, 2022, except for the initial five areas, CSB respondents were asked to identify any components of a comprehensive crisis system that are slated to be available during state fiscal year (FY) 2022. Sixteen of the 28 CSB (57%) respondents indicated that components would be added to their respective CSB catchment areas during FY 2022. Of those 16 CSB respondents that will be adding additional crisis system components, the majority (14, 88%) plan to add at least one adult MCT (see Figure 13). A table detailing the upcoming components that each CSB respondent reported is in Appendix C.

Figure 13. Distribution of Upcoming Crisis System Components[5]

Note that this is only among CSB respondents that indicated components would be added in FY 2022.



Stepping Up Initiative

For the stake of comprehensiveness, CSB respondents were asked if any jurisdictions within their catchment areas participate in the Stepping Up Initiative. The Stepping Up Initiative is a county-level effort to reduce the prevalence of individuals with mental health diagnoses in jails that is sponsored by the Council of State Governments Justice Center. Five CSB respondents indicated that they have a county that participates in the Stepping Up Initiative within their respective catchment areas (see Figure 14 on the next page).

[5] A CSU will be added within the Fairfax CSB catchment area, however, it will be a replacement for the Brandon House CSU within the Prince William CSB catchment area.

Figure 14. CSB Respondents' Jurisdictions Participating in the Stepping Up Initiative

CSB Respondent	Jurisdiction Participating in Stepping Initiative
Arlington County Community Services Board	Arlington County
Fairfax-Falls Church Community Services Board	Fairfax County
Harrisonburg-Rockingham Community Services Board	Rockingham County
Loudoun County Department of MH, SA and Developmental Services	Loudoun County
Norfolk Community Services Board	Virginia Beach City

Crisis Intervention Team Respondents

Currently, there are thirty-eight CIT programs throughout the Commonwealth: They are primarily organized by CSB catchment areas (see list in Appendix C). By partnering with neighboring CIT programs, all CSBs have access to CIT. Representatives from all thirty-eight CIT programs did not respond to the survey. As with the CSB respondents, the results discussed here pertain to information provided by CIT respondents to the inventory survey.

The vast majority of CIT respondents indicated that neighboring CSBs do not participate in their respective programs. Still, Loudoun CIT reported that Alexandria CSB participates in its program. Of course, LE agencies are an essential participant in CIT programs. As is depicted in Figure 15, multiple LE agencies participate in each CIT program. Representatives from PSAPs are another key participant in CIT program. In fact, 83% of CIT respondents indicated that they have PSAP participants in their respective programs (see Figure 16 on the next page).

Core CIT training consists of 40 hours. Curricula vary by CIT program, however, DBHDS has published guidance regarding essential elements of a CIT program. Often CIT programs offer advanced training beyond the base 40 hours for those who are interested. Slightly more than half of the CIT respondents (9, 53%) noted that they do not offer advanced training beyond 40 hours.

Figure 15. Law Enforcement Participants in CIT Respondents' Programs

CIT Respondent	Participating LE Agencies
Alexandria CIT	Alexandria City Sheriff's Office
	Alexandria Police Department
Arlington County CIT	Arlington County Police Department
	Arlington County Sheriff's Office
	Metro Washington Airport Authority Pd
Blue Ridge CIT	Augusta County Sheriff's Office
	Blue Ridge Community College Pd
	Highland County Sheriff's Office
	Staunton City Sheriff's Office
	Staunton Police Department

	Virginia School For The Deaf And Blind Campus Pd
	Virginia State Police Area 17
	Waynesboro City Sheriff's Office
	Waynesboro Police Department
Danville-Pittsylvania CIT	Danville City Sheriff's Office
	Danville Police Department
	Gretna Police Department
	Hurt Police Department
	Pittsylvania County Sheriff's Office
	Virginia State Police Area 43
Fairfax CIT	Fairfax City Police Department
	Fairfax County Police Department
	Fairfax County Sheriff's Office
	Falls Church Police Department
	George Mason University Police Dept.
	Herndon Police Department
	Metro Washington Airport Authority Pd
	Northern Va Community College Pd
	Vienna Police Department
Greater Prince William CIT	Haymarket Police Department
	Manassas City Police Department
	Manassas Park City Police Dept.
	Prince William County Police Department
	Prince William County Sheriff's Office
	Virginia State Police Area 11
Harrisonburg-Rockingham CIT	Bridgewater College Police Department
	Bridgewater Police Department
	Broadway Police Department
	Dayton Police Department
	Elkton Police Department
	Grottoes Police Department
	Harrisonburg Police Department
	James Madison University Police Department
	Rockingham Co. Sheriff's Office
	Timberville Police Department
	Virginia State Police Area 16
Henrico CIT	Charles City County Sheriff's Office
	Henrico County Division Of Police
	Henrico County Sheriff's Office
	New Kent County Sheriff's Office
Highlands CIT	Abingdon Police Department
	Bristol City Sheriff's Office
	Bristol Police Department
	Damascus Police Department
	Glade Spring Police Department
	Virginia State Police Area 4

	Washington County Sheriff's Office
Loudoun County CIT	Leesburg Police Department
	Loudoun County Sheriff's Office
	Metro Washington Airport Authority Pd
	Purcellville Police Department
Lynchburg-Central Virginia CIT	Amherst County Sheriff's Office
	Amherst Police Department
	Appomattox County Sheriff's Office
	Bedford County Sheriff's Office
	Bedford Police Department
	Campbell County Sheriff's Office
	Central Virginia Community College Pd
	Liberty University Police Department
	Lynchburg City Sheriff's Office
	Lynchburg Police Department
New River Valley CIT	Blacksburg Police Department
	Carilion Clinic Police Department - Roanoke
	Christiansburg Police Department
	Dublin Police Department
	Floyd County Sheriff's Office
	Giles County Sheriff's Office
	Montgomery County Sheriff's Office
	Narrows Police Department
	Pearisburg Police Department
	Pembroke Police Department
	Pulaski County Sheriff's Office
	Pulaski Police Department
	Radford City Sheriff's Office
	Radford Police Department
	Radford University Police Department
	Virginia Tech Pd
Norfolk CIT	Norfolk City Sheriff's Office
	Norfolk International Airport PD
	Norfolk Police Department
	Norfolk State University Police Department
Northwestern CIT	Berryville Police Department
	Clarke County Sheriff's Office
	Frederick County Sheriff's Office
	Front Royal Police Department
	Lord Fairfax Community College Police Department
	Luray Police Department
	Middletown Police Department
	Mount Jackson Police Department
	New Market Police Department
	Page County Sheriff's Office
	Shenandoah County Sheriff's Office

	Shenandoah Police Department
	Stanley Police Department
	Stephens City Police Department
	Strasburg Police Department
	Virginia State Police Area 13
	Virginia State Police Area 14
	Warren County Sheriff's Office
	Winchester City Sheriff's Office
	Winchester Police Department
	Woodstock Police Department
Planning District 1 CIT	Appalachia Police Department
	Big Stone Gap Police Department
	Coeburn Police Department
	Gate City Police Department
	Jonesville Police Department
	Lee County Sheriff's Office
	Mountain Empire Community College Campus Pd
	Norton City Sheriff's Office
	Norton Police Department
	Pennington Gap Police Department
	Pound Police Department
	Saint Paul Police Department
	Scott County Sheriff's Office
	University of Virginia College at Wise PD
	Weber City Police Department
	Wise County Sheriff's Office
	Wise Police Department
Rockbridge-Bath CIT	Bath County Sheriff's Office
	Buena Vista Police Department
	Buena Vista Sheriff's Office
	Csx Transportation Police
	Glasgow Police Department
	Lexington Police Department
	Norfolk Southern Railway Police
	Rockbridge County Sheriff's Office
	Virginia Military Institute Police Department
	Virginia State Police Area 39
Virginia Beach CIT	Virginia Beach City Sheriff's Office
	Virginia Beach Police Department

Figure 16. Law Enforcement Participants in CIT Respondents' Programs

CIT Respondent	Participating PSAPs
Alexandria CIT	Alexandria (FCC ID: 7079)
Arlington County CIT	Falls Church (FCC ID: 7124)
Blue Ridge CIT	Augusta (FCC ID: 7085)
	Highland (FCC ID: 7146)

	Staunton (FCC ID: 7211)
	Waynesboro (FCC ID: 7223)
Danville-Pittsylvania CIT	Danville (FCC ID: 7116)
	Pittsylvania (FCC ID: 7181)
Fairfax CIT	Fairfax (FCC ID: 7123)
Greater Prince William CIT	Manassas (FCC ID: 7162)
	Prince William (FCC ID: 7186)
Harrisonburg-Rockingham CIT	Harrisonburg-Rockingham (FCC ID: 7144)
Henrico CIT	Henrico (FCC ID: 7145)
	New Kent (FCC ID: 7170)
Highlands CIT	Bristol (FCC ID: 7091)
	Washington (FCC ID: 7222)
Lynchburg-Central Virginia CIT	Amherst (FCC ID: 7082)
	Appomattox (FCC ID: 7083)
	Bedford (FCC ID: 7087)
	Campbell (FCC ID: 7095)
	Lynchburg (FCC ID: 7160)
New River Valley CIT	Floyd (FCC ID: 7127)
	Giles (FCC ID: 7134)
	New River Valley (FCC ID: 8501)
	Pulaski (FCC ID: 7187)
	Radford (FCC ID: 7188)
Planning District 1 CIT	Lee (FCC ID: 7156)
	Norton (FCC ID: 7174)
	Scott (FCC ID: 7197)
	Wise (FCC ID: 7229)
Rockbridge-Bath CIT	Bath (FCC ID: 7086)
	Rockbridge (FCC ID: 7194)
Virginia Beach CIT	Virginia Beach (FCC ID: 7218)

Crisis Intervention Team Assessment Center Respondents

As noted above, CITACs are an essential component of a comprehensive crisis system that allows law enforcement to transfer custody of an individual who is to be evaluated involuntarily under an emergency custody order (ECO). Most CITACs are coordinated by CIT program coordinators; however, that is not always the case, so the CITAC respondents are presented separately here. Among the CITAC respondents, two represented a CITAC alone, not a CITAC and its associated CIT program.

In general, there is a one-to-one relationship between CIT programs and CITACs. Nonetheless, three CIT programs currently have two associated CITACs: Southside CIT, Arlington County CIT, and Greater Prince William CIT. The results are presented separately here for primary and secondary CITACs. For CIT programs with one associated CITAC, the term “primary” is still utilized for ease of discussion.

Though CITACs are typically thought of as location for discretionary LE drop-offs (see Appendix C for a list of LE agencies that utilize respondents' CITACs), a variety of professionals can refer individuals to a CITAC for crisis evaluation and other services. For instance, many respondents indicated that their primary CITACs accepted referrals from CSB case managers (10, 53%), private behavioral health providers (9, 47%), hospital emergency department staff (9, 47%), EMS (7, 37%), and fire and rescue (7, 37%). Almost half of respondents' primary CITACs (9, 47%) also accept self-referrals. Some respondents noted that their CITACs also accept referrals from public and private grade schools, colleges and universities, primary care physicians, and parole and probation officers. It is important to note that several respondents indicated that their respective CITACs only serve individuals who are under an ECO.

In addition to accepting referrals from various professionals, CITACs can offer an expanded array of services (c.f., October 2020 CITAC Expansion Plan). More than one-half of CITAC respondents' primary CITACs (10, 53%) have the ability to perform medical screenings. The majority of respondents' CITACS (14, 74%) offer peer support services. Access to services such as case management (4, 21%) and pharmacy (2, 11%) are less common among respondents' CITACs. One CITAC respondent, New River Valley CSB, noted in an "Other" write-in response that it will be significantly expanding its service array to include peer services, case management, expedited medical clearance, and medication access as of July 2021.

As with other components of a comprehensive crisis system, there are limits to CITACs' capacity. Most respondents' primary CITACs can accommodate a maximum total of fewer than 10 individuals at any given time (see Figure 17). For primary CITACs that can accept individuals who are not in LE custody under an ECO, the maximum capacity for individuals under ECO is often lower than the maximum capacity (see Figure 18 on the next page).

Figure 17. Maximum Total Capacity of CSB Respondents' Primary CITACs

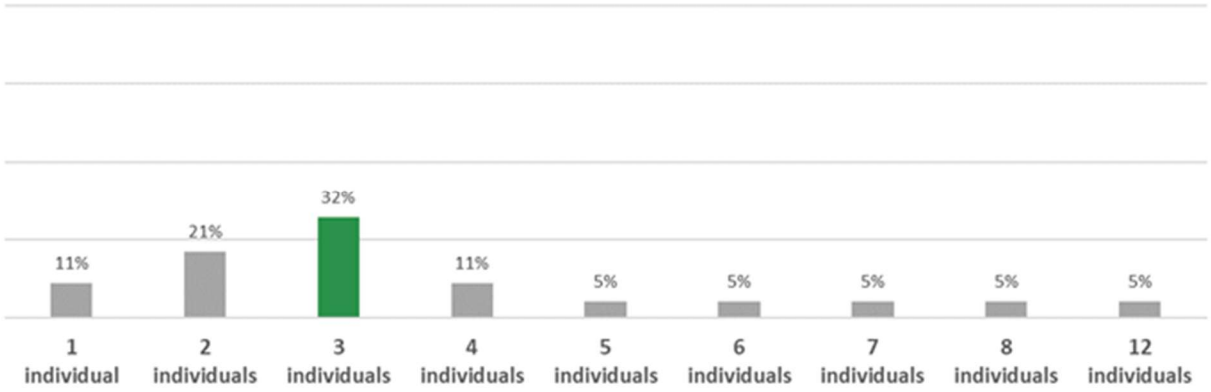
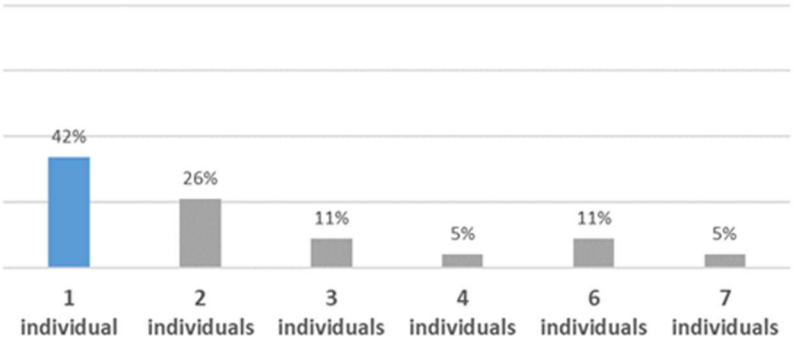


Figure 18. Maximum Capacity for Individuals under ECO at CB Respondents' Primary CITACs



As with primary CITACs, respondents' reported that secondary CITACs can accept referrals from professionals other than LE. In fact, all three secondary CITACs can reportedly accept referrals from sources other than LE officers, including CSB case managers (3, 100%) and self-referral (3, 100%). Nonetheless, the array of services offered at respondents' secondary CITACs is more limited. For example, two of the three secondary CITACs do not currently conduct medical screenings. Still, one respondent indicated that its secondary CITAC offer peer support services.

As the name might suggest, secondary CITACs tended to have lower capacity than their primary counterparts. All of the respondents' secondary CITACs can accommodate fewer than six individuals at any given time. For instance, once respondent reported that its secondary CITAC can accommodate only two individuals at any given time. All three of the secondary CITACs can accommodate only one individual in LE custody under ECO at any given time.

Public Safety Answering Point Respondents

While the nation works towards making a call to 988 for a behavioral health emergency as ubiquitous as a call to 911 for a medical emergency, PSAPs are a key stakeholder in ensuring successful implementation of the Marcus Alert system. PSAPs will be charged with altering the way in which they triage calls involving behavioral health emergencies (see Triage Framework section). As PSAPs are asked to alter their operations in order to ensure that individuals receive timely, appropriate responses when seeking help for behavioral health emergencies, it is important to ascertain an overview of their current operations.

As noted above, the survey was distributed to 124 PSAPs that are considered primary by VDEM NGS with respect to the NG911 transition. The majority of the PSAP respondents were on this distribution list; however, two PSAPs that were not on the primary list also completed the survey. Among all PSAP respondents, 95% (58) noted that they receive calls directly when individuals dial 9-1-1

on landline or wireless phones. This result reinforces the challenges with determining whether a PSAP is "primary."

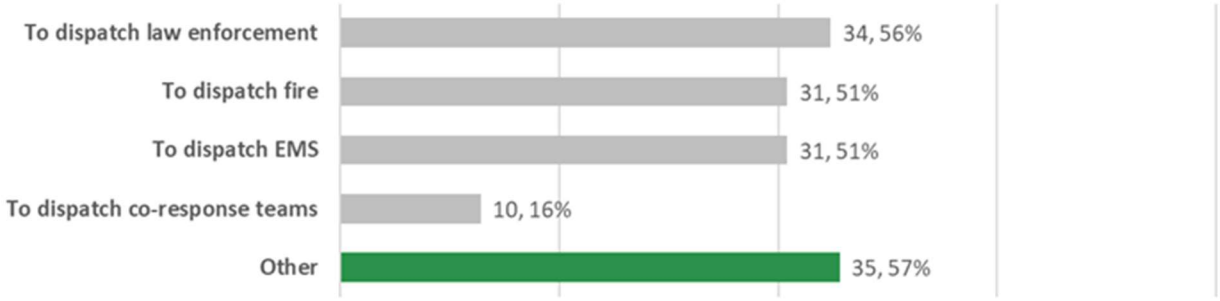
Like other components of a comprehensive crisis system, PSAPs are not homogenous: They do not all dispatch the same types of first responders. Among PSAP respondents, the vast majority indicated that they dispatch the traditional first responders: LE (59, 97%), EMS (60, 98%), and fire and rescue (60, 98%). Sixteen of the PSAP respondents (26%) indicated that they currently dispatch CRTs (see Figure 19).

Figure 19. PSAP Respondents Currently Dispatching CRTs

PSAP Respondent
Amherst (FCC ID: 7082)
Augusta (FCC ID: 7085)
Charlotte (FCC ID: 7099)
Colonial Heights (FCC ID: 7110)
Frederick (FCC ID: 7131)
Halifax (FCC ID: 7141)
Martinsville-Henry (FCC ID: 7164)
New River Valley (FCC ID: 8501)
Newport News (FCC ID: 7171)
Pittsylvania (FCC ID: 7181)
Prince William (FCC ID: 7186)
Pulaski (FCC ID: 7187)
Russell (FCC ID: 7195)
Shenandoah (FCC ID: 7198)
Wise (FCC ID: 7229)
York-Poquoson-Williamsburg (FCC ID: 7232)

A key component of the Marcus Alert triage framework presented herein is transferring calls to the forthcoming 988 crisis call center (see Triage Framework section). Consequently, one aim of the inventory survey was to ascertain when PSAPs currently transfer calls (see Figure 20). The primary reason for transferring calls among PSAP respondents was "Other." All PSAP respondents cited transferring misrouted calls that occur outside of their designated geographical area as the "Other" reason that calls are transferred. One type of transfer was notably absent: The majority of PSAP respondents (56, 92%) noted that they do not have a protocol for transferring calls to lines like the National Suicide Prevention Lifeline. Nonetheless, 42 PSAP respondents (69%) indicated that their respective PSAPs have a dedicated computer-aided dispatch (CAD) code for behavioral health emergencies.

Figure 20. Reasons PSAP Respondents Transfer Calls



As the state planning workgroup engaged in developing the triage framework, it became clear that PSAPs' work is highly technical. Thus, PSAP respondents were asked to provide details about the technology that they currently use to handle call data and dispatch responses to emergency calls. Of the PSAP respondents, 92% (56) indicated that they currently use a CAD. Unfortunately, PSAPs' technical systems are largely inaccessible to neighboring PSAPs or other entities—an issue that is being addressed through national initiatives like NG911, 911DataPath, APCO Unified CAD Project, etc. One way PSAPs facilitate collaboration despite the varied technology use is through CAD-to-CAD data sharing agreements. Among the PSAP respondents, there are nine that currently have CAD-to-CAD data sharing agreements with other PSAPs: Bristol (FCC ID: 7091), Essex (FCC ID: 7121), Loudoun (FCC ID: 7157), Newport News (FCC ID: 7171), Wintergreen (not primary on VDEM list), Prince George (FCC ID: 7185), Prince William (FCC ID: 7186), Twin County (FCC ID: 7215), and York-Poquoson-Williamsburg (FCC ID: 7232). A list of the PSAP with which these PSAP respondents have agreements is in Figure 21. It is important to note that one PSAP respondent indicated that it has a CAD-to-CAD agreement with a PSAP in Maryland. Another PSAP respondent noted having a CAD-to-CAD agreement with a PSAP on an Army base.

Figure 21. PSAP Respondents' CAD-to-CAD Agreements

PSAP Respondent	PSAP in CAD-to-CAD Agreement
Bristol (FCC ID: 7091)	Waynesboro (FCC ID: 7223)
Essex (FCC ID: 7121)	King and Queen (FCC ID: 7151)
Loudoun (FCC ID: 7157) [6]	Alexandria (FCC ID: 7079)
	Arlington (FCC ID: 7084)
	Fairfax (FCC ID: 7123)
	Manassas (FCC ID: 7162)

[6] There is an interstate CAD-to-CAD data sharing agreement among the following PSAPs surrounding the nation's capital: Fairfax County, Arlington County, Alexandria City, Metropolitan Washington Airports Authority, Loudoun County, Prince William County, Montgomery County, MD, and Prince George's County, MD.

	Manassas Park (FCC ID: 7163)
	MWAA (FCC ID: 8567)
	Prince William (FCC ID: 7186)
	Other: Montgomery (MD), Prince George's (MD)
Newport News (FCC ID: 7171)	Hampton (FCC ID: 7142)
Other: Wintergreen	Nelson (FCC ID: 7169)
Prince George (FCC ID: 7185)	Other: Fort Lee Army Police
Prince William (FCC ID: 7186)	Alexandria (FCC ID: 7079)
	Arlington (FCC ID: 7084)
	Loudoun (FCC ID: 7157)
	MWAA (FCC ID: 8567)
Twin County (FCC ID: 7215)	Other: Grayson County 2ndary PSAP
York-Poquoson-Williamsburg (FCC ID: 7232)	James City (FCC ID: 7150)

Law Enforcement Respondents

Given the plethora of LE agencies throughout the Commonwealth, LE respondents were grouped according to the category in which they appear in the DCJS directory. The majority of LE respondents were from police departments (46, 48%). Sheriffs' departments were the second most common type of LE agency (37, 39%). Among the LE respondents were nine college and university police departments and three Virginia State Police Areas. The Virginia State Police were included as a stakeholder since, per DCJS, they provide backup for smaller agencies that may not offer 24/7 coverage.

One of the first questions asked of LE respondents was regarding their agencies participation in CIT training. As is detailed in subsequent sections, one recommendation that emerged from the state planning workgroup is for LE officers participating in CRTs to be CIT-trained. The majority (83, 87%) of LE respondents indicated that their agency does not currently participate in a CRT; none of the respondents reported previously having a CRT that could not be sustained. Nonetheless, most respondents (82, 86%) indicated that their agency currently participates in CIT training (see Figure 22). A list of all LE respondents and the CSBs that coordinate the CIT programs in which they participate can be found in Appendix C. Interestingly, slightly less than half of LE respondents (41, 43%) indicated that their agencies CIT train 100% of their officers. The advantages and disadvantages of CIT training all officers were oft discussed among the state planning workgroup members.

Figure 22. LE Respondents Reporting Participation in a CRT

Law Enforcement Respondents Reporting CRT Participation
Alexandria Police Department
Arlington County Police Department
Augusta County Sheriff's Office

Christopher Newport University Pd
Danville Police Department
Fairfax County Sheriff's Office
Fauquier County Sheriff's Office
Hampton Police Department
Henrico County Division Of Police
Nelson County Sheriff's Office
Norton Police Department
Prince William County Police Department

Since LE officers are one of the first responders that are usually dispatched by PSAPs, the inventory survey sought to elucidate the existing relationships among LE respondents and the PSAPs in their respective geographical areas. Forty-five percent of LE respondents (43) indicated that they receive transferred calls from PSAPs, two respondents terminated the survey early and did not respond to this question. In thinking about planning for the Marcus Alert system it is important to note that one LE respondents noted that they are transferred calls from a PSAP in Maryland. See Appendix C for a list of LE respondents and the PSAPs that transfer calls to them.

Current Crisis System Utilization

Currently, crisis evaluations are only conducted by certified pre-admissions screening clinicians (also known as evaluators) that are employed by or contracted with CSBs. Thus, the total number of crisis evaluations conducted throughout the Commonwealth can be readily ascertained (see Figure 23). In FY 2020, a total of 74,805 crisis evaluations were performed throughout the state. Thirty percent of those crisis evaluations (22,801) resulted from ECOs, and 31% of those evaluations (23,512) resulted in TDOs for involuntary psychiatric hospitalization. Note that these counts do not necessarily represent a count of distinct individuals who have interfaced with the crisis system since one individual may have more than one crisis evaluation over the course of 12 months.

Figure 23. FY 2020 Crisis Evaluations

Month	Total Crisis Evaluations	Emergency Custody Orders		Temporary Detention Orders	
		Total	Percentage of Total Crisis Evaluations	Total	Percentage of Total Crisis Evaluations
July 2019	6927	1963	28%	2042	30%
August 2019	7100	2166	31%	2196	31%
September 2019	7131	2047	29%	2179	31%
October 2019	7426	1989	27%	2062	28%
November 2019	6432	1754	27%	1833	29%

December 2019	6301	1852	29%	1868	30%
January 2020	6764	1956	29%	1954	29%
February 2020	6590	1816	28%	1907	29%
March 2020	5582	1800	32%	1831	33%
April 2020	4360	1714	39%	1757	40%
May 2020	4805	1827	38%	1873	39%
June 2020	5387	1917	36%	2010	3%
Totals	**74805**	**22801**	**30%**	**23512**	**31%**

Projected Crisis System Utilization

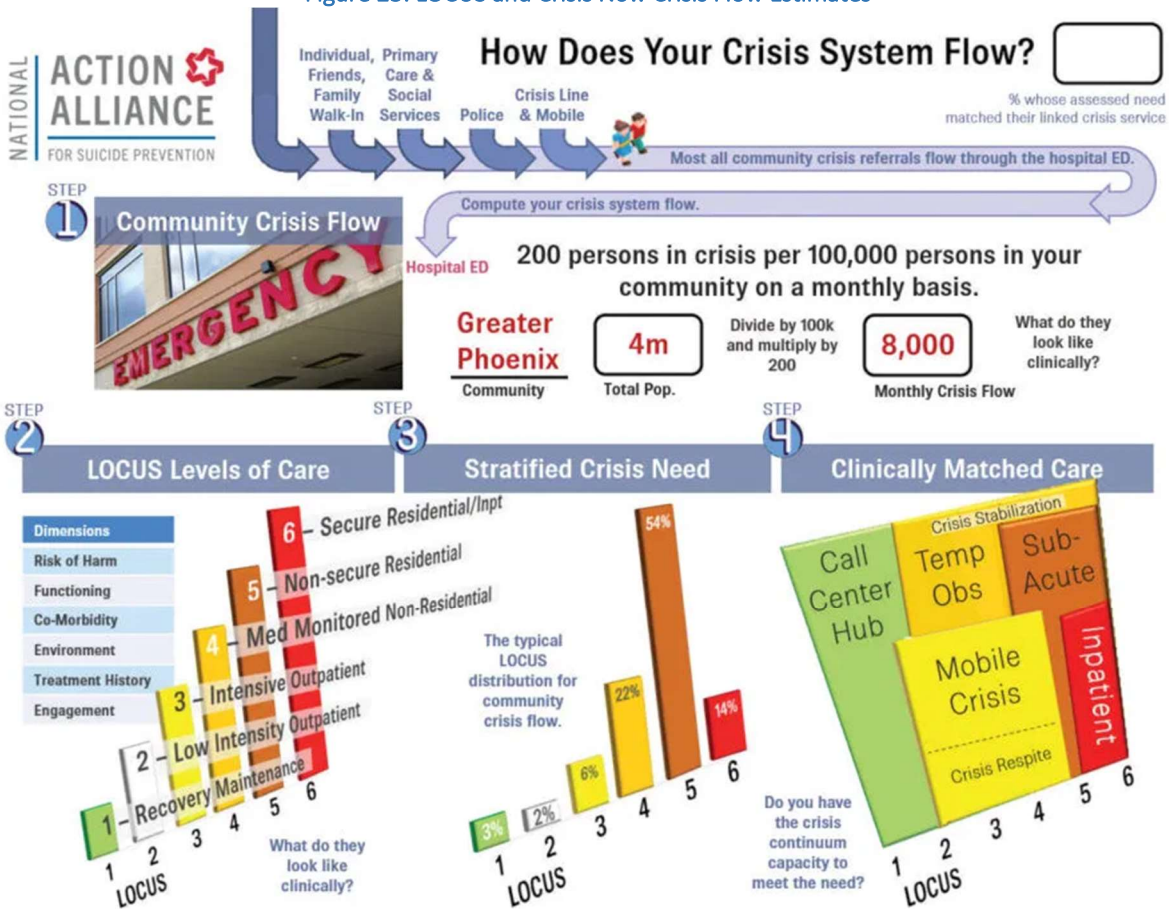
As is noted above—and detailed in the Triage Framework section—this state plan for the implementation of the Marcus Alert system includes a triage framework that will alter that way in which responses are dispatched when individuals dial 9-1-1 (and, eventually, 9-8-8) for behavioral health emergencies. The triage framework is a quick guide for telecommunicators (also known as call takers or dispatchers) at PSAPs and regional 988 crisis call centers to assess the urgency with which a response to a behavioral health crisis is needed. Meanwhile, the Level of Care Utilization Standards (LOCUS) is a longer assessment, endorsed by the Crisis Now model, that is used to determine the appropriate level of care required to help individuals experiencing crises return to their baseline functioning. The LOCUS assesses six dimensions: risk of harm, functioning, co-morbidity, environment, treatment history, and engagement (see Figure 25 on the next page).

Though the LOCUS is an assessment used to ascertain the acuity of care required to aid individuals in returning to their pre-crises baselines, it can be administered by non-clinicians who have been trained to complete it. Nonetheless, the state plan does not set forth an expectation that 911 telecommunicators must complete LOCUS assessments for behavioral health-related calls. Instead, it is envisioned that 988 staff and other behavioral health first responders, such as mobile crisis teams, will administer the LOCUS as part of their response.

The LOCUS divides behavioral health care into six levels that correspond to the acuity of clinical care required to reestablish individuals' equilibrium (see Figure 25): LOCUS Level 1 is recovery maintenance, LOCUS Level 2 is low intensity outpatient, LOCUS Level 3 is intensive outpatient, LOCUS Level 4 is medically monitored non-residential, LOCUS Level 5 is non-secure residential, and LOCUS Level 6 is secure residential or inpatient psychiatric hospitalization. For each LOCUS level, there are corresponding types of clinical care (see Figure 25 Step 4). For instance, individuals whose distress indicates a LOCUS Level 1 can typically reestablish baseline functioning by receiving telephonic assistance through a crisis call center hub. Per Crisis Now, approximately 87% of individuals who seek

help for behavioral health crisis can be assisted outside of secure residential/inpatient settings (see Figure 25 Step 3).

Figure 25. LOCUS and Crisis Now Crisis Flow Estimates



Source

Estimates of the number of individuals who will flow through Virginia's crisis system on a monthly basis according to the Crisis Now formula included in Figure 25 above are depicted in Figures 26 through 33, starting on the next page. Figures 26 and 27 include tables of the estimated monthly crisis flow overall and by LOCUS level for each city/county and CSB catchment area, respectively. The monthly overall estimated crisis flow is depicted visually in maps in Figures 28 and 29. Crisis flow estimates for youth under the age of 18 years are presented in tabular form in Figures 30 and 31 and depicted in maps in Figures 32 and 33.

Please continue on the next page.

Figure 26. Monthly Crisis Estimates by CSB

Below are crisis estimates by CSB catchment area based on the Crisis Now monthly crisis flow formula. Population counts are 2019 estimates from the U.S. Census Bureau.

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
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**

Figure 27. Monthly Crisis Estimates by City and County

Below are monthly crisis estimates by jurisdiction (city or county) based on the Crisis Now crisis flow formula. Population counts are 2019 estimates from the U.S. Census Bureau.

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

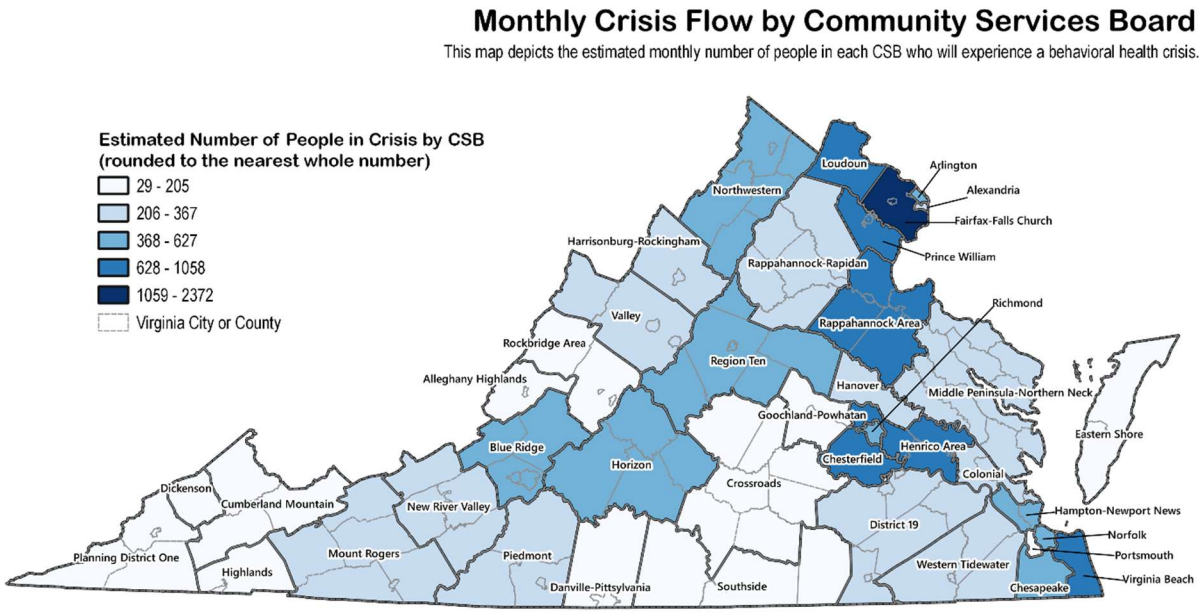
Craig County	5,131	10	0	0	1	2	6	1
Culpeper County	52,605	105	3	2	6	23	57	15
Cumberland County	9,932	20	1	0	1	4	11	3
Dickenson County	14,318	29	1	1	2	6	15	4
Dinwiddie County	28,544	57	2	1	3	13	31	8
Essex County	10,953	22	1	0	1	5	12	3
Fairfax County	1,147,532	2,295	69	46	138	505	1,239	321
Fauquier County	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

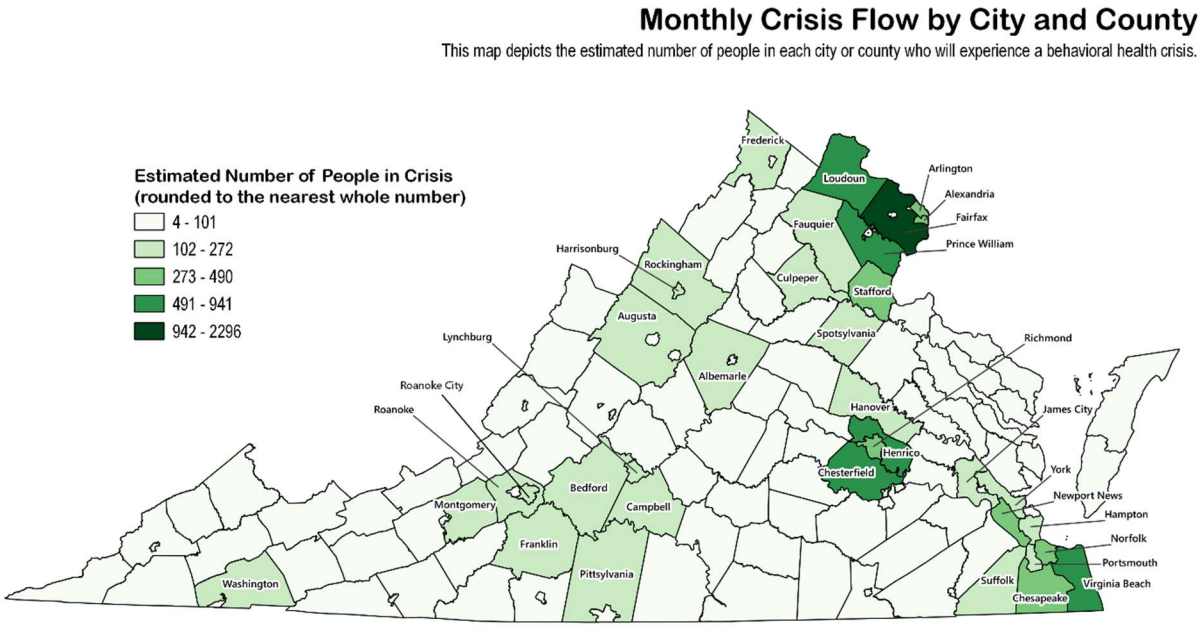
Galax City	6,347	13	0	0	1	3	7	2
Hampton City	134,510	269	8	5	16	59	145	38
Harrisonburg City	53,016	106	3	2	6	23	57	15
Hopewell City	22,529	45	1	1	3	10	24	6
Lexington City	7,446	15	0	0	1	3	8	2
Lynchburg City	82,168	164	5	3	10	36	89	23
Manassas City	41,085	82	2	2	5	18	44	12
Manassas Park City	17,478	35	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**

Figure 28. Map of Estimated Monthly Crisis Flow by CSB



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.

Figure 29. Map of Estimated Monthly Crisis Flow by City 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 and the Crisis Now crisis flow estimate equation. Natural break (jenks) were used to categorize the data.

Figure 30. Youth Monthly Crisis Estimates by CSB

Below are monthly youth crisis estimates by CSB based on the Crisis Now crisis flow formula. Population counts are from the Centers for Disease Control Wonder database.

CSB	DBHDS Region	Total 2019 Population under 18 Years	Total Monthly Estimate of Youth in Crisis (rounded)	Monthly Estimate of Youth in Crisis at LOCUS 1	Monthly Estimate of Youth in Crisis at LOCUS 2	Monthly Estimate of Youth in Crisis at LOCUS 3	Monthly Estimate of Youth in Crisis at LOCUS 4	Monthly Estimate of Youth in Crisis at LOCUS 5	Monthly Estimate of Youth in Crisis at LOCUS 6
Alexandria	2	28692	57	2	1	3	13	31	8
Alleghany Highlands	1	3864	8	0	0	0	2	4	1
Arlington	2	42954	86	3	2	5	19	46	12
Blue Ridge	3	52731	105	3	2	6	23	57	15
Chesapeake	5	59114	118	4	2	7	26	64	17
Chesterfield	4	83011	166	5	3	10	37	90	23
Colonial	5	35539	71	2	1	4	16	38	10
Crossroads	4	19050	38	1	1	2	8	21	5
Cumberland Mountain	3	16452	33	1	1	2	7	18	5
Danville-Pittsylvania	3	19771	40	1	1	2	9	21	6
Dickenson	3	2801	6	0	0	0	1	3	1
District 19	4	37039	74	2	1	4	16	40	10
Eastern Shore	5	8992	18	1	0	1	4	10	3
Fairfax-Falls Church	2	276372	553	17	11	33	122	298	77
Goochland-Powhatan	4	9453	19	1	0	1	4	10	3
Hampton-Newport News	5	69649	139	4	3	8	31	75	20
Hanover	4	23347	47	1	1	3	10	25	7
Harrisonburg-Rockingham	1	26627	53	2	1	3	12	29	7
Henrico Area	4	79784	160	5	3	10	35	86	22
Highlands	3	13034	26	1	1	2	6	14	4
Horizon	1	51559	103	3	2	6	23	56	14
Loudoun	2	115266	231	7	5	14	51	124	32

Middle Peninsula-Northern Neck	5	26044	52	2	1	3	11	28	7
Mount Rogers	3	21723	43	1	1	3	10	23	6
New River Valley	3	29754	60	2	1	4	13	32	8
Norfolk	5	47017	94	3	2	6	21	51	13
Northwestern	1	52047	104	3	2	6	23	56	15
Piedmont	3	26426	53	2	1	3	12	29	7
Planning District One	3	16160	32	1	1	2	7	17	5
Portsmouth	5	21790	44	1	1	3	10	24	6
Prince William	2	141263	283	8	6	17	62	153	40
Rappahannock Area	1	92822	186	6	4	11	41	100	26
Rappahannock-Rapidan	1	41108	82	2	2	5	18	44	12
Region Ten	1	49419	99	3	2	6	22	53	14
Richmond	4	39686	79	2	2	5	17	43	11
Rockbridge Area	1	6792	14	0	0	1	3	7	2
Southside	3	15210	30	1	1	2	7	16	4
Valley	1	24488	49	1	1	3	11	26	7
Virginia Beach	5	98974	198	6	4	12	44	107	28
Western Tidewater	5	35024	70	2	1	4	15	38	10
Total		**1860848**	**3723**	**112**	**75**	**222**	**822**	**2007**	**523**

Figure 31. Youth Monthly Crisis Estimates by Jurisdiction

Below are monthly youth crisis estimates by jurisdictions (city or county) based on the Crisis Now crisis flow formula. Population counts are from the Centers for Disease Control Wonder database.

City/County	Total 2019 Population under 18 Years	Total Monthly Estimate of Youth in Crisis (rounded)	Monthly Estimate of Youth in Crisis at LOCUS 1	Monthly Estimate of Youth in Crisis at LOCUS 2	Monthly Estimate of Youth in Crisis at LOCUS 3	Monthly Estimate of Youth in Crisis at LOCUS 4	Monthly Estimate of Youth in Crisis at LOCUS 5	Monthly Estimate of Youth in Crisis at LOCUS 6
Accomack County	6690	13	0	0	1	3	7	2

Albemarle County	21553	43	1	1	3	9	23	6
Alleghany County	2714	5	0	0	0	1	3	1
Amelia County	2740	5	0	0	0	1	3	1
Amherst County	6114	12	0	0	1	3	7	2
Appomattox County	3342	7	0	0	0	1	4	1
Arlington County	42954	86	3	2	5	19	46	12
Augusta County	14008	28	1	1	2	6	15	4
Bath County	627	1	0	0	0	0	1	0
Bedford County	15532	31	1	1	2	7	17	4
Bland County	939	2	0	0	0	0	1	0
Botetourt County	6302	13	0	0	1	3	7	2
Brunswick County	2668	5	0	0	0	1	3	1
Buchanan County	3639	7	0	0	0	2	4	1
Buckingham County	3031	6	0	0	0	1	3	1
Campbell County	10642	21	1	0	1	5	11	3
Caroline County	7007	14	0	0	1	3	8	2
Carroll County	5301	11	0	0	1	2	6	1
Charles City County	1024	2	0	0	0	0	1	0
Charlotte County	2484	5	0	0	0	1	3	1
Chesterfield County	83011	166	5	3	10	37	90	23
Clarke County	2855	6	0	0	0	1	3	1
Craig County	899	2	0	0	0	0	1	0
Culpeper County	13019	26	1	1	2	6	14	4
Cumberland County	1881	4	0	0	0	1	2	1
Dickenson County	2801	6	0	0	0	1	3	1
Dinwiddie County	5678	11	0	0	1	2	6	2
Essex County	2018	4	0	0	0	1	2	1
Fairfax County	266825	534	16	11	32	117	288	75
Fauquier County	16452	33	1	1	2	7	18	5
Floyd County	3047	6	0	0	0	1	3	1

Fluvanna County	5406	11	0	0	1	2	6	2
Franklin County	10506	21	1	0	1	5	11	3
Frederick County	20307	41	1	1	2	9	22	6
Giles County	3409	7	0	0	0	1	4	1
Gloucester County	7446	15	0	0	1	3	8	2
Goochland County	4081	8	0	0	0	2	4	1
Grayson County	2560	5	0	0	0	1	3	1
Greene County	4710	9	0	0	1	2	5	1
Greensville County	1861	4	0	0	0	1	2	1
Halifax County	6836	14	0	0	1	3	7	2
Hanover County	23347	47	1	1	3	10	25	7
Henrico County	74158	148	4	3	9	33	80	21
Henry County	9686	19	1	0	1	4	10	3
Highland County	292	1	0	0	0	0	0	0
Isle of Wight County	7723	15	0	0	1	3	8	2
James City County	15109	30	1	1	2	7	16	4
King and Queen County	1230	2	0	0	0	1	1	0
King George County	6590	13	0	0	1	3	7	2
King William County	3912	8	0	0	0	2	4	1
Lancaster County	1640	3	0	0	0	1	2	0
Lee County	4322	9	0	0	1	2	5	1
Loudoun County	115266	231	7	5	14	51	124	32
Louisa County	7541	15	0	0	1	3	8	2
Lunenburg County	2304	5	0	0	0	1	2	1
Madison County	2671	5	0	0	0	1	3	1
Mathews County	1379	3	0	0	0	1	1	0
Mecklenburg County	5706	11	0	0	1	3	6	2
Middlesex County	1694	3	0	0	0	1	2	0
Montgomery County	15070	30	1	1	2	7	16	4
Nelson County	2663	5	0	0	0	1	3	1

New Kent County	4602	9	0	0	1	2	5	1
Northampton County	2302	5	0	0	0	1	2	1
Northumberland County	1755	4	0	0	0	1	2	0
Nottoway County	2962	6	0	0	0	1	3	1
Orange County	7770	16	0	0	1	3	8	2
Page County	4725	9	0	0	1	2	5	1
Patrick County	3050	6	0	0	0	1	3	1
Pittsylvania County	11124	22	1	0	1	5	12	3
Powhatan County	5372	11	0	0	1	2	6	2
Prince Edward County	3648	7	0	0	0	2	4	1
Prince George County	8442	17	1	0	1	4	9	2
Prince William County	126300	253	8	5	15	56	136	35
Pulaski County	5940	12	0	0	1	3	6	2
Rappahannock County	1196	2	0	0	0	1	1	0
Richmond County	1525	3	0	0	0	1	2	0
Roanoke County	18518	37	1	1	2	8	20	5
Rockbridge County	3870	8	0	0	0	2	4	1
Rockingham County	17828	36	1	1	2	8	19	5
Russell County	4974	10	0	0	1	2	5	1
Scott County	3843	8	0	0	0	2	4	1
Shenandoah County	9164	18	1	0	1	4	10	3
Smyth County	5752	12	0	0	1	3	6	2
Southampton County	3275	7	0	0	0	1	4	1
Spotsylvania County	33433	67	2	1	4	15	36	9
Stafford County	39639	79	2	2	5	17	43	11
Surry County	1063	2	0	0	0	0	1	0
Sussex County	1697	3	0	0	0	1	2	0
Tazewell County	7839	16	0	0	1	3	8	2
Warren County	8686	17	1	0	1	4	9	2
Washington County	9663	19	1	0	1	4	10	3

Westmoreland County	3445	7	0	0	0	2	4	1
Wise County	7135	14	0	0	1	3	8	2
Wythe County	5675	11	0	0	1	2	6	2
York County	16050	32	1	1	2	7	17	4
Alexandria City	28692	57	2	1	3	13	31	8
Bristol City	3371	7	0	0	0	1	4	1
Buena Vista City	1317	3	0	0	0	1	1	0
Charlottesville City	7546	15	0	0	1	3	8	2
Chesapeake City	59114	118	4	2	7	26	64	17
Colonial Heights City	4103	8	0	0	0	2	4	1
Covington City	1150	2	0	0	0	1	1	0
Danville City	8647	17	1	0	1	4	9	2
Emporia City	1273	3	0	0	0	1	1	0
Fairfax City	5906	12	0	0	1	3	6	2
Falls Church City	3641	7	0	0	0	2	4	1
Franklin City	2070	4	0	0	0	1	2	1
Fredericksburg City	6153	12	0	0	1	3	7	2
Galax City	1496	3	0	0	0	1	2	0
Hampton City	28167	56	2	1	3	12	30	8
Harrisonburg City	8799	18	1	0	1	4	10	2
Hopewell City	5851	12	0	0	1	3	6	2
Lexington City	978	2	0	0	0	0	1	0
Lynchburg City	15929	32	1	1	2	7	17	4
Manassas City	11023	22	1	0	1	5	12	3
Manassas Park City	3940	8	0	0	0	2	4	1
Martinsville City	3184	6	0	0	0	1	3	1
Newport News City	41482	83	2	2	5	18	45	12
Norfolk City	47017	94	3	2	6	21	51	13
Norton City	860	2	0	0	0	0	1	0
Petersburg City	7071	14	0	0	1	3	8	2

Poquoson City	2747	5	0	0	0	1	3	1
Portsmouth City	21790	44	1	1	3	10	24	6
Radford City	2288	5	0	0	0	1	2	1
Richmond City	39686	79	2	2	5	17	43	11
Roanoke City	22083	44	1	1	3	10	24	6
Salem City	4929	10	0	0	1	2	5	1
Staunton City	4823	10	0	0	1	2	5	1
Suffolk City	21956	44	1	1	3	10	24	6
Virginia Beach City	98974	198	6	4	12	44	107	28
Waynesboro City	5365	11	0	0	1	2	6	2
Williamsburg City	1633	3	0	0	0	1	2	0
Winchester City	6310	13	0	0	1	3	7	2
Total	**1860848**	**3721**	**95**	**62**	**217**	**820**	**2002**	**520**

Figure 32. Map of Estimated Monthly Youth Crisis Flow by CSB

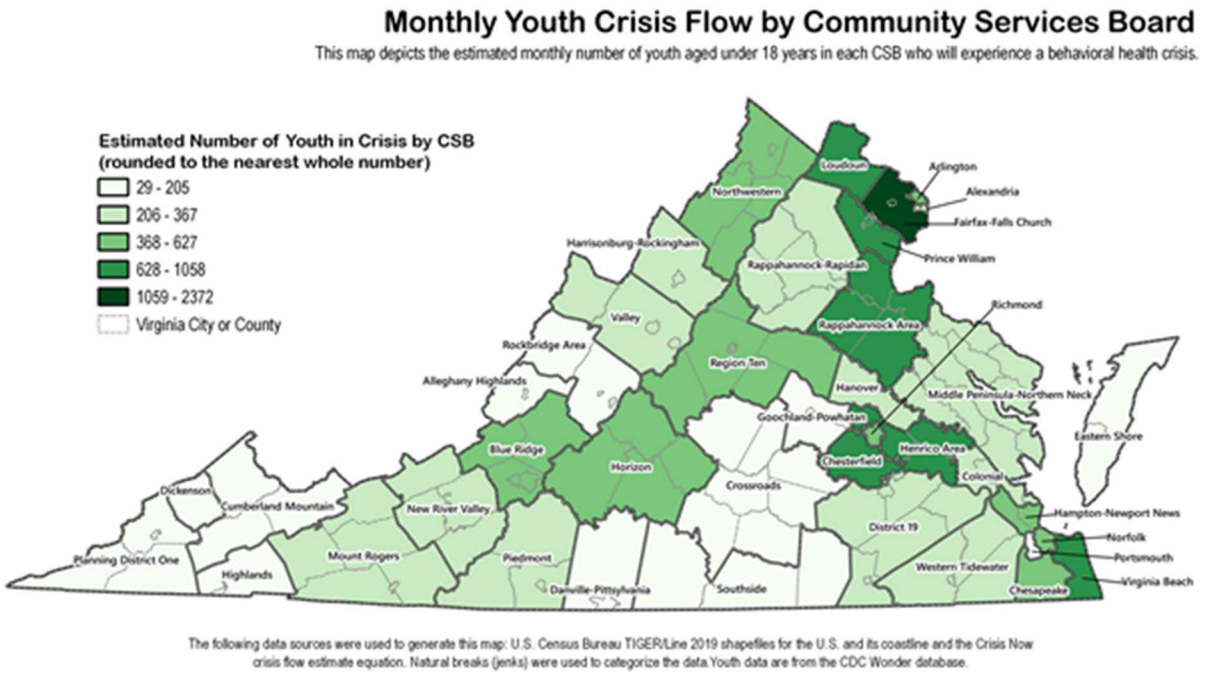
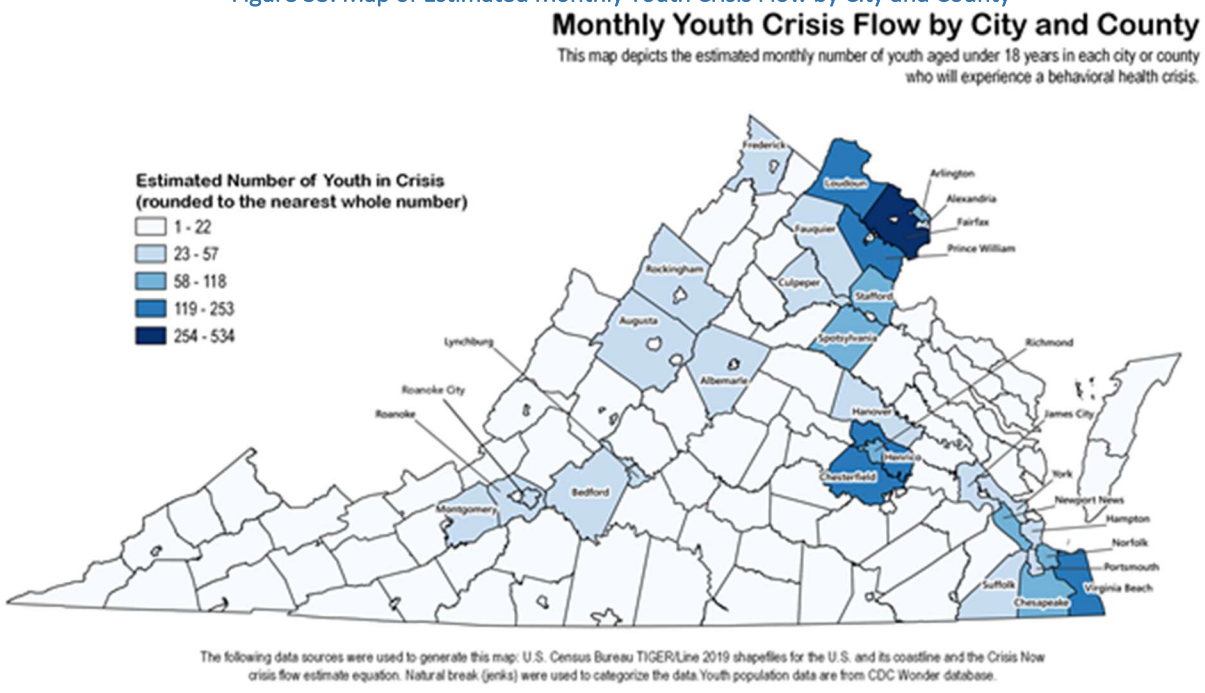


Figure 33. Map of Estimated Monthly Youth Crisis Flow by City and County

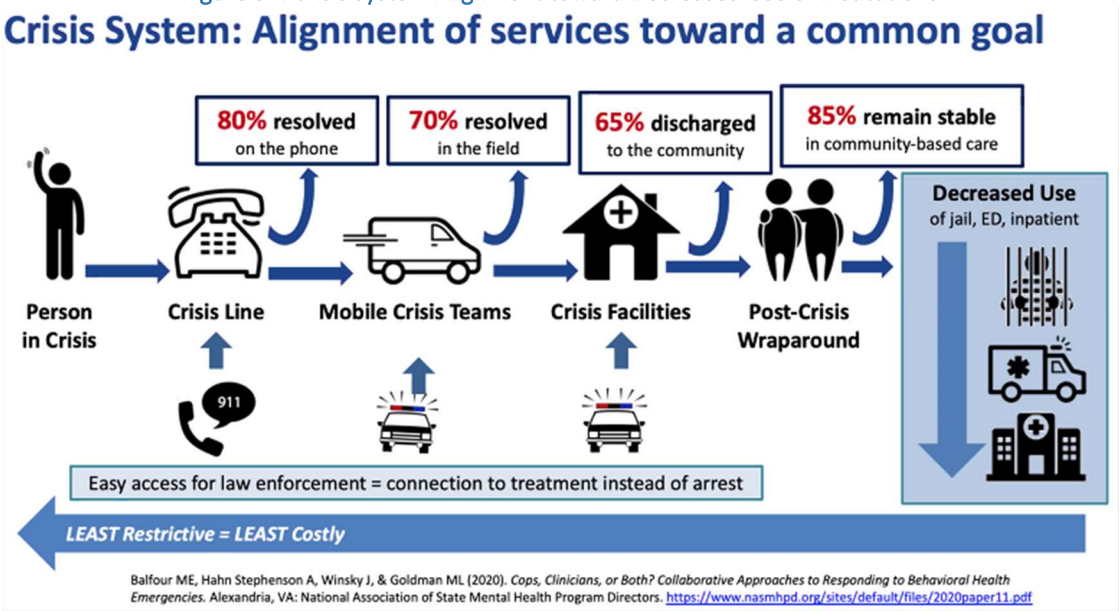


There will likely always be individuals who experience periods in which symptoms temporarily increase and require intervention to reestablish equilibrium. Nonetheless, the crisis response system can be realigned so that inequities inherent in the system are diminished—hopefully, resulting in individuals

being more comfortable seeking help before the peak of a crisis—and a comprehensive array of services is available to help individuals who do seek help return to their baseline functioning in the least restrictive environment. As is depicted in Figure 34, with a comprehensive crisis response system in place, 80% of crises could be resolved over the phone. Of the remaining 20% of crises that cannot be resolved over the phone, 70% could be resolved in the field (e.g., through mobile crisis teams). Of those crises that cannot be resolved in the field, 65% could be resolved in crisis facilities, such as crisis stabilization units, with individuals being discharged to the community once back at their baseline.

If the estimated number of individuals who will flow through the crisis system across the Commonwealth is used (17,073; see Figure 26), 13,658 crises could be resolved over the phone, 2,391 crises could be resolved in the field, and 666 crises could be resolved in crisis facilities, resulting in discharge to the community. Of the 3,057 individuals experiencing crises that could be resolved in the field or crisis facilities, 85% (2,598) would remain stable in community-based care. Consequently, of the estimated 17,073 monthly crises, no more than 358 crises would result in individuals receiving institutional care in hospital EDs or inpatient psychiatric facilities or being taken to jail.

Figure 34. Crisis System Alignment toward Decreased Use of Institutions



Current State and Local Funding for Crisis and Emergency Services

An overview of state and local funding for crisis and emergency services is provided. With respect to Emergency Services, estimates are based on 2019 CSB expenses. It is important to note that the comprehensive crisis continuum defined in the Act is conceptualized as cross-disability. Yet, existing appropriations are disability-specific, which can limit blending of funding.

Component of the Crisis System	Funding Line Description	Amount	Status
Regional Call Centers			
	Call Center Staff (general fund; 790)	$4,697,020	Forthcoming (July 1, 2021)
	988 tax	$0.12 per line (total unknown)	Forthcoming
	Dispatch software (DOJ Trust Fund)	$5,000,000 (one time) $500,000 ongoing	Current
Mobile Crisis Teams			
	REACH Adult*	$13,303,980	Current
	REACH Child/Adult*	$10,117,757	Current
	Youth crisis and psychiatry (funds two regional programs)		
	STEP-VA Children	$5,800,000	Current
	STEP-VA SMI with cognitive impairment	$2,000,000	Current
	STEP-VA Adult	$6,154,924	Forthcoming (July 1, 2021)
Marcus Alert (local protocols and teams)			
	Marcus Alert initial areas (general fund)	$3,000,000	Forthcoming (July 1, 2021)
Place-based acute crisis care			
	Adult CSUs		Current
	Youth CSUs		Current
	CITACs		Current (planned changes are forthcoming)
Emergency Services			
	CSB reported general fund expenses	$28,400,000	Current as of 2019
	CSB reported local funding for ES	$13,200,000	Current as of 2019
Medicaid Funding			
	Medicaid reimbursement for ES	$7,900,000	Reported by CSBs for 2019
	New Project BRAVO rates (four crisis services)	(total unknown; 85% FMAP per ARPA may change estimates for general fund)	Forthcoming (December, 2021)

*This includes crisis stabilization/therapeutic group homes as well.

With respect to Emergency Services funding, the Department of Behavioral Health and Developmental Services sent out a call for data to all 40 of Virginia's Community Services Boards on October 17, 2019. To address the concern that emergency services—a vital, code-mandated function of the CSBs—is underfunded, CSBs were asked for financial information pertaining to emergency services.

CSBs utilize unrestricted general funds for this Code-mandated function (there are not specific appropriations directed to ES). The majority of ES costs are for personnel. On average, each CSB reported 16.18 emergency evaluators, both part time and full time, or one evaluator for every 12,993 people in that CSB's catchment area. CSBs serving mostly rural populations have an average of 14.1 evaluators, or one evaluator for every 10,241 people served. CSBs serving mostly urban populations have an average of 19 total evaluators, or one evaluator for every 16,948 people served.

There is a positive correlation between the number of full-time evaluators and total expenditures for both urban and rural CSBs, but there is almost no correlation between the number of full-time evaluators and total funding—a finding consistent with insufficient funding for emergency services. Further study of this issue, with more reliable data, is necessary. CSBs cannot continue to function at substantial losses for a function that is required of them by law. Due to large variation in ES department structure, size, and duties outside of prescreening function, it is unclear to what extent current emergency services workloads and capacity will shift as mobile crisis response becomes available statewide, and/or whether some emergency services capacity could provide mobile crisis response.

System costs that do not currently have dedicated funding to cover estimated costs include call center staff (approximately 50% funded; potential for 988 tax revenue to provide additional funding); additional mobile crisis teams to achieve statewide coverage; additional local Marcus Alert area funds (5 areas currently funded); and one time and ongoing costs for Crisis Receiving Centers (and rural adaptations to provide similar functions, including 23-hour observation). Reports on regionalization of CITACs, as well as new 5% crisis set-aside of the Mental Health Block Grant, include information regarding some of the costs of building these functions across Virginia. Given all of the factors at play, including 988 tax revenue, ARPA block grant funds, ARPA 85% crisis FMAP, a more complex financial model of the crisis system in its entirety (across payers and funding sources) should be conducted during FY 2022.

Section II: State-level Plan Components

Four-Level Triage Framework

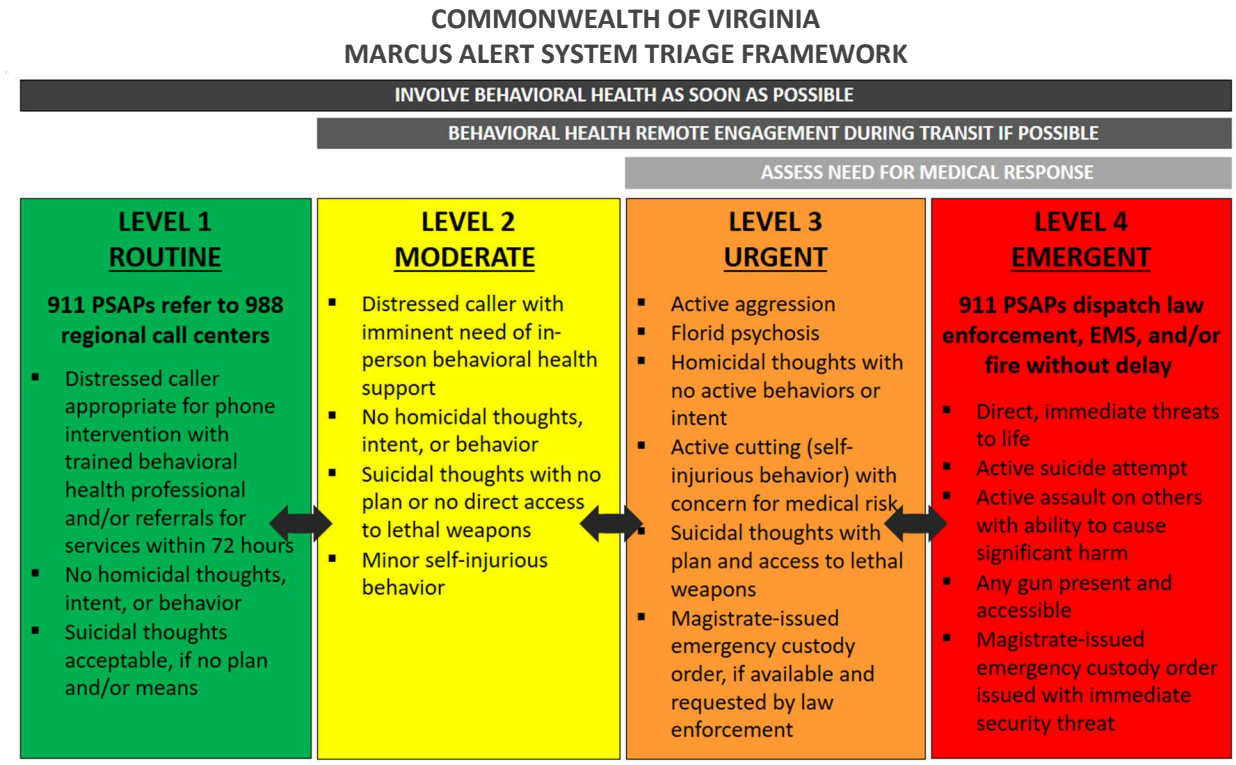
The four-level state framework (see Figure 35 on the next page) creates a way for stakeholders to communicate across sectors as well as across areas of the state. Each area plan will be required to complete more detailed specifications for each level, including how it is defined in the context of existing protocols and triage software used by PSAPs. The four levels are primarily a triage system focused on how *urgently* a response is needed.

The four-level triage serves multiple purposes in the state plan. First, the four-level triage system provides guidelines for evaluating and classifying the urgency level of behavioral health emergency situations to help ensure the appropriate response per the state and local Marcus Alert plans. 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 minimum standards and the range of appropriate response options for different levels of urgency, which then will be used by local implementations to communicate their plans for state approval. Fourth, the four-level triage system provides the framework for ongoing assessment and continuous quality improvement. It would not be possible for the system to be clearly described and evaluated across the state without a common language to discuss levels of urgency, including measuring the range of dispatched responses or assessing system trends (e.g., increasing number of behavioral health only responses over time). 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.

Please continue on the next page.

Figure 35. Marcus Alert Triage Framework

This graphic highlights the key descriptors for each of the four levels.



Level 1 is the lowest urgency level. Callers are distressed, but there is no immediate threat. Non-life-threatening situations include passive desires not to be alive with no plan or active suicidal intent, requests for referrals and information, general feelings of overwhelm, stress, loneliness, and fatigue. It is required that Level 1 calls are transferred to a 988 call center. Response options are described below, but, in general, Level 1 calls are likely to be able to be resolved with time spent on the phone with a trained 988 call taker, including call takers with lived and family experience themselves, who can provide listening, empathy, support, resources, connection to services, and follow up.

Level 2 situations include situations where clinical intervention is needed to reduce the advancement of greater risk. Individuals with suicidal thoughts but no intent, plan, means, capability or weapons would be considered Level 2. Minor self-injurious behavior that would not require medical attention beyond basic first aid, such as scratching into the skin with a paperclip or pin, would also be considered Level 2. Individuals experiencing withdrawal from non-life threatening substances or dependence on alcohol, benzodiazepines or barbiturates, but not in active withdrawal with no history of withdrawal seizures or detox symptoms may fit the recommended response for Level 2 from a behavioral health crisis response, and EMS dispatch is needed to evaluate withdrawal symptoms.

Situations involving active aggression would be classified as Level 3. Individuals with active psychosis disconnected from reality would be considered Level 3, as well as individuals with homicidal thoughts with no active intent or access to means. Individuals with suicidal thoughts and a specified plan, but no lethal weapons present, are classified as a Level 3 situation. Individuals engaging in self-injurious behavior that could cause life-threatening bodily injury (e.g., using a sharp knife) would be a Level 3 situation. Third-party calls for service, if missing important details on the scene safety would likely be considered Level 3. 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 ECO ordering law enforcement to take custody. The belief is a trained behavioral health provider, whether in person or via remote engagement, 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.

Level 4, or Emergent, situations are situations too unpredictable and potentially life threatening to have any delay in dispatch, and law enforcement (and EMS if needed) should be dispatched. These situations include direct threats to life, individuals who are actively assaultive and possess the means to cause life threatening harm to others or themselves. Individual who have made active suicide attempts where injuries have already occurred or a situation where suicide is imminent would be considered Level 4. Those situations may include a gun in the hand, pills ingested, a hanging scenario in place, a knife in hand with an unwillingness to secure the knife, all along with expressed homicidal or suicidal intent and without expressed ambiguity or significant barriers to acting on the intent or plan.

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, 2) the focus on specific behaviors/dimensions at each level and 3) requirements that local plans describe specific developmental considerations for decision making and supporting the use of multiple response options at some levels (particularly Level 3). Considering youth specifically, 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. STEP-VA includes nine STEPs and will support the 40 CSBs to shift from being required to provide two (three, if funding is available) Code-mandated services to being required to provide a consistent array of nine services (same day access, primary care screening, outpatient services, crisis services, peer and family supports, service members, military, veterans and family services, psychosocial rehabilitation, case management, and care coordination). The crisis services STEP focuses on building a statewide mobile crisis response system, with dispatch of mobile crisis teams coordinated through regional call centers and mobile crisis hubs. Funding for children's STEP-VA mobile crisis ($5,800,000 of total $7,800,000 appropriation was earmarked for children) was first appropriated in state fiscal year 2020, and additional funding for adult mobile crisis was appropriated in state fiscal year 2021. Funds were 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 services have been operationalized through STEP-VA and Behavioral Health Redesign for Access, Value, and Outcomes (known as Project BRAVO, the initiative to improve behavioral health services in the Medicaid benefit). Four crisis reimbursement codes were recently defined collaboratively with stakeholders (under the "Behavioral Health Enhancements" workgroup structure, prior to the Marcus Alert legislation). 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. 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., 988 or 911 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.

Mobile crisis teams are defined generally by the Marcus-David Peters Act; mobile crisis is a behavioral health service, so there are also key definitional components in DBHDS licensing regulations, STEP-VA requirements, and the DMAS Medicaid State Plan. It is important to note that each of those documents are subject to change under different authorities and timelines. To align with the timing of initial Marcus Alert implementation, the proposed start date for the new Medicaid rates was December 1, 2021, and this proposal was submitted to CMS for consideration as a Virginia state plan amendment (SPA). 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). 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

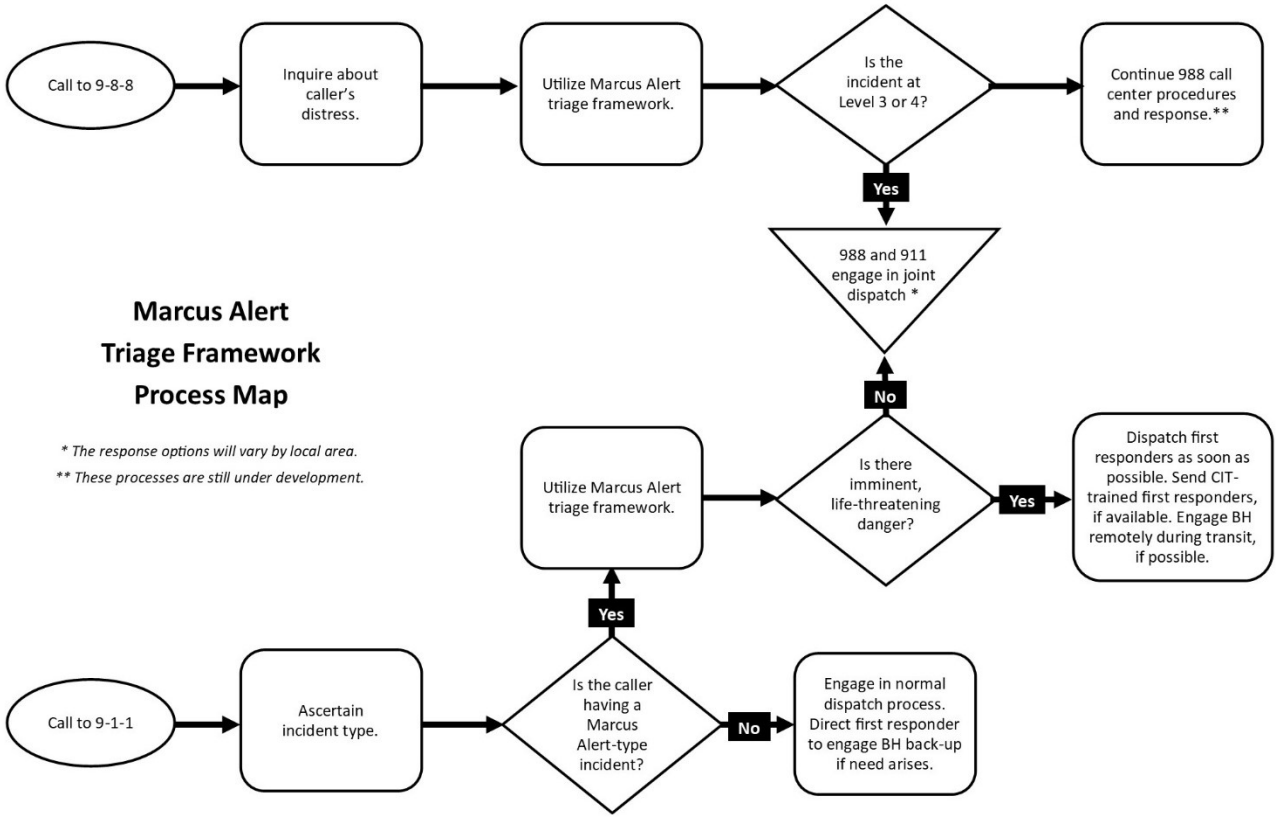
Medicaid revenue, will not achieve 24/7 coverage statewide, which is defined as a response within one hour 90% of the time, with allowances for a 90-minute response in some rural areas. Although a specific date for full coverage by mobile crisis teams cannot be ensured, considering that there may be additional funding for crisis services (including enhanced FMAP for Medicaid under American Rescue Plan, 5% crisis set aside for Mental Health Block Grant beginning in 2022, and potential uses for 988 tax revenue), it is estimated that robust statewide coverage of the one-hour response (90-minute rural response) will be achieved by July 2023 (12 months following the 988 federal requirement being in place). 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 or under a memorandum of understanding with 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 agreement (arrangement could vary) 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 both response and providers for mobile crisis response services.

988 and Regional Call Centers

Regional 988 call centers are a key aspect of the STEP-VA/BRAVO mobile crisis implementation. At a federal level, it is required that all states have the three digit number 988 link minimally to the National Suicide Prevention Lifeline (NSPL) by July 16, 2022. Most states are utilizing this as an opportunity to link this three-digit code to the broader behavioral health crisis continuum. One local protocol required per the Act (Protocol #1) focuses on the ability of PSAPs to transfer designated calls from 911 to 988 regional call centers. Ultimately, the goal is a system where a call to 988, 911, or other crisis lines all connect the individual or family in crisis to an all-payer crisis services continuum in which the response does not differ based on the access point used (i.e., “no wrong number”). Since the 988 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 in Figure 36 on the next page to demonstrate the connection between the 988 system and the 911 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.

Figure 36. High-Level Marcus Alert Triage Process Map



For the majority of the five DBHDS regions, the regional mobile crisis hub is also the fiscal agent/lead CSB for the regional call center. Some items of the Community Input survey may have relevance for the implementation of 988 and the regional call centers. Respondents were asked how often they would use "a three-digit number they could call whenever they feel emotionally overwhelmed, that provides assessment over the phone and connects you to services based on the type of situation. Based on the type of situation, services could be providing immediate over the phone support, sending a mobile crisis team to you within about an hour, or connecting you to a provider for a next-day appointment." Overall responses were as follows and indicated general interest in utilizing such a call line for one's own needs.

Use of Three-Digit Code among All Respondents

Response	Count	Percentage
Less than once a year	165	24%
Never	119	17%

Several times a year	119	17%
Once a year	74	11%
Declined to Answer	67	10%
Once a month	50	7%
Several times a month	42	6%
Once a week	22	3%
Several times a week	17	2%
Every day	6	1%

For respondents with family experience, the same inquiry was made regarding the use of a three-digit call line when a loved one was in need of support or services. Responses were overall similar and indicated that most would use such a call line.

Use of Three-Digit Code for Loved Ones

Response	Count	Percentage
Several times a year	117	28%
Less than once a year	60	14%
Declined to Answer	58	14%
Several times a month	51	12%
Once a year	48	11%
Once a month	29	7%
Several times a week	22	5%
Never	17	4%
Once a week	9	2%
Every day	7	2%

Respondents were asked about the types of stressors that were emotionally overwhelming in the last 12 months. Here, the responses by those with personal experience with behavioral health crisis are presented (additional results in Appendix D):

Stressor	Count	Percentage
…relationship stress or family issues	153	65%
…stress over managing my or a loved one's mental health diagnosis	99	42%
…utility bills (water, gas, electricity, TV, internet, phone)	82	35%
…the cost of medication(s) and treatment(s)	81	34%
…housing	64	27%
…parenting stress or concerns about my kids	62	26%
Other	60	26%
…stress over managing my or a loved one's intellectual or developmental disability	42	18%
…lack of transportation access	41	17%

…lack of health insurance	35	15%
…court date or court fees	30	13%
…lack of food access	28	12%
None of the above	16	7%
…lack of phone access	14	6%

Equity at Intercept 0 Initiative

Equity issues in both behavioral health crisis care and law enforcement must be 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, or 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 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 weapons such as firearms as well as less lethal tools. 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 Medicaid 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 support this focus on

equity at Intercept 0 to 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:

- *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; as well as partnerships with youth serving organizations and social justice/racial equity-oriented organizations*
- *professional development and supports for crisis service training with a focus on anti-racism, disability justice, and language access; and*
- *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 per their proposals—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 takes a

view broader than just Intercept 0 services 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 crisis work.

Statewide Training Standards

Training standards will be defined and 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. Given the statewide training structure that 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 (this is a contractual relationship). Training plans will be 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; compliance will be monitored. Supervisory staff will be expected to have the same knowledge as line staff and to use that knowledge to

impact and evaluate performance; there must be a mechanism for ongoing clinical review and supervision.

The statewide children's mobile crisis training is already under development, and includes six modules in the following areas: de-escalation, screening, triage, assessment, safety, child and family dynamics, trauma, and intellectual and developmental disabilities.

The statewide adult mobile crisis and call center trainings have not yet been developed, but an overview of the core competencies that will be required are described here.

Core Competency	Dimensions
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

A cross-profession advanced Marcus Alert training will be offered in a cross-disciplinary approach, wherein behavioral health crisis providers, dispatchers, and law enforcement partners all attend the same training sessions. The topics that will be covered in the cross-profession training curriculum are included below in the law enforcement competency table (see Figure 37).

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 Special Session:

§9.1-1112.1. 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 input into the Marcus Alert training requirements. Entities which should have an opportunity to review and provide input include DBHDS, Equity at Intercept 0, Crisis Coalition, Virginia Sheriffs Association, Virginia Chiefs of Police Association, and the Regional Training Academy Association. This agreement will be pursued during the first year of implementation.

(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

Figure 37. Law Enforcement Basic and Advanced Marcus Alert Training Topics

	DCJS Uniform Curriculum Requirements[7]	Cross Profession Advanced Marcus Alert Training[8]
De-escalation training and techniques	Yes	
Working with individuals with mental health and substance use disorder	Yes	
Working with individuals with developmental disabilities	Yes	
Cultural diversity, bias-based policing, implicit bias	Yes	
Use of force in context of behavioral health crises	Yes	
Relevant state and federal laws	Yes	Yes*
Cultural humility and historical trauma		Yes
Disability justice perspective		Yes
Anti-racism perspective, advanced mitigation of race-based discrimination		Yes
Intersections of race and behavioral health, 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		Yes
Intersections of de-escalation, implicit bias, and wellness/burnout (across occupations)		Yes

**Relevant state and federal laws may exceed time constraints of basic requirements, in which case all relevant state and federal laws for the Marcus Alert which are not integrated into basic law enforcement training will be included in the advanced Marcus Alert training curriculum development. Advanced Marcus Alert training topics are cross-profession.*

Because any trainings beyond what can be integrated into the basic and in-service trainings are ultimately discretionary at the local level, such as the advanced Marcus Alert training, partnerships will

[7] This includes both basic and in-service requirements.
[8] These advanced training requirements are for all professionals involved in the crisis response system, including law enforcement, behavioral health, and call takers.

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.

Telecommunicator and Dispatch Training Standards

As state planning progressed, it quickly became clear that 911 telecommunicators will play a great role in determining the immediate need for services in a behavioral health emergency. Therefore, minimum training standards in behavioral health (including behavioral health crises secondary to mental health, substance use disorder, developmental disabilities, or brain injury), acuity levels, and interventions will be needed for all PSAP call takers in the commonwealth. As part of the development of the 988 regional call centers, there will be a RFP developed and a vendor selected to develop a high-quality training curriculum meeting all National Suicide Prevention Lifeline standards. DBHDS will work with this vendor to then develop a telecommunicator-focused basic training that condenses the training into the materials needed to know from the perspective of a telecommunicator who is collaborating with the call center. DBHDS will ensure that this module can serve as a stand-alone training for 911 dispatch/PSAP staff. Dispatch staff are also recommended to complete the Advanced Marcus Alert training (described above in Figure 37 as part of a team training approach conducted across sectors).

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 988 number as an access point to the behavioral health crisis continuum, which is why the public service campaign is primarily being defined as a state-level component of the plan (initial areas will also provide outreach and information as part of the initial implementations in their local areas, but 988 materials will be standardized across the state). 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 988 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 988.

Section III: Local Marcus Alert System Requirements

Guidelines for Local Planning Group Formation and Initial Planning

There are five steps of the local planning process. The Community Roadmap is the document that outlines the details of these five local planning steps. The five 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 about the parameters of the State Plan options and requirements 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**. A standard document for submitting the required components of the plan is provided. Some reporting from the roadmap must be included with the submission, in addition to the three protocols, the triage crosswalk, and an attestation to quarterly reporting (all required statewide prior to July 1, 2022). There are also components described which will be required by the phased in implementation date (e.g., local quality improvement structures, detailed data cross walk).

Voluntary Database Requirement for Each 911 PSAP

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 911, behavioral health, and law enforcement. Localities may consider software solutions which allow for individuals to provide information to 911 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. Localities should consult with their legal counsel to ensure that decisions made regarding the voluntary database comply with HIPAA. 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.

Protocol #1: Transferring Calls from 911 to 988

Protocol #1 refers to the development of policies and procedures for 911 to divert calls to 988. This diversion is required at urgency Level 1 (Routine) and is recommended to be included as a key response option at Level 2 (Moderate). "Full diversion" refers to the transfer of a call without any required follow up with responsibility for the response being fully with 988. Another consideration for the coordination of 911 and 988 was referred to by group members as the "Poison Control Model." What is referred to as the "Poison Control Model" is appropriate and recommended at Level 2, and is potentially appropriate at Level 3, presuming coordination for in-person response is included as part of model (as is possible with Poison Control protocols). This approach broadly refers to modeling policies and procedures at the PSAP after existing poison control protocols. From a 911 perspective, Poison Control-related protocols are similarly based on urgency, with phone coordination and alternative response (I.e., non-EMS dispatch) as the appropriate response for some situations based on Emergency Medical Dispatch (EMD) triage levels. For situations that likely require an EMS response, the Poison Control center (of which there are 55 across the nation, three in Virginia) still plays a role, for example, providing instructions over the phone simultaneously with the dispatch of EMS. A comprehensive description of Poison Control protocols across Virginia is much beyond the scope of this report, rather, the purpose of highlighting the model is for localities to make comparisons and consider parallels

between these protocols and the goals of the Marcus Alert at various levels of urgency. As emergency medical dispatch protocols (EMDs) become required across the state (see § 56-484.16:1), it is possible that more standard recommendations or considerations between the interface between mobile crisis responses and 911 call centers will emerge in commercial EMDs that are used in Virginia. To meet the minimum standards for Protocol #1, PSAPs must integrate the four-level urgency triage framework into their technical specifications and set policies and workflows to ensure that calls can be transferred from 911 to 988. The minimum standard is that Level 1 calls are diverted to 988. For Protocol #1, it is recommended that Level 2 calls are also coordinated between 911 and 988, and that a Poison Control Model be explored as a potential parallel for coordinating between entities.

Protocol #2: Law Enforcement Backup for Mobile Crisis

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 988 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.
In order to define roles and responsibilities between parties in this agreement, it may be important to consider that law enforcement plays multiple roles in responding to behavioral health crises from a Virginia perspective. These three roles are:

- **"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).
- **"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.
- **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, as “do no harm” focuses moreso on one identified individual (i.e., the person experiencing the behavioral health crisis or to whom behavioral health services have been called).

Co-responder teams and other coordinated activities between behavioral health (QMHPs, including QMHP-A and QMHP-C, 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, particularly when there are multiple governmental interests at play. 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 will take the lead on structuring these agreements with law enforcement partners, for example, it may be one standard agreement which could be signed by any law enforcement agency able to provide back up as needed within that area. Initial funding for the development of these call centers and hubs will begin July 1, 2021, thus, these hubs are in an early development phase and these agreements can be developed over the first 12 months of implementation to meet the Marcus Alert requirement of July 1, 2022. The regional call centers are as follows, although it is important to note that these represent the fiscal agents as services may be subcontracted. Regions may or may not have the call center infrastructure and mobile crisis “hubs” at the same location, and regions 3 and 5 have “sub hubs” for mobile crisis.

Region 1: Region 10 Community Services Board
Region 2: Fairfax-Falls Church Community Services Board

Region 3: PD1/Frontier Health
Region 4: Richmond Behavioral Health Authority
Region 5: Western Tidewater Community Services Board

From a technical perspective, agreements between the regional call centers and law enforcement agencies providing backup must include the four following components at a minimum. The Evaluation Task Force, which will be working with the PSAPs in the initial areas during the first half of state fiscal year 2022, will be a key group in detailing the additional technical specifications needed to ensure call transfer and communication procedures.

Technical processes needed to request backup in the most efficient manner possible:

- 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).
- Clear information regarding what training any back-up sent will have.
- Responsibilities for both parties under the MOU.

It is recommended, but not required, that agreements include provisions that staffing patterns will be set to support goal that back-up officers sent will be voluntarily CIT trained or have received the advanced Marcus Alert training.

Protocol #3: Specialized Law Enforcement Response for Behavioral Health Crisis

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.

The Marcus Alert approach for Protocol #3 is built around an organizational approach provided (see graphic on the next page) 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.”

Law Enforcement: Organizational approach to serving community members with behavioral health needs

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 Achieving Community Coverage

Per the Act,

C. 1. No later than December 1, 2021, the Department shall establish five Marcus alert programs and community care or mobile crisis teams, one located in each of the five Department regions.
No later than July 1, 2023, the Department shall establish five additional Marcus alert system programs and community care or mobile crisis teams, one located in each of the five Department regions.
Community services boards or behavioral health authorities that serve the largest populations in each

region, excluding those community services boards or behavioral health authorities already selected under subdivision 1, shall be selected for programs under this subdivision.

The Department shall establish additional Marcus alert systems and community care teams in geographical areas served by a community services board or behavioral health authority by July 1, 2024, July 1, 2025, and July 1, 2026. No later than July 1, 2026, all community services board and behavioral health authority geographical areas shall have established a Marcus alert system that uses a community care or mobile crisis team.

The initial Marcus Alert programs will be developed in the following areas:
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)

Then, *all* localities must establish protocols #1, #2, and #3 by July 1, 2022, but the provision of mobile crisis teams and community care teams can be phased in over the next five years (final date of July 1, 2026).

The areas required to implement the full Marcus Alert (protocols by July 1, 2022 and community coverage by July 1, 2023) by July 1, 2023, as they must be those serving the largest population in the region will be from the CSB catchment areas:

Region 1: Rappahannock Area Community Services Board
Region 2: Fairfax-Falls Church Community Services Board
Region 3: Blue Ridge Behavioral Healthcare
Region 4: Henrico Area Mental Health and Developmental Services
Region 5: Hampton-Newport News Community Services Board

As described in the state components of the plan, reliable statewide coverage by STEP-VA/BRAVO mobile crisis teams is estimated by July 2023 (12 months following the 988 federal requirement being in place). Thus, achieving full compliance with the Marcus Alert requirements (Protocols #1, 2, and 3 and community coverage by mobile crisis or community care teams) may vary based on the approach to community coverage taken. Although STEP-VA coverage (one-hour response time, with an allowed for up to 90 minutes in rural areas) meets the overall requirement for some coverage by mobile crisis, as areas define their specialized responses, it is expected that a range of mobile response teams (mobile crisis and community care) will also be developed at the local level. Because community coverage can be achieved in a number of ways, specifically by connecting protocols and other resources to the network of STEP-VA/BRAVO mobile crisis teams or by developing additional local teams, 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). Areas that select to implement on a voluntary basis will be supported by DBHDS each year (beginning with the cohort due to implement July, 2023, if there are additional areas who would like to implement on that timeline), and if fewer than one area per region self-select to implement for July 2024 or 2025, areas will be selected based on readiness factors. It is expected that, if sufficient funding is available, areas may choose to implement on an earlier timeline overall (i.e., areas will prefer to implement July 2023 and July 2024, since protocols must be in place July, 2022).

Response Options for Specialized Responses and Community Coverage

The Poison Control Model of coordinating responses was described prior (Protocol #1), and mobile crisis team coverage through STEP-VA/BRAVO teams dispatched from regional hubs were also described as a state component of the plan. Here, we provide considerations for additional aspects of community coverage and different options for developing local community care teams. Specifically, we define three different types of community care teams based on Virginia and national models with similar purposes and aims for localities to consider when achieving community coverage.

Telehealth/Remote Behavioral Health Response

Telehealth approaches have some overlap with a Poison Control Model and have shown evidence of success in collaborations between law enforcement and behavioral health in other parts of the country. For example, in Texas, the Harris County Sheriff's Office implemented a telepsychiatry pilot program with patrol deputies in December 2017. That program evolved into a pilot telehealth program

called the Clinician and Officer Remote Evaluation (CORE) program, which was piloted and evaluated. Telehealth was selected as an approach due to the ease of access, the safety of the approach, the cost of the approach, and concerns about workforce shortages in behavioral health. This program considered telehealth a "force multiplier," based on the idea that, through the purchase of iPads and setting up policies and procedures, they could leverage nine mental health clinicians to meet the mental health needs of individuals encountered by 100 patrol officers in a large geographical area. Harris County Sheriff's Department summarized their steps to implementation as follows. They recommend CIT training for all officers utilizing the system, noting in their materials that the techniques needed to work with individuals in a behavioral health crisis are "diametrically opposed" to traditional law enforcement tactics as described in the Memphis Model for CIT.

Harris County Described Steps for Implementing a Telehealth Connection Program:

1. Identify the need and interest: talk with law enforcement and behavioral health
2. Identify a qualified behavioral health agency willing to provide the service. You may want to start with mobile crisis teams already providing emergency evaluations.
3. Secure funding to purchase equipment.
4. Decide on the video conferencing software to use.
5. Decide on the wireless carrier to use. Assess area for "dead zones."
6. Start with a small pilot.
7. Select officers who are enthusiastic about the program.
8. Decide on data capture/tracking to assess the program's effectiveness.
9. Train personnel - law enforcement and behavioral health - on hardware and software.

Source: Dr. Don Kamin, Director, Institute for Police, Mental Health & Community Collaboration, New York State

Increased STEP-VA/BRAVO Teams

It is also important to note that a locality may seek primary coverage by STEP-VA/BRAVO teams but seek a more rapid response for more urgent situations. Thus, local team development may be comprised of additional mobile crisis teams which are employed locally or are contracts with local private providers with agreements to provide additional coverage for a more rapid response than the

STEP-VA/BRAVO benchmark of one hour. Any mobile crisis teams developed locally would need to be under an agreement with the regional hubs to ensure coordinated dispatch.

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 structure any community care teams that are developed (within the definition above). The decision to invest in additional mobile crisis teams (beyond those available regionally through STEP-VA), community care teams, 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 to staff 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 types of teams which meet the definition for community care team. Finally, we provide examples and further references regarding these different approaches to community care teams, including co-responder teams.

Community Care Team Composition: Team Members
Law enforcement officer. A law enforcement officer assigned to a community care team as a permanent duty assignment should have a minimum of one year working in the field as a certified officer and have completed CIT training. It is recommended that the law enforcement officer is self-selected (or even chosen through competitive process) and supervisor approved for the assignment. 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 local, regional, or state Marcus Alert staff. A recommended best practice is for law enforcement officers to seek specialized training in recognition and de-escalation for all previously listed topics and 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 (independently licensed not required). Mental health professionals include Qualified Mental Health Professionals (QMHP), licensed mental health professional (LMHP) or those working towards credentials (eligible). 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. Many master's degree programs in the fields of Social Work, Counseling, and Psychology 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. It is recommended that Peer Recovery Specialists complete CIT core training, preferably with the local CIT program. Peers serving on a community care team should 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 VDH 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 VDH and will have active agency representation on the local cross-agency 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 credential or licensure (where applicable), consistent active participation within the cross-sector 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/permanent duty community care team personnel must complete Advanced Marcus Alert training (through the state-sanctioned cross-disciplinary version or with other advanced trainings that integrate the topics listed in the Statewide Training Standards 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.

It is also recommended that members of community care teams include cross-discipline familiarization to include data sharing and security, scene safety, common language protocols (i.e.,

protocols that do not rely on jargon from within one discipline that may be less familiar to other team members), 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-responder 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 participating in a ride-along or other co-response capacity (even when not assigned to permanent duty) meet the same recommended minimums. Additionally, any officer assigned as a permanent duty co-responder should have access to additional and advanced training for recognition and de-escalation of individuals who have intellectual and developmental disabilities or acquired brain injuries, more frequently and/or 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 (coordinated 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-responder team could not be supported due to the population size).
Presentation: There is general universal agreement that characteristics of police uniforms are important in how police officers are perceived as well as how police officers behave. Yet, there are varying viewpoints regarding what the costs/benefits of different “messaging” of different uniform types. A crisp, professional uniform (including factors such as being unwrinkled and belt appearing secure) has been shown to communicate authority, power, and competency and may be a protective

factor against assaults on police officers in contexts separate from behavioral health crisis. A "soft" uniform that is less formal than a typical duty uniform is expected (but not proven) to send messages regarding friendliness and approachability. Interestingly, research on soft uniforms specifically, for example, in the youth correctional setting, demonstrates that the primary impact of the uniform is on the behavior of the officer. In general, it is thought that a soft uniform may provide easier initial communications in some circumstances while still allowing officers access to all necessary safety equipment—as a specific illustration, many soft uniforms have the appearance moreso of a paramedic uniform (polo shirt with insignia/professional logo), cargo pants, communication device visible on chest, baseball-style cap). Because of the resources in some communities and the nature of the team assignment (permanent 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 law enforcement officers that could respond to crisis scenes of high acuity (e.g., by wearing an easily identifiable lanyard/identification card).

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. Stakeholder group members with extensive experience in these contexts (CIT, law enforcement) recommended that ballistic protection be offered/provided to mental health professionals serving on a co-response team. The inherent risks that accompany travelling in a law enforcement vehicle and co-responding to unknown and unpredictable situations should be contemplated and considered. Appropriate policy governing the provision and utilization of such protective equipment shall be up to a locality. Localities may also choose to offer ballistic protection to mental health professionals working on other types of community care teams.

Intervention: Co-responder teams are unique in that they work as a collaborative unit. In general, the law enforcement officer ensures scene safety and the mental health professional leads the

communication and intervention with the person in crisis. This should not be construed to mean that the law enforcement officer cannot/should not use their own mental health training and rapport building skills. 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 Team without law enforcement. Community Care Teams outside of the "co-responder 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, including providing community based, preventive services and outreach. Due to this, a community care team may be staffed and equipped in any number of combinations that support responses for varying acuity levels of individuals. First, we describe the response/approach of community care teams without law enforcement as members of the team.

Community Care Team (without Law Enforcement) Approach
Response: Team members 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 a single 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. Because this configuration does not involve law enforcement, 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. It is recommended that members of community care teams be easily identifiable as team members both for the professional purpose of identification to persons in crisis as well as if law

enforcement is called to the scene as back-up (all area law enforcement who may be called on to serve in a back-up capacity should be made aware of the presentation of the community care team).

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 providing immediate support and 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, supporting the individual with peer support, or providing general support (including meeting basic needs such as food, water) and awaiting a mobile crisis response or clinical assessment.

Finally, we describe a version of a community care team that takes a preventive approach and involves law enforcement members. A key feature of this model is that preventive community care teams have responsibilities outside of an immediate response to calls for service, and carry a "caseload" of individuals, providing diversion, connection to services, ongoing visits, and support during times of high stress (e.g., following a call for crisis). A positive, empowering team culture and collaborative relationships with other groups is likely a key factor in the development, success, and sustainability of a community care team. Although cross-sector quarterly meetings are required regardless of the Marcus Alert approach taken, preventive community care teams with law enforcement often meet on a weekly basis, and these meetings are inclusive of cross-agency partners. Key partnerships for preventive community care include adult protective services, fire and rescue/EMT, and the local school system.

Preventive Community Care Team (with Law Enforcement) Approach

Response: Preventive community care teams have responsibilities outside of an immediate response to calls for service, and carry a "caseload" of individuals, providing diversion, connection to services, ongoing visits, and support during times of high stress (e.g., following a call for crisis). Regarding the immediate response, community care teams provide on-scene responses similar to those described above (community care team, no law enforcement, and co-responder team), with a focus on diversion and connecting individuals to needed services. 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. Because of the ongoing nature of the response, it is likely that the

team will take a flexible approach to who attends service calls and whether team members go on any calls alone (e.g., to individuals who are well known to the team).
Presentation: If a locality is committing to a permanent duty assignment as part of a preventive community care team, a soft uniform should be considered (see further discussion and details under co-responder team description). Non-law enforcement team members commonly wear street clothes or business casual dress (with identifying features, such as a lanyard and ID badge). 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.
Intervention: Depending on local team composition and the call for service, interventions may vary. For higher acuity situations, law enforcement likely secures the scene prior to other interventions. Community care interventions focus on linking individuals to the appropriate supports and services. EMT or fire/rescue members may attend to minor injuries, social workers may work with the individual in crisis or family members to determine next steps (e.g., transport to a crisis receiving or assessment center).

Additional Considerations for Community Care 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 (ECO/TDO) may only be completed by law enforcement officers. While this can be accomplished by requesting police as a backup to crisis calls that are initially handled by a behavioral health-only response, 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.

Currently, we are undergoing a paradigm shift regarding whether, and to what extent, law enforcement support is needed to ensure safety during most behavioral health crises. Yet, it is well known that the current Virginia landscape includes an over-representation of "deep end" or emergent calls due to lack of access to crisis care in the community. In other words, the crises that are observed by our current emergency services and law enforcement first responders are often emergent and mental health clinicians perceive a need for a safety related support much of the time. We understand that for people on the front lines, hearing about research statistics does not increase feelings of safety and security. Although specific actionable options were not identified at a state level during the planning period, there are safety-related supports from alternative paradigms that deserve further attention. We recognize that safety related supports are an important part of the mobile crisis response we build, and approach this flexibly, acknowledging that safety-related supports are not synonymous with law enforcement. We 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, intimidated, or discriminated against. Thus, as paradigms related to safety related supports expand, the role of 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) will continue to be explored. 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. The ultimate goal is to divert behavioral health crises from primary law enforcement response.

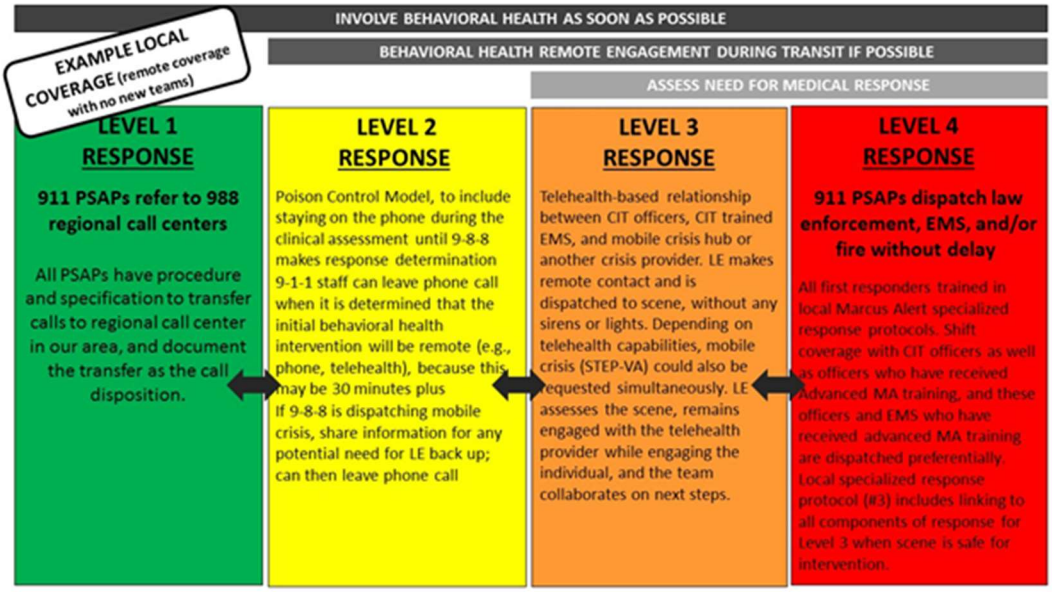
Examples of Local Plans for Community Coverage

Community coverage by a mobile crisis response can be achieved a number of ways, and all approaches 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 transfer of calls from 911 to 988, Level 4 is required emergent response, and there are a range of options that can be selected among or layered across all levels. Level 2 is a recommended diversion/Poison Control Model with 988 that results in a STEP-VA/BRAVO mobile crisis dispatch. Level 3 options include remote

or telehealth support to bridge the time it takes for a mobile crisis response, community care team response (with or without law enforcement), specialized children's mobile crisis or REACH mobile crisis, or co-responder teams when there is a safety concern. These approaches may be appropriate as follow-up to Level 4 responses, wherein a law enforcement or EMS response is required to precede a behavioral health intervention. These examples for coverage presented on the following pages are provided as a guiding heuristic and to demonstrate the types of approaches considered acceptable at the different urgency levels, as well as to demonstrate the coverage provided by STEP-VA/BRAVO teams. The local protocols themselves will be much more detailed regarding operationalization of the approach.

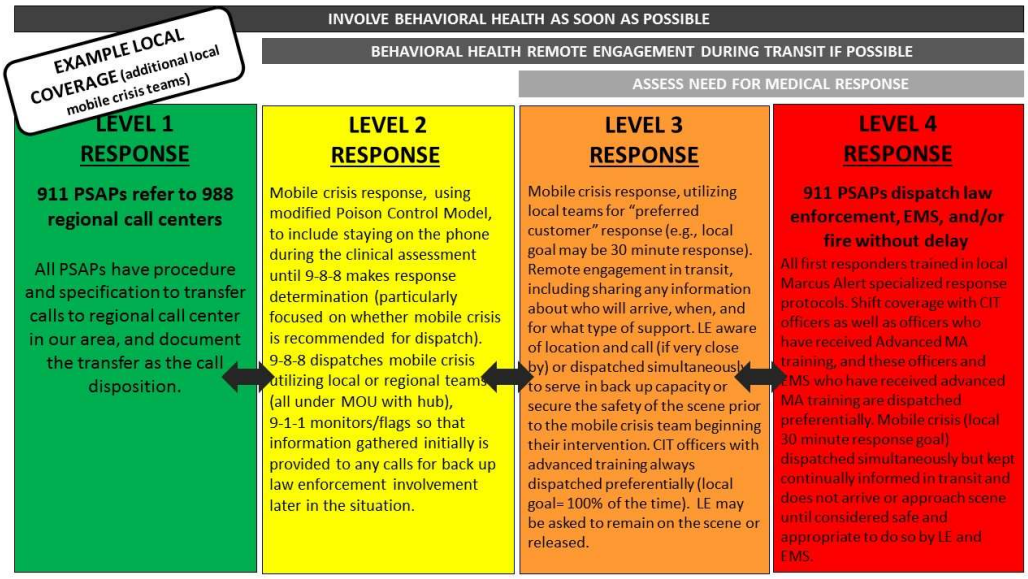
First, an example of how community coverage can be achieved with STEP-VA/BRAVO teams and supplemental procedures:

Figure 38. Community Coverage via STEP-VA/BRAVO MCTs Only



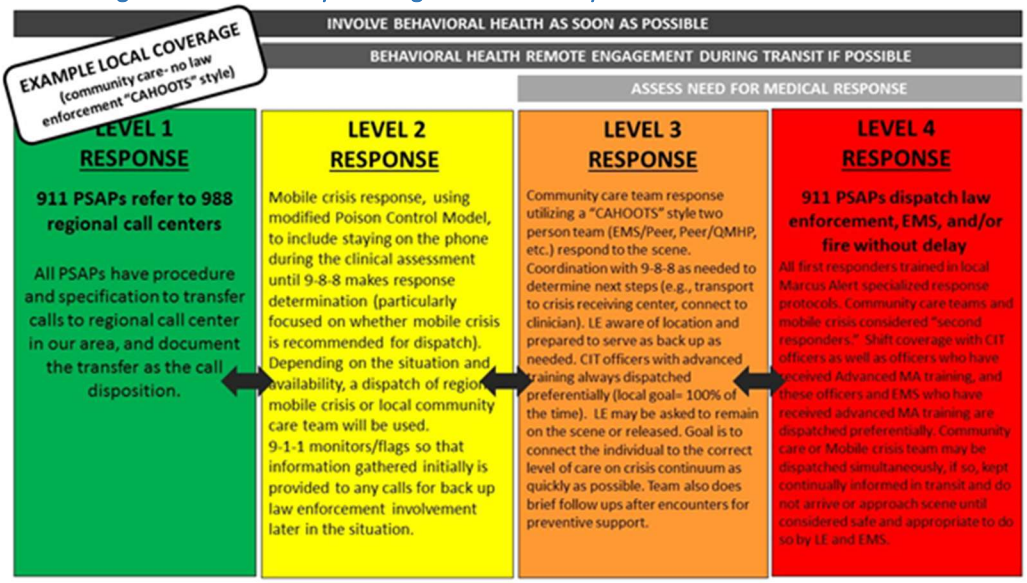
Second, an example of how coverage could be achieved by increasing the number of mobile crisis teams in your area (dispatched by the regional hub with a response time quicker than 1 hour):

Figure 39. Community Coverage via Additional, Local MCTs



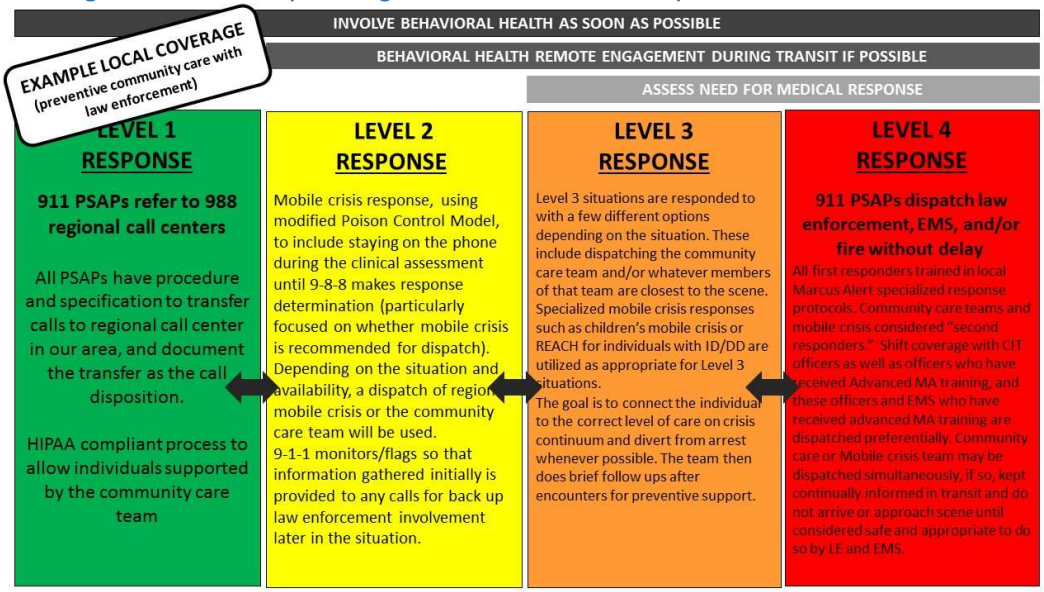
Third, an example of achieving coverage using a community care team without law enforcement, often considered a "CAHOOTS" style team (which can consist of any combination of community care team member types):

Figure 40. Community Coverage via Community Care Team without LE Members



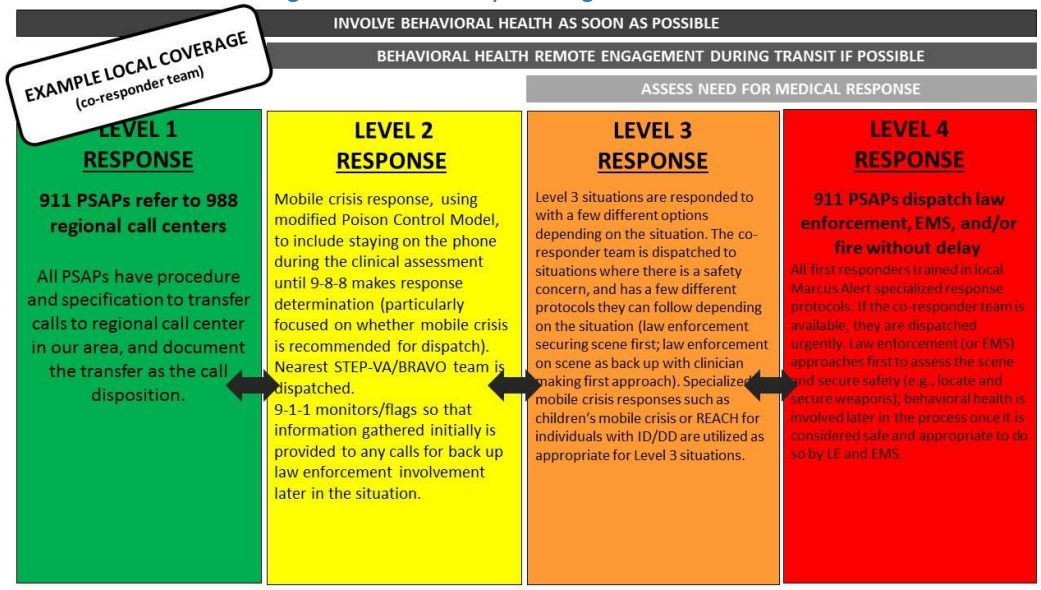
Fourth, an example of community coverage with a preventive community care team with law enforcement:

Figure 41. Community Coverage via Preventive Community Care Team with LE Members



Fifth, an example of community coverage including a co-responder team:

Figure 42. Community Coverage via a CRT with LE



These arrangements are not the only configurations to accomplish the requirements of the Act. There are likely other arrangements that meet the minimum standards (as well as best practices) that are not reflected here.

Minimum Standards for Local Marcus Alert Systems (across Protocols 1, 2, and 3):

- *Voluntary database is available for residents to provide information, updated regularly, confidentiality and privacy is considered with local legal staff.*
- *The four-level framework is adopted for standard communication and response planning across professions.*
    - *Level 1 calls must be diverted to 988.*
    - *Level 2 calls are coordinated with 988; local plans must include provisions for including behavioral health as a first responder (see Response Options section).*
    - *Level 3 calls include multiple response options across agencies/entities, including a behavioral health-only response option.*
    - *Plan must include provisions for how Level 3 calls will be handled for adults, youth, and individuals with developmental disabilities.*
    - *Level 4 calls include law enforcement or EMS, an "emergent response" that is not delayed.*
    - *The four-level framework is integrated into the CAD by the PSAP by July 2022.*

- *All agencies within the area comply with state training standards.*
- *Memorandums of agreement (consistent with the state requirements) are developed between the call center hub and any responding law enforcement agency (Protocol #2).*
- *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-informed.*
- *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-trained officers and officers with advanced Marcus Alert training is outlined.*
- *Attendance at cross-sector quarterly local meetings occurs regularly.*
- *Submission of quarterly data (additional details under development) adheres to requirements.*

Best Practice Considerations for Local Marcus Alert Systems

In addition to meeting the minimum standards,

- *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).*
- *Take a systems view and, when resources are constrained, build behavioral health-focused supports as a priority over other investments.*
- *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.*
- *Ensure there are behavioral health-only approaches available at Level 3 for youth and individuals with developmental disabilities, particularly if there is a law enforcement lead for your locality's adult Level 3 primary response option.*
- *Consider partnerships across jurisdictional boundaries, particularly when it increases efficiency (e.g., for any telehealth-based coverage).*
- *Consider a "layered" approach, with investments aligning with community values vs. the selection of one specific team type only.*
- *Level 2 calls follow a poison-control model with 988, unless community care teams have a special function at Level 2 (e.g., "frequent utilizers" case management function).*
- *Level 3 calls involving youth are coordinated with 988 and specialized children's mobile crisis teams.*
- *Level 3 calls involving individuals with ID/DD are coordinated with 988 and specialized developmental disability mobile crisis teams/REACH program.*
- *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.*
- *All law enforcement officers received eight-hour mental health first aid.*
- *Provide 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.*
- *Provide advanced workshop based trainings on cultural humility and cultural competence.*
- *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.*
- *LE integrates special requirements regarding mental health, developmental disabilities, and substance use across key agency policies such as use of force and bias-based policing.*
- *Have a high level of engagement in cross-sector quarterly meetings and data-driven quality improvement processes at the local level.*

Local Plan Submission, Review, and Approval

There are two supplemental documents that are important for local plan development and submission. This includes the Community Roadmap and the Marcus Alert Local Plan. The Community Roadmap provides a pathway, with both required and optional exercises, for local plan development. The Marcus Alert Local Plan is the packet of documents that are submitted for approval. A web portal for submission is under development and will be on the DBHDS website: https://dbhds.virginia.gov/marcusalert. If for any reason the web portal is inaccessible, communication, questions, or a PDF of the application can be submitted to marcusalert@dbhds.virginia.gov (note: plans submitted in this format will receive follow up technical support to submit in the preferred format). An overview of the submission requirements from the Marcus Alert Local Plan document are provided here.

Figure 43. Checklist for a Completed Marcus Alert Local Plan Submission
Below are the components required to achieve compliance with the Act by July 1, 2022.

1	Documentation of Sections 1-4 of the roadmap (when "decide and document" is noted, it	July 1, 2022 statewide	Text submission

	should be included in your summary)*		
2	List of stakeholder group members*	July 1, 2022 statewide	Excel file upload
3	Triage crosswalk connecting 4 urgency levels to PSAP specifications*	July 1, 2022 statewide	Text submission (4 separate text boxes for 4 levels) and PDF upload
4	Copy of Protocol #1*	July 1, 2022 statewide	PDF upload
5	Copy of Protocol #2*	July 1, 2022 statewide	PDF upload
6	Copy of Protocol #3*	July 1, 2022 statewide	PDF upload
7	Triage crosswalk connecting 4 urgency levels to responses/protocols 1,2, 3*	July 1, 2022 statewide	Text submission (4 separate text boxes for 4 levels) and PDF upload
8	Checklist of minimum standards and best practice considerations for law enforcement involvement	July 1, 2022 statewide	PDF checklist
9	Statement on accountability for quarterly cross sector meetings and quarterly data reporting*	July 1, 2022 statewide	Text submission
10	Contact information for application overall and core reporting, PSAP reporting contact, and law enforcement reporting contact*	July 1, 2022 statewide	Individual text boxes for contact information
11	Statement of barriers, needs, or concerns for implementation*	Optional	Text submission

**These components must be submitted by initial areas by October 15, 2021 for December 1, 2021 implementation*

Figure 44. Checklist for a Completed Marcus Alert Local Plan Submission

Below are components required by areas' phased-in coverage date as well as additional compliance components.

1	Updates/changes to any other materials listed above	Yearly or when changes occur	Varies by component

2	Revised triage crosswalk connecting 4 urgency levels to responses/protocols 1,2,3 and community coverage	Phased implementation date	Text submission (4 separate text boxes for 4 levels)
3	Description of community coverage and team types*	Phased implementation date	Text submission
4	Logic Model	Phased implementation date	PDF upload
5	Data collection plan (crosswalked with future guidance)	Phased implementation date	Text submission
6	Local QI process description	Phased implementation date	Text submission
7	Budget (if any)*	Phased implementation date	Line item budget entry

Note: the specifics of the components that are part of the phased implementation submission are subject to change following initial implementation in first 5 areas

**These components must be submitted by initial areas by October 15, 2021 for December 1, 2021 implementation.*

Please allow four to six weeks for plan submission review. Reporting requirements will go into effect October 1, 2022 (quarter 1 of implementation). Data submission testing with initial areas will occur on an ongoing basis during development. It is estimated that statewide data submission testing period will take six months (running 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.

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. This will be managed by the formation of a Marcus Alert Evaluation

Task Force. Membership and attendance will be asked of DBHDS and DCJS technical and program leads, OEMS, VDEM, crisis call center platform vendor, technical and program leads from initial area PSAPS, initial area program leads, and one subject matter expert from the initial workgroup in each of these areas: law enforcement, CIT, equity, and regional mobile crisis hub/988. 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. It cannot be overemphasized how complicated the technical aspects of data sharing between these entities will be, which will require resources at all involved agencies which contribute to the reporting structure, but all stakeholders understand that reporting and accountability are written into the legislation.

Key Indicators and Outcomes

A general survey was sent to stakeholder group members regarding perceptions and priorities for the evaluation of the success of the Marcus Alert system and implementation. Sixteen stakeholder group members completed the survey, so it cannot be assumed that these results reflect the view of all group members. All responses will be provided to the Evaluation Task Force for their ongoing planning. First, respondents were asked to rate the importance of evaluating (using a "five star" rating scale) six general domains of outcomes related to the Marcus Alert. The table is organized by domain, with domains listed in order of highest average rating of importance to lowest average rating of importance.

Domain	Average Rating (out of 5)
data points related to locality's compliance with training requirements and other requirements (such as having approved protocols)	4.21
data points related to law enforcement diversion and the development of new teams such as community care teams and other diversion teams	4.21
data points related to racial disparities in access and outcomes	4.00
data points related to 988 and the behavioral health crisis system (intercept 0)	3.86
data points related to voluntary/involuntary status, restraint, use of force, and safety	3.79
data points related to community engagement (including involvement in planning and awareness of resources and services)	3.71

These ratings were consistent with general discussions regarding the importance of compliance and accountability, measuring development of the system over time, and the importance of considering racial disparities. Group members were also asked to consider potential key measures and outcomes within each of the six domains. The most frequently endorsed measures are listed here. It is important

to note that the Evaluation Task Force will need to determine the feasibility and operationalization of these measures.

Compliance with Local Requirements

- *Number or percentage of areas with complete, submitted plans by July 1, 2022*
- *Number of percentage of areas with approved Protocol #1, 2, and 3 by July 1, 2022*
- *Percentage of crisis behavioral health providers who receive required training*
- *Percentage of PSAP staff who receive required training*
- *Percentage of LE officers who receive required training*
- *Number or percentage of staff across professions who take the advanced MA training*

Behavioral Health System Development and Diversion

- *Number of mobile crisis teams formed and responses*
- *Number of community care teams (no law enforcement) formed and number of responses*
- *Total number of calls going to 988 from the community (this indicates that community members are calling 988 more and more when having a behavioral health emergency)*
- *Total number or percentage of calls going from 911 to 988 (this shows that 911 centers are following protocol of diverting some calls to the 988 center)*
- *Response time for STEP-VA/BRAVO mobile crisis (this shows that the behavioral health only response is arriving within an hour, or could show that the response is getting quicker over time)*
- *Percentage of the time that STEP-VA/BRAVO teams are calling for law enforcement back up (decreases to this over time would indicate increased behavioral health only response and less reliance on law enforcement)*
- *Changes in proportions of level of crisis calls over time (in other words, are people calling earlier in the crisis cycle before it is a level 3 or 4 situation, both for 988 and 911)*
- *State investment in alternatives to law enforcement for crisis care*

Law Enforcement System Changes

- *Law enforcement drop off time decreasing*
- *Number of community care teams with law enforcement formed and number of responses*
- *Number of co-responder programs formed and number of responses*
- *State investment for law enforcement training and development*

Individual and Family Crisis Experiences

- *Total number of ECOs decreasing in areas where MA has been implemented*
- *Total number of TDOs decreasing in areas where MA has been implemented*
- *the rate at which people served by the different team types experience a use of force*
- *number and/or change over time in injuries*
- *satisfaction of consumers*
- *satisfaction of families*

Racial Disparities

- *Racial disparities in calling for LE back up for behavioral health crisis response*
- *Racial disparities in connection to care across team types*
- *Racial disparities in use of control, force, or arrest by LE when LE responds alone*
- *Racial disparities in sending 911 calls to 988*
- *Disparities in use of control or force by LE when LE responds alone by different disability types*

Community Awareness

- *utilization of the voluntary database by locality*
- *changes in proportions of level of crisis calls over time (in other words, are people calling earlier in the crisis cycle before it is a level 3 or 4 situation, both for 988 and 911)*
- *community awareness of 988*
- *satisfaction of sectors involved (providers, law enforcement, schools, hospitals)*

Respondents were also asked to consider different approaches to evaluation during initial implementation of the Marcus Alert. Most responses indicated that taking approximately 12 months to develop a baseline and track data would be a first step in setting up more formal benchmarks or targets. It was recommended that a developmental approach be taken (success measured in change and growth) and that areas where there are difficulties implementing (i.e., geographic areas) be identified early so that support can be provided while systems are still under development. One specific concern regarding data collection was regarding the collection of data on use of restraints such as handcuffs as well as collection of data on use of force. On one hand, community input indicated that being handcuffed was a key issue in perceived loss of dignity and trauma associated with crisis response. At the same time, handcuffs are often required per law enforcement policy for transport, and, as described throughout the report, the governmental role of law enforcement is at times specifically to restrain and

transport a person in a “treatment before tragedy” function. Related to use of force, the concern was that any use of force reported would be considered an excessive or inappropriate use of force, and this would reflect poorly on law enforcement specifically even if the use of force was to achieve a “treatment before tragedy” or other appropriate governmental function. A number of options were presented to group members, including collecting the data without any other actions, not collecting this data at all, and collecting the data but attempting to mitigate this risk of misinterpretation. The most commonly endorsed risk mitigation (endorsed by all but one survey respondent) was to measure these outcomes but be very careful to always explain very clearly the role of these actions in law enforcement completing their duties for example in executing an ECO, and the purpose of showing a decrease being to show an overall increase in empowerment, voluntary treatment, and de-escalated interactions. Other strategies endorsed to a lesser extent (but endorsed) were to consider this primarily as a state level outcome, not an individual area performance metric. Because of these concerns, the details of how these data points would be collected was considered by the group. The use of force categories recommended for reporting are:

- *Empty hand controls (strikes, kicks, takedowns)*
- *OC (“pepper spray”) deployed*
    - *Decontamination conducted by:*
- *Baton used*
- *CED/Taser discharged*
- *Service weapon/firearm pointed*
- *Service weapon/firearm discharged*

The additional actions and controls recommended for reporting are:

- *Hand restraints applied and double locked*
- *Leg restraints applied and double locked*
- *Soft hand and/or leg restraints applied and double locked*
- *Released on summons*
- *Arrested*

Regarding end point of the interactions, the following outcomes are recommended:

- *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*

Local Reporting Requirements

In a general sense, in order to construct measures as described above, there are three data sources necessary. Each component will be required quarterly, and any requirements that can be built directly into the crisis call center platform will be integrated in that way. The three components are:

1) **Call center data.** 911 PSAPs will be required to submit data on calls classified as Marcus Alert Levels 1, 2, 3, and 4 and their associated call dispositions. Similarly, 988 call center data and associated call dispositions will be submitted. Due to the vast variation in how calls are classified and how that information is captured, a state-standard crosswalk will be required to compile data. The Evaluation Task Force will finalize the crosswalk prior to December 1, 2021. Call types, Marcus Alert level, and disposition (transfer to 988, dispatch law enforcement, dispatch co-responder team, dispatch mobile crisis, dispatch fire/EMS) will be included in the crosswalk for CAD data submissions. 911 PSAP representation on the Evaluation Task Force will ensure that plans are feasible.

2) **Mobile response data (mobile crisis and community care teams).** 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 call center data platform. A 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. Due to overlap between CITAC reporting requirements and potential elements required for Marcus Alert reporting, DBHDS divisions and data warehouse will consider the feasibility of combining these two reporting requirements to avoid redundancy. Key areas for reporting will likely include basic event information, basic information about the individual in crisis, use of force (with standard definitions), other law enforcement actions taken, transport, and outcome of the field encounter (with standard definitions, focused primarily on connections to different aspects of the crisis continuum).

3) **Law enforcement field response data.** A mobile crisis response will not be provided for every Marcus Alert situation, including situations where it is not identified as a Marcus Alert situation until an officer has already responded. The third reporting requirement is regarding event resolution data, specifically, to capture data on Marcus Alert Level 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; it is our understanding that this is rare. 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 or have a mechanism to access 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, transport etc). Law enforcement representation on the Evaluation Task Force will be a liaison to the larger law enforcement community to ensure that plans are feasible.

Marcus Alert Accountability Framework

As a complex law with state and local components, and multiple agencies and secretariats, Marcus Alert accountability structures are considered to be three fold. These three components are considered 1) existing accountability structures between local agencies, state agencies, and the general assembly, 2) cross-sector accountability, and 3) community accountability. Key outcomes, which were described generally above, will be further operationalized by the Evaluation Task Force and the state stakeholder group at the six month follow up meetings. Stakeholder group members will have an opportunity to raise objections at the six month follow up meetings. In general, outcomes will include meeting basic requirements (compliance), submitting complete quarterly data, and performance and progress on selected outcomes.

Existing Accountability Structures

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, and will have a distinct Exhibit to that Performance Contract for each regional call center. 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 NG911. Meanwhile, the Office of Emergency Medical Services within the Virginia Department of Health has purview over the existing 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.

Cross-Sector Marcus Alert Accountability (Local)

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 Marcus Alert (local or regional) 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 (currently funded in each region) 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. We will also explore the need for an MOU with VDEM and 9-1-1 Service Board regarding state-level partnership.

Critical incident reviews of cases should be required to occur at the program (i.e., local or team) 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). Local program meetings and critical incident reviews would be the avenue to do quality improvement at a local level. Examples of review activities to undertake include:

- *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)*
- *Review any interactions that end in arrest*
- *Review any interactions that end in injury of anyone*
- *Review any interactions that include use of force*
- *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)*
- *Performance of Protocol #3 specifically (i.e., could those situations could have been predicted/diverted earlier)*
- *Public outreach regarding voluntary database utilization rates, public awareness campaign, etc.*

Cross Sector Marcus Alert Accountability (State)

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, structured through ongoing meetings to occur at least quarterly.

Community Accountability (Local)

The third accountability structure relates to community accountability, and ensuring that there is transparency regarding the Marcus Alert system development and outcomes for community members. At the local level, all described accountability structures are based on the review of de-identified data, which is always reviewed in aggregate. Including racial and ethnic disparities is required. Disability types will also be disaggregated when possible. In smaller areas, it is important to note that confidentiality and privacy is a key consideration and cannot be compromised. The recommended structures for local community accountability are as follows. Twice yearly, the area stakeholder group (initial local planning group must continue to meet the composition requirements as members leave and are replaced) must be reconvened by the local program (or regional) 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 (selected from the group, preferably on a volunteer basis) should provide written comments from the stakeholder group regarding recommended improvements to the system. The local or regional 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.

Community Accountability (State)

Regarding accountability to the broader Virginia community, 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 (attend, review data, make presentations) 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 (the ongoing state stakeholder group and the Black-led Crisis Coalition) 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 (whether recommendations are taken or not) in the implementation plan for the following year and reported back on in the following year's comprehensive report to the Joint Commission on Health Care.

Summary of Accountability Framework

As emphasized throughout the plan, a polycentric governance approach was taken, given the high level of complexity of the project. In the 1960s, Vincent Ostrom adopted the term polycentricity (traced back to Miachael Polanyi's 1951 publication, The Logic of Liberty, Reflections, and Rejoinders) to describe governance characterized by multiple, overlapping political units that has the ability to achieve greater efficiency in production and provision of public services and goods than a centralized government if particular market-like characteristics exist.[9] These theoretical claims were supported by empirical evidence and later strengthened by Elinor Ostrom's 8 Design Principles of Polycentric Governance characterizing best practices and describing sustainable rules and structures. These 8 principles relate to boundaries of a system; congruence aligning with local needs and conditions; opportunity for local participation in defining rules; rights of community members in rule setting participation respected by outside authorities; approaches for monitoring conflicts; methods to sanction violators of rules; opportunity for low-cost conflict resolution; and the implementation of multiple, nested layers of organization.[10] The Prosocial Process[11] distills these principles down to make them more actionable to support the formation of productive, equitable, and collaborative groups as follows:

- *Shared identity and purpose*
- *Equitable distribution of contributions and benefits*
- *Fair and inclusive decision making*
- *Monitoring agreed upon behaviors*

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[9] Carlisle & Gruby, 2017. Polycentric systems of governance: a theoretical model for the commons. Policy Studies Journal, 47(4): 927-952.

[10] Dell'Angelo, J., McCord, P., Gower, D., Carpenter, S., Caylor, K. & Evans, T., 2016. Community water governance on Mount Kenya: an assessment based on Ostrom's design principles of natural resource management. Mountain Research and Development, 36(1): 102-115.

[11] Atkins, P., Wilson, D.S., Hayes, S.C. (2019). Prosocial: Using evolutionary science to build productive, equitable, and collaborative groups. New Harbinger Publications, Inc. Oakland, CA. See also: https://www.prosocial.world/)

- *Graduated responding to helpful and unhelpful behaviors*
- *Fast and fair conflict resolution*
- *Authority to self govern when governing according to principles 1-6*
- *Collaborative relations with other groups utilizing principles 1-7 (allows the governance structure to scale)*

The following have been observed when polycentric principles are implemented in a governance system: 1) increased capacity to implement social and environmental change; 2) in complex natural resource systems, polycentricity provides good "institutional fit"; and 3) redundancy in governance increased the ability to efficiently mitigate risks. In 2019, Virginian (and other) experts note the particular relevance of polycentric arrangements:

"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."[12] (Aligica, Boettke, & Taro, 2019, pg. 68)

These descriptions are not provided for academic contemplation, but to begin to build a framework for accountability regarding the Marcus Alert that can be leveraged to achieve *consistent and robust protections* and *positive outcomes* statewide for all Virginians, while respecting local needs and expertise. As described, the success of such arrangements relies on adherence to specific principles at each level of governance. In other words, the requirement of specific accountability structures and processes at the local level (cross sector and community accountability, through quarterly meetings and ongoing stakeholder engagement) is a key factor in ensuring that local needs are met and that local Marcus Alert systems are able to develop in response to local needs.

At the state level, Virginia DBHDS and DCJS share responsibility for reporting the status of the Marcus Alert to the Joint Commission 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. In order to also adopt the core design principles at the state level, per this state plan, we identify, in addition to those entities listed above, the Equity at Intercept 0 leads, the Crisis

[12] Aligica, P.G., Boettke, P.J., & Tarko, V. (2019) Public Governance and the Classical-Liberal Perspective. Oxford University Press: NY, NY.

Coalition, the original Marcus Alert stakeholder group and regional mobile crisis hubs as additional entities to include in the further development and evaluation of the implementation from a state perspective. 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. Given these complicated structures and overlapping domains; it is possible that a more formal arrangement should be considered for formation during the initial years of implementation to ensure ongoing accountability.

Summary of State Implementation Plan

This state plan provides the initial framework for the implementation of the Marcus-David Peters Act. With significant cross-sector and stakeholder input, this plan provides initial information about state-level responsibilities and frameworks (four-level urgency triage, STEP-VA/BRAVO mobile crisis, 988/regional call centers, statewide training standards, and a public service campaign) as well as the local requirements for developing a local Marcus Alert system and coming into compliance with the requirements of the Act (local planning process, development of a voluntary database, development of three protocols, developing a plan for community coverage, whether or not additional teams are formed, a comprehensive list of minimum standards across local requirements, and how to submit a plan for approval). A framework for the ongoing development of a robust evaluation plan and structures for community feedback 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. Ultimately, the purpose of the Marcus-David Peters Act is to provide a behavioral health response to Virginians experiencing a behavioral health crisis, and individuals with mental health disorders, substance use disorders, developmental disabilities, brain injuries, and their loved ones and natural supports must remain at the center of the conversation. Thus, we end by summarizing the local and state supports, including areas where variation is expected statewide, that are included in the implementation plan and can be expected by Virginians as the Marcus Alert and other associated components of the comprehensive crisis system are implemented statewide.

Summary of Marcus Alert Components for Virginians in Crisis

Marcus Alert Local Supports	State and Regional Crisis Supports
A voluntary database to provide information to your local 9-1-1 dispatch prior to a crisis (July 1, 2021) if there are things you would like them to know about you	Access to 24/7 crisis support through 9-8-8 by December, 2021, including phone support, connection to appointments, peer supports, assessments, and National Suicide Prevention Lifeline resources
A detailed four-level triage system defined so that all crises are categorized as objectively as possible and connected to the most appropriate response that is available (July 1, 2022)	An in-person response by behavioral health within about an hour when 9-8-8 deems that as the best response (increased coverage towards 24/7 will be built over the next two years)
Assurance that all first responders have training in mental health and de-escalation, as well as knowledge of Marcus Alert protocols (training to begin July 1, 2022)	Assurance that law enforcement agencies called as back up for a behavioral health crisis response are under an agreement and have been trained (July 1, 2022)
Specialty local teams or responses, some of which do and some of which do not involve law enforcement, to respond more urgently than statewide mobile crisis, such as community care teams, co-responder teams, or telehealth solutions (phased dates statewide)	An equity at Intercept 0 initiative with a goal of increasing Black-led, BIPOC-led, and peer-led crisis providers representation in Virginia's behavioral health crisis services continuum, and achieving 24-hour coverage with behavioral health teams through public-private partnerships
Process for transferring calls from local 9-1-1 to the behavioral health 9-8-8 line when a behavioral health only response is needed, and procedures for handling calls in a coordinated fashion (July 1, 2022)	A yearly public report regarding the performance and outcomes of the system, including any racial disparities in access and outcomes and a statement regarding system performance from the perspective of the equity network and coalition (each November)

Developing this array of supports in a manner that is accessible for all Virginians will take time, training, funding, culture and paradigm shifts, extensive collaboration between sectors and across levels of government, preferably adhering to the recommended polycentric principles, and a commitment to ongoing quality improvement and community engagement.

Addendum: Broader Considerations

A number of broader system considerations beyond the scope of the state plan 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) Consideration regarding a state-wide approach to the voluntary database was raised by a number of stakeholders. Because localities must implement this part of the Marcus Alert this year (July, 2021), a statewide approach (assuming there was funding available) may not be logical at this time. Yet, if addressed on a quick timeline, it is possible that a statewide solution could be achieved, if stakeholders continue to elevate this type of solution.
3) 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 deserve consideration. 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.
4) There are significant costs associated with most aspects of this plan, without clear funding sources. Regarding the funding of behavioral health teams and mobile crisis services, there is a need for all payers, to include Medicare and private insurance, to pay for mobile crisis services when accessed through the public system. Although we are building a cross-disability system in terms of access, there are also additional costs associated with ensuring there is appropriate infrastructure and expertise to provide specialized child services as well as other specialized services. There are also significant costs associated with training and time requirements of law enforcement. There will also be costs of this implementation that will fall on local PSAPs, which deserve additional attention because they play an extremely important role in the success of the system which is not as apparent as the role of behavioral health and law enforcement when reading the Act (i.e., authorities and responsibilities specific to local PSAPs and state agencies are not clearly called out). Across all agencies, there will be costs associated with the increased burden of reporting and documentation, and because evaluation is a key component of the Act (including a focus on health disparities), the importance of reporting and documentation should be highlighted. Concerns for funding in rural areas were specifically raised, where number of crises (and hence, total reimbursement) are generally low and law enforcement agencies only have a very small number of people on staff.
5) To meet the evaluation requirements, there will be a significant burden placed on PSAPs and local law enforcement (there will also be a burden placed on the mobile crisis teams, but they are not called out specifically because the paperwork burden on mobile crisis teams is primarily due to other required documentation that isn't specific to the Marcus Alert). The issue was

raised that if this flow of information is required (from PSAPs and LE), there should be a mechanism for the state to provide personalized feedback/reporting back to the areas. One solution to this would be one or more regional crisis system analysts for each region who could take on this role. At the state level, most reporting will be aggregated, and although this meets the requirements of the Act, it does not provide benefit to the localities (but does increase paperwork/reporting burden).

6) Throughout the planning process, concerns regarding quality and quality oversight of training and training curriculums were raised. These concerns were not able to be fully addressed as broader quality oversight processes are much broader than the Marcus Alert plan and could not be addressed directly by this planning group.
7) Throughout the planning process, questions were raised regarding whether or not the Marcus Alert protocols would include specific guidance for law enforcement to utilize when determining whether or not a criminal matter, when criminal actions were observed due to law enforcement's presence in one of the defined governmental functions related to behavioral health crisis response, would be pursued. It was determined that the state-level plan did not have scope to include such recommendations, but there is nothing that precludes localities from setting up such recommendations for their own area, as long as there is not a conflict with existing laws and regulations. A "catch-22" was noted, wherein officer discretion was described as a key factor in whether or not charges would be pursued, yet, the group raised concerns that bias would make any benefits of these discretionary considerations more or less accessible to different groups.
8) Throughout the planning process, concerns related to building coverage for behavioral health mobile crisis response were raised, particularly due to national workforce shortages in behavioral health and the need for 24/7 coverage for a robust response. Significant investments such as loan repayment programs, training programs and pathways to licensure, have a role to play in the success of the Marcus Alert. 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 overall system transformation will take time as behavioral health coverage increases.

Appendix A. Marcus Alert Stakeholder Group Members

Members of the state stakeholder group, including *ex officio* members and proxies, are listed below.

Alex Harris
Angela Hicks
Anika Richburg
Anna Mendez
Anne McDonnell
Anthony McDowell
A'tasha Christian
Ben Breaux
Ben Tyler
Bruce Cruser
Chloe Edwards
Christy Evanko
Dallas Leamon
Daryl Fraser
Daryl Washington
Elizabeth Bouldin-Clopton
Ellen Dague
Eric Blevins
Eric English
H. Steve Richardson
Harvey Powers
Heather Baxter
Heather Norton
Janelle Gilmer
Jennifer Faison
Jim LaGraffe
John Lindstrom
Jon Holbrook
Josie Mace
Kandace Miller-Phillips
Kari Norris
Katharine Hawkes
Katherine Hunter
Katie Boyle
Kim Young
Kristen Chesser
Lashawnda Singleton
Latasha Simmons
Lisa Jobe-Shields
Lisa Madron
Lois Bias
Mark Blackwell
Mary Begore
Melissa Heifetz
Mindy Carlin
Mira Signer
Myra Anderson
Natale Ward Christian
Nicky Fadley
Niki Bailey
Nina Marino
Patrick Halpern
Patty Smith
Princess Blanding
Rebecca Holmes
Redic Morris
Ryan Banks
Sabrina Burress
Sarah Wilson
Stephen Craver
Steve Drew
Steven Willoughby
Tamara Starnes
Tim Carter
Tonya Milling
Toyin Ola
Victor McKenzie
Wayne Handley
William Dean

Appendix B. Resources

Resources detailing best practices in police-mental health collaborations and innovative approaches for overhauling the crisis response system were shared throughout the state planning process. A list of those inputs and additional resources is provided here to aid areas in their local planning processes. These resources have been roughly categorized, however, the categories are not discrete. For instance, there is information regarding language access in some of the best practices documents.

Articles

Enhancing the Capacity of the Mental Health and Addiction Workforce: A Framework (Think Bigger Do Good)

Preventing Risk and Promoting Young Children's Mental, Emotional, and Behavioral Health in State Mental Health System (Think Bigger Do Good)

Systemic, Racial Justice–Informed Solutions to Shift "Care" From the Criminal Legal System to the Mental Health Care System (Think Bigger Do Good)

The Living Room, a Community Crisis Respite Program: Offering People in Crisis an Alternative to Emergency Departments (Global Journal of Community Psychology Practice)

Race and Reasonableness in Police Killings (Columbia Law)

Best Practices

Crisis Services: Meeting Needs, Saving Lives (SAMHSA)

This document includes multiple resources, including the behavioral health crisis care best practice toolkit and other resources that are referenced separately.

Crisis Residential Best Practices Handbook (Crisis Now)

National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (SAMHSA)

Community Responder Models

A Community Guide for Development of a Crisis Diversion Facility: A Model for Effective Community Response to Behavioral Health Crisis

Evaluation of the Indianapolis Mobile Crisis Assistance Team

Minneapolis, MN Alternatives to Police Response

Responding to Individuals in Behavioral Health Crisis via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers (IACP)

Comprehensive Crisis Response Systems

Roadmap to an Ideal Crisis System (The National Council)

Roadmap for Behavioral Health Reform

Transforming Services is Within Our Reach (Crisis Now)

Crisis Services' Role in Reducing Avoidable Hospitalization (NASMHPD)

Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care (NASMHPD)
Note that this is a link to a webinar recording on policy recommendations.

Crisis Intervention Team

CIT Methods for Using Data to Inform Practice: A Step-by-Step Guide (SAMHSA)

Designing CIT Programs for Youth (NAMI)

Responding to Youth with Mental Health Needs: A CIT for Youth Implementation Manual (NAMI)

Emergency Communications

APCO Operational, Technical, and Training Standards
Note that there are multiple standards documents available for download.

CAD Overview (DHS)
Note that this overview is intended for the layperson who is unfamiliar with PSAP operations.

NG911 Overview

NG911 Roadmap: Connecting Systems Nationwide

NG911 for Public Safety Leaders

NG911 for Law Enforcement Leaders

Telecommunicator Job Reclassification

Triage Frameworks from Georgia and Los Angeles County, CA (Crisis Now)

Information Sharing

Establishing an Information-Sharing Approach (BJA)
Note that there are links to several resources, including sample MOUs and HIPAA BAAs.

Sharing Behavioral Health Information within Police-Mental Health Collaborations (CSG)

Note that there are links to other resources, some of which are referenced separately within this appendix.

Team Planning for Data-Driven Justice (NACo)

Using Technology to Improve the Delivery of Behavioral Health Crisis Services in the United States (NASMHPD)

Dr. Margie Balfour: CRISES Framework for Quality Metrics (Crisis Now Learning Community)

Note that her full article is available here.

Language Access and 911

Answering the Call for Help in All Languages

Text-to-911 Translation (DHS)

Legal Issues in Crisis Response

Disability Response Team (The Arc)

Legal Issues in Crisis Services (NASMHPD)

Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws (CSG)

Police-Mental Health Collaboration (PMHC)

Crisis Response Services for People with Mental Illnesses or Intellectual and Developmental Disabilities: A Review of the Literature on Police-based and Other First Response Models (Vera)

Types of PMHC Collaborations (BJA)

Essential Elements of PMHC Programs (BJA)

PMHC Self-Assessment Tool (CSG)

PMHC Program Checklists (CSG)

Note that there are checklists specific to law enforcement and behavioral health leaders.

Law Enforcement Mental Health Learning Sites (CSG)

The Variability in Law Enforcement State Standards: A 42-State Survey on Mental Health and De-Escalation Training (CSG)

CITAC Expansion Plan (DBDHS)

Sequential Intercept Model (PRAINC)

Executive Order Safe Policing for Safe Communities: Addressing Mental Health, Homelessness, and Addiction Report (SAMHSA)

Stepping Up Initiative Toolkit

Intellectual and Developmental Disabilities: 10 Facts Law Enforcement Officers Need to Know (BJA and The Arc)

Tailoring Crisis Response and Pre-Arrest Diversion Models for Rural Communities (SAMHSA)

SAMHSA GAINS Center for Behavioral Health and Justice Transformation
Note that this is the main page for the center, which houses a variety of resources.

Repositories

Crisis Now Technical Assistance Publications Library
Note that this is a link to a repository of resources from Crisis Now. Many of these resources can also be accessed through NASMHPD.

NASMHPD Technical Assistance Coalition Assessment Working Papers
Note that this link contains a list of all working papers produced on a variety of topics.

SMI Adviser (APA and SAMHSA)
Note that this is a searchable knowledge base for clinicians, family, and individuals.

Webinars

Academic Training to Inform Police Responses: A National Curriculum to Enhance Police Engagement with People with Behavioral Health Issues and Developmental Disabilities (IACP)
Note that there are numerous links to other resources, including a link to the Transforming Dispatch and Crisis Response Services: Meeting Challenges with Innovation webinar recording.

Help Not Handcuffs: Legislation & Community Models (NAMI)
Note this is a link to a four-part series of webinar recordings.

Diverting People with Intellectual and Developmental Disabilities from the Criminal Justice System (CSG)

Understanding the Problem: Crafting the Right Response (National Response)
Note that this is the first webinar recording in a five-part series.

Mental Health is Not a Crime: How 988 and Crisis Services Will Transform Care (National Response)
Note that this the second webinar recording in a five-part series.

Rethinking Workforce (National Response)
Note that this is the third webinar recording in a five-part series.

Care Where We Need It (National Response)
Note that this is the fourth webinar recording in a five-part series.

Stop Crisis Before It Starts (National Response)
Note that this is the fifth webinar recording in a five-part series.

Taking the Call: A National Conference Exploring Innovative Community Responder Models (CSG)
Note that this is a webinar recording previewing a virtual conference scheduled for October 20, 2021.

Overview of Evidence-based Tools and Approaches Across SIM (SAMHSA)
Note that this is a link to a webinar recording.

Youth

Youth Mobile Response Services (CLASP)

Making the Case for a Comprehensive Children's Crisis Continuum of Care (NASMHPD)

Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm (NASMHPD)
Note that this is one brief in a ten-brief series.

Pediatric Behavioral Health Urgent Care

Appendix C. Current System Inventory Additional Tables

Additional CSB Respondent Tables

Below are additional tables related to CSB respondents' responses.

Private Crisis Providers by CSB Respondent

CSB respondents were permitted to write in any known private crisis providers that operate within their respective catchment areas.

CSB Respondent	Private Crisis Providers
Arlington County Community Services Board	REACH AND CR2
Chesterfield Community Services Board	Many... National Counseling Group is the largest
Danville-Pittsylvania Community Services	EPIC - crisis stabilization
District 19 Community Services Board	Community based providers
Fairfax-Falls Church Community Services Board	PRS Crisis Link: Suicide prevention 988 2-text lines
Hanover County Community Services Board	National Counseling Group, Intercept and others
Henrico Area Mental Health and Developmental Services	National Counseling Group--mobile Crisis Stabilization WHOA Behavioral Health--mobile crisis stabilization
Highlands Community Services	Family Preservation: Crisis intervention and Crisis stabilization
New River Valley Community Services	EHS offers mobile crisis, National Counseling Group offers mobile crisis
Norfolk Community Services Board	Commonwealth ICT, National Counseling group
Prince William County Community Services Board	REACH, CR2
Rappahannock Area Community Services Board	National Counseling
Richmond Behavioral Health Authority	National Counseling Counseling Group, Intercept One, many others doing community based crisis stabilization.
Valley Community Services Board	Intercept (very limited)

FY 2022 Upcoming Crisis System Components by CSB Respondent

CSB Respondent	Upcoming Crisis System Component
Alleghany Highlands Community Services Board	23-hour observation center
	Adult mobile crisis team
	Co-response team with LE
	Crisis text line
	Other (please specify)
Arlington County Community Services Board	Adult mobile crisis team
	Child/youth mobile crisis team
	Co-response team with EMS
	Co-response team with fire and rescue

	Crisis text line
Chesterfield Community Services Board	Adult mobile crisis team
Cumberland Mountain Community Services	23-hour observation center
	Adult mobile crisis team
Danville-Pittsylvania Community Services	Adult mobile crisis team
	Other (please specify)
District 19 Community Services Board	Adult mobile crisis team
Henrico Area Mental Health and Developmental Services	Adult mobile crisis team
Highlands Community Services	23-hour observation center
	Adult mobile crisis team
	Co-response team with EMS
	Co-response team with fire and rescue
	Co-response team with LE
	CSU
Loudoun County Department of MH, SA and Developmental Services	Other (please specify)
Mount Rogers Community Services Board	23-hour observation center
	Adult mobile crisis team
	Other (please specify)
New River Valley Community Services	23-hour observation center
Norfolk Community Services Board	23-hour observation center
	Adult mobile crisis team
	Child/youth mobile crisis team
	CITAC
	Co-response team with EMS
	Co-response team with fire and rescue
	Co-response team with LE
Piedmont Community Services	Adult mobile crisis team
Prince William County Community Services Board	Adult mobile crisis team
	Other (please specify)
Rappahannock Area Community Services Board	Adult mobile crisis team
	Co-response team with LE
Richmond Behavioral Health Authority	Adult mobile crisis team
	Co-response team with LE
	Other (please specify)

"Other" FY 2022 Upcoming Crisis System Components by CSB Respondent

CSB Respondent	"Other" Upcoming Crisis System Component
Alleghany Highlands Community Services Board	Crisis Call Center
Danville-Pittsylvania Community Services	The local area are exploring the possibility of co-response teams with law enforcement or other professionals such as EMS/fire/rescue. Our agency is interested in the 23 hour observation center.

Loudoun County Department of MH, SA and Developmental Services	Rapid 911
Mount Rogers Community Services Board	Possible expansion of both youth and adult CSU, two crisis care centers will be 24/7, adult mobile crisis will be expanded, Marcus Alert Response team
Prince William County Community Services Board	Smart 911, expansion of Coresponder team, expansion of outreach and engagement team.
Richmond Behavioral Health Authority	23 Hour Observation is under consideration

Additional CITAC Respondent Tables

Below are additional tables related to CITAC respondents' responses.

LE Agencies Utilizing CITAC Respondents' Primary CITACs

CIT Respondent Associated with Primary CITAC	LE Agency Utilizing CITAC
Southside CIT	Colonial Heights City Sheriff's Office
	Colonial Heights Police Department
	Dinwiddie County Sheriff's Office
	Emporia City Sheriff's Office
	Emporia Police Department
	Greensville County Sheriff's Office
	Hopewell City Sheriff's Office
	Hopewell Police Department
	Mckenney Police Department
	Petersburg City Sheriff's Office
	Petersburg Police Department
	Prince George County Police Department
	Prince George County Sheriff's Office
	Richard Bland College Police Department
	Surry County Sheriff's Office
	Sussex County Sheriff's Office
	Virginia State Police Area 1
	Virginia State Police Area 5
	Virginia Union University Pd
	Waverly Police Department
Mount Rogers CIT	Chilhowie Police Department
	Galax Police Department
	Hillsville Police Department
	Marion Police Department
	Rural Retreat Police Department
	Saltville Police Department
	Smyth County Sheriff's Office
	Wythe County Sheriff's Office
	Wytheville Police Department
Alexandria CIT	Alexandria City Sheriff's Office
	Alexandria Police Department

Arlington County CIT	Arlington County Police Department
	Arlington County Sheriff's Office
	Falls Church Police Department
	Metro Washington Airport Authority Pd
Blue Ridge CIT	Augusta County Sheriff's Office
	Blue Ridge Community College Pd
	Highland County Sheriff's Office
	Staunton City Sheriff's Office
	Staunton Police Department
	Virginia State Police Area 17
	Waynesboro City Sheriff's Office
	Waynesboro Police Department
Danville-Pittsylvania CIT	Danville City Sheriff's Office
	Danville Police Department
	Gretna Police Department
	Hurt Police Department
	Pittsylvania County Sheriff's Office
Greater Prince William CIT	Haymarket Police Department
	Manassas City Police Department
	Prince William County Police Department
	Prince William County Sheriff's Office
Harrisonburg-Rockingham CIT	Bridgewater College Police Department
	Bridgewater Police Department
	Broadway Police Department
	Dayton Police Department
	Elkton Police Department
	Grottoes Police Department
	Harrisonburg Police Department
	Rockingham Co. Sheriff's Office
	Timberville Police Department
	Virginia State Police Area 16
Henrico CIT	Charles City County Sheriff's Office
	Henrico County Division Of Police
	Henrico County Sheriff's Office
	New Kent County Sheriff's Office
Highlands CIT	Abingdon Police Department
	Bristol City Sheriff's Office
	Bristol Police Department
	Damascus Police Department
	Glade Spring Police Department
	Virginia State Police Area 4
	Washington County Sheriff's Office
Loudoun County CIT	Leesburg Police Department
	Loudoun County Sheriff's Office
	Metro Washington Airport Authority Pd
	Middleburg Police Department

	Purcellville Police Department
Lynchburg-Central Virginia CIT	Amherst County Sheriff's Office
	Amherst Police Department
	Appomattox County Sheriff's Office
	Bedford County Sheriff's Office
	Bedford Police Department
	Campbell County Sheriff's Office
	Central Virginia Community College Pd
	Liberty University Police Department
	Lynchburg City Sheriff's Office
	Lynchburg Police Department
New River Valley CIT	Blacksburg Police Department
	Christiansburg Police Department
	Dublin Police Department
	Floyd County Sheriff's Office
	Giles County Sheriff's Office
	Montgomery County Sheriff's Office
	Narrows Police Department
	Pearisburg Police Department
	Pembroke Police Department
	Pulaski County Sheriff's Office
	Pulaski Police Department
	Radford Police Department
	Radford University Police Department
	Virginia Tech Pd
Norfolk CIT	Norfolk Police Department
	Norfolk State University Police Department
	Old Dominion University Police Dept.
Northwestern CIT	Berryville Police Department
	Clarke County Sheriff's Office
	Frederick County Sheriff's Office
	Front Royal Police Department
	Lord Fairfax Community College Police Department
	Luray Police Department
	Middletown Police Department
	Mount Jackson Police Department
	New Market Police Department
	Page County Sheriff's Office
	Shenandoah County Sheriff's Office
	Shenandoah Police Department
	Stanley Police Department
	Stephens City Police Department
	Strasburg Police Department
	Warren County Sheriff's Office
	Winchester City Sheriff's Office

	Winchester Police Department
	Woodstock Police Department
Planning District 1 CIT	Appalachia Police Department
	Big Stone Gap Police Department
	Coeburn Police Department
	Gate City Police Department
	Jonesville Police Department
	Lee County Sheriff's Office
	Mountain Empire Community College Campus Pd
	Norton City Sheriff's Office
	Norton Police Department
	Pennington Gap Police Department
	Pound Police Department
	Saint Paul Police Department
	Scott County Sheriff's Office
	University of Virginia College at Wise PD
	Weber City Police Department
	Wise County Sheriff's Office
	Wise Police Department
Rockbridge-Bath CIT	Buena Vista Police Department
	Buena Vista Sheriff's Office
	Lexington Police Department
	Rockbridge County Sheriff's Office
	Virginia Military Institute Police Department
Virginia Beach CIT	Virginia Beach City Sheriff's Office
	Virginia Beach Police Department

LE Agencies Utilizing CITAC Respondents' Secondary CITACs

CITAC Respondent Operating Secondary CITAC	LE Users
Southside CIT	Colonial Heights City Sheriff's Office
	Colonial Heights Police Department
	Dinwiddie County Sheriff's Office
	Emporia City Sheriff's Office
	Emporia Police Department
	Greensville County Sheriff's Office
	Hopewell City Sheriff's Office
	Hopewell Police Department
	Mckenney Police Department
	Petersburg City Sheriff's Office
	Petersburg Police Department
	Prince George County Police Department
	Prince George County Sheriff's Office
	Richard Bland College Police Department
	Surry County Sheriff's Office

	Sussex County Sheriff's Office
	Virginia State Police Area 1
	Virginia State Police Area 5
	Virginia State University Police Dept
	Waverly Police Department
Arlington County CIT	Arlington County Police Department
	Arlington County Sheriff's Office
	Falls Church Police Department
	Metro Washington Airport Authority Pd
Greater Prince William CIT	Haymarket Police Department
	Manassas City Police Department
	Prince William County Police Department
	Prince William County Sheriff's Office

Additional LE Respondent Tables

Below are additional tables related to LE respondents' responses.

Law Enforcement Respondents' CIT Participation

Law Enforcement Respondent	CIT-Coordinating CSB
Alexandria Police Department	Alexandria Community Services Board
Amelia County Sheriff's Office	Crossroads Community Services Board
Amherst County Sheriff's Office	Horizon Behavioral Health
Area 12	Rappahannock-Rapidan Community Services Board
Area 27	Highlands Community Services
Arlington County Police Department	Arlington County Community Services Board
Ashland Police Department	Hanover County Community Services Board
Augusta County Sheriff's Office	Valley Community Services Board
Bedford County Sheriff's Office	Horizon Behavioral Health
Bristol Police Department	Highlands Community Services
Buckingham County Sheriff's Office	Crossroads Community Services Board
Chincoteague Police Department	Eastern Shore Community Services Board
Christopher Newport University Pd	Hampton-Newport News Community Services Board
Clarke County Sheriff's Office	Northwestern Community Services
Colonial Heights Police Department	District 19 Community Services Board
Culpeper Police Department	Rappahannock-Rapidan Community Services Board
Danville Police Department	Danville-Pittsylvania Community Services
Dublin Police Department	New River Valley Community Services
Essex County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board
Fairfax City Police Department	Fairfax-Falls Church Community Services Board
Fairfax County Sheriff's Office	Fairfax-Falls Church Community Services Board
Falls Church Police Department	Fairfax-Falls Church Community Services Board
Fauquier County Sheriff's Office	Rappahannock-Rapidan Community Services Board
Floyd County Sheriff's Office	New River Valley Community Services
Front Royal Police Department	Northwestern Community Services
Gloucester County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board
Goochland County Sheriff's Office	Region Ten Community Services Board

Hampton Police Department	Hampton-Newport News Community Services Board
Hanover County Sheriff's Office	Hanover County Community Services Board
Henrico County Division Of Police	Henrico Area Mental Health and Developmental Services
Herndon Police Department	Fairfax-Falls Church Community Services Board
Hopewell Police Department	District 19 Community Services Board
James City County Police Department	Colonial Behavioral Health
James Madison University Police Department	Blue Ridge Behavioral Healthcare
King William County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board
Lake Monticello Police Department	Region Ten Community Services Board
Loudoun County Sheriff's Office	Loudoun County Department of MH, SA and Developmental Services
Lynchburg City Sheriff's Office	Horizon Behavioral Health
Lynchburg Police Department	Horizon Behavioral Health
Madison County Sheriff's Office	Rappahannock Area Community Services Board
Manassas City Police Department	Prince William County Community Services Board
Manassas Park City Police Dept.	Prince William County Community Services Board
Mathews County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board
Metro Washington Airport Authority Pd[13]	Loudoun County Department of MH, SA and Developmental Services
Middleburg Police Department	Loudoun County Department of MH, SA and Developmental Services
Mountain Empire Community College Campus Pd	Planning District One Behavioral Health Services
Nelson County Sheriff's Office	Region Ten Community Services Board
New Kent County Sheriff's Office	Henrico Area Mental Health and Developmental Services
Northern Va Community College Pd	Fairfax-Falls Church Community Services Board
Northumberland County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board
Nottoway County Sheriff's Office	Crossroads Community Services Board
Old Dominion University Police Dept.	Norfolk Community Services Board
Orange Police Department	Rappahannock-Rapidan Community Services Board
Powhatan County Sheriff's Office	Chesterfield Community Services Board
Prince William County Police Department	Prince William County Community Services Board
Radford Police Department	New River Valley Community Services
Rappahannock County Sheriff's Office	Rappahannock-Rapidan Community Services Board
Richmond International Airport Police	Henrico Area Mental Health and Developmental Services
Roanoke County Police Department	Blue Ridge Behavioral Healthcare
Rockbridge County Sheriff's Office	Rockbridge Area Community Services
Russell County Sheriff's Office	Cumberland Mountain Community Services
Salem City Sheriff's Office	Blue Ridge Behavioral Healthcare
Salem Police Department	Blue Ridge Behavioral Healthcare
Scott County Sheriff's Office	Highlands Community Services

[13] Note that there is a discrepancy: Several CIT respondents noted having Metro PD participate in their respective programs.

Shenandoah County Sheriff's Office	Northwestern Community Services
Suffolk City Sheriff's Office	Western Tidewater Community Services Board
Timberville Police Department	Harrisonburg-Rockingham Community Services Board
Vinton Police Department	Blue Ridge Behavioral Healthcare
Virginia Commonwealth University Police Dept.	Richmond Behavioral Health Authority
Virginia Tech Pd	New River Valley Community Services
Virginia Western Community College PD	Blue Ridge Behavioral Healthcare
Warsaw Police Department	Middle Peninsula-Northern Neck Community Services Board
Waynesboro Police Department	Valley Community Services Board
West Point Police Department	Middle Peninsula-Northern Neck Community Services Board
Westmoreland County Sheriff's Office	Middle Peninsula-Northern Neck Community Services Board
Williamsburg Police Department	Colonial Behavioral Health
Wilson Workforce And Rehabilitation Center	Valley Community Services Board
Wintergreen Police Department	Region Ten Community Services Board
Wise County Sheriff's Office	Planning District One Behavioral Health Services
Wise Police Department	Planning District One Behavioral Health Services
York - Poquoson Sheriff's Office	Colonial Behavioral Health

LE Respondents Receiving Transferred Calls from PSAPs

Law Enforcement Respondent	Transferring PSAP
Area 12	Fauquier (FCC ID: 7126 / 7221)
	Rappahannock (FCC ID: 7189)
Area 27	Bristol (FCC ID: 7091)
	Scott (FCC ID: 7197)
	Washington (FCC ID: 7222)
Ashland Police Department	Hanover (FCC ID: 7143)
Augusta County Sheriff's Office	Augusta (FCC ID: 7085)
Bristol Police Department	Bristol (FCC ID: 7091)
Buckingham County Sheriff's Office	Buckingham (FCC ID: 7094)
Chincoteague Police Department	Eastern Shore (FCC ID: 7119)
Culpeper Police Department	Culpeper (FCC ID: 7114)
Danville Police Department	Danville (FCC ID: 7116)
Division of Capitol Police	Richmond City (FCC ID: 7191)
Dublin Police Department	Pulaski (FCC ID: 7187)
Fairfax City Police Department	Fairfax (FCC ID: 7123)
Falls Church Police Department	Arlington (FCC ID: 7084)
Floyd County Sheriff's Office	Floyd (FCC ID: 7127)
Front Royal Police Department	Warren (FCC ID: 7220)
Hanover County Sheriff's Office	Hanover (FCC ID: 7143)
Herndon Police Department	Fairfax (FCC ID: 7123)
Hopewell Police Department	Hopewell (FCC ID: 7147)
Lake Monticello Police Department	Buckingham (FCC ID: 7094)
	Charlottesville-UVA-Albemarle (FCC ID: 7101)
	Cumberland (FCC ID: 7115)

	Fluvanna (FCC ID: 7128)
	Goochland (FCC ID: 7136)
	Louisa (FCC ID: 7158)
Loudoun County Sheriff's Office	Loudoun (FCC ID: 7157)
Manassas City Police Department	Manassas (FCC ID: 7162)
	Prince William (FCC ID: 7186)
Mathews County Sheriff's Office	Mathews (FCC ID: 7165)
Middleburg Police Department	Loudoun (FCC ID: 7157)
Nelson County Sheriff's Office	Amherst (FCC ID: 7082)
	Appomattox (FCC ID: 7083)
	Augusta (FCC ID: 7085)
	Buckingham (FCC ID: 7094)
	Charlottesville-UVA-Albemarle (FCC ID: 7101)
New Kent County Sheriff's Office	New Kent (FCC ID: 7170)
Northern Va Community College Pd	Alexandria (FCC ID: 7079)
	Arlington (FCC ID: 7084)
	Fairfax (FCC ID: 7123)
	Loudoun (FCC ID: 7157)
	Manassas (FCC ID: 7162)
	Manassas Park (FCC ID: 7163)
	MWAA (FCC ID: 8567)
	Prince William (FCC ID: 7186)
Northumberland County Sheriff's Office	Lancaster (FCC ID: 7154)
	Richmond County (FCC ID: 7190)
	Westmoreland (FCC ID: 7225)
Northumberland County Sheriff's Office	Other: St. Marys Co. Maryland
Norton Police Department	Dickenson (FCC ID: 8222)
	Lee (FCC ID: 7156)
	Norton (FCC ID: 7174)
	Russell (FCC ID: 7195)
	Scott (FCC ID: 7197)
	Wise (FCC ID: 7229)
Old Dominion University Police Dept.	Norfolk (FCC ID: 7172)
Powhatan County Sheriff's Office	Powhatan (FCC ID: 7184)
Roanoke County Police Department	Roanoke County (FCC ID: 7193)
Rockbridge County Sheriff's Office	Rockbridge (FCC ID: 7194)
Russell County Sheriff's Office	Buchanan (FCC ID: 7093)
	Dickenson (FCC ID: 8222)
	Scott (FCC ID: 7197)
	Tazewell (FCC ID: 7214)
	Washington (FCC ID: 7222)
	Wise (FCC ID: 7229)
Shenandoah County Sheriff's Office	Shenandoah (FCC ID: 7198)
Virginia Commonwealth University Police Dept.	Richmond City (FCC ID: 7191)
Virginia Tech Pd	New River Valley (FCC ID: 8501)
Warsaw Police Department	Richmond County (FCC ID: 7190)

Washington Metro Area Transit PD	Alexandria (FCC ID: 7079)
	Arlington (FCC ID: 7084)
	Fairfax (FCC ID: 7123)
	Falls Church (FCC ID: 7124)
	Loudoun (FCC ID: 7157)
Waynesboro Police Department	Waynesboro (FCC ID: 7223)
Williamsburg Police Department	York-Poquoson-Williamsburg (FCC ID: 7232)
Wintergreen Police Department	Nelson (FCC ID: 7169)
Wise County Sheriff's Office	Dickenson (FCC ID: 8222)
	Lee (FCC ID: 7156)
	Norton (FCC ID: 7174)
	Russell (FCC ID: 7195)
	Scott (FCC ID: 7197)
Wise Police Department	Wise (FCC ID: 7229)

Distribution List

Below is a list of all entities to which a link to the online inventory survey was disseminated. As noted in the body of the plan, ten law enforcement agencies could not be contacted due to missing or inaccurate email address: Haymarket Police Department, Warren County Sheriff's Office, Carilion Clinic Police Department (Roanoke), Appalachia Police Department, Bloxom Police Department, Edinburg Police Department, Hallwood Police Department, Saxis Police Department, Tangier Police Department, Isle Of Wight County Sheriff's Office, and Blue Ridge Community College PD.

Community Services Boards

Alexandria
Alleghany Highlands
Arlington
Blue Ridge
Chesapeake
Chesterfield
Colonial
Crossroads
Cumberland Mountain
Danville-Pittsylvania
Dickenson
District 19
Eastern Shore
Fairfax-Falls Church
Goochland-Powhatan
Hampton-Newport News
Hanover
Harrisonburg-Rockingham
Henrico Area
Highlands
Horizon
Loudoun
Middle Peninsula-Northern Neck
Mount Rogers
New River Valley
Norfolk
Northwestern
Piedmont
Planning District One
Portsmouth
Prince William
Rappahannock Area
Rappahannock-Rapidan
Region Ten
Richmond
Rockbridge Area
Southside
Valley
Virginia Beach
Western Tidewater

Crisis Intervention Team Programs

Alexandria CIT

Alleghany Highlands CIT
Arlington County CIT
Blue Ridge CIT
Chesapeake CIT
Chesterfield CIT
Colonial Area CIT
Crossroads CIT
Cumberland Mountain CIT
Danville-Pittsylvania CIT
Eastern Shore CIT
Fairfax CIT
Greater Prince William CIT
Hampton-Newport News CIT
Hanover CIT
Harrisonburg-Rockingham CIT
Henrico CIT
Highlands CIT
Loudoun County CIT
Lynchburg-Central Virginia CIT
Middle Peninsula-Northern Neck CIT
Mount Rogers CIT
New River Valley CIT
Norfolk CIT
Northwestern CIT
Piedmont CIT
Planning District 1 CIT
Portsmouth CIT
Rappahannock Area CIT
Rappahannock-Rapidan CIT
Richmond CIT
Roanoke CIT
Rockbridge-Bath CIT
South Central CIT
Southside CIT
Thomas Jefferson Area CIT
Virginia Beach CIT
Western Tidewater CIT

Law Enforcement Agencies

Abingdon Police Department
Albemarle County Police Department
Alberta Police Department
Alexandria Police Department
Altavista Police Department
Amherst Police Department
Aquia Harbour Police Department
Arlington County Police Department
Ashland Police Department
Bedford Police Department
Berryville Police Department
Big Stone Gap Police Department
Blacksburg Police Department
Blackstone Police Department
Bluefield Police Department
Boones Mill Police Department
Bowling Green Police Department
Boydton Police Department
Boykins Police Department
Bridgewater Airpark Police Department
Bridgewater Police Department
Bristol Police Department
Broadway Police Department
Brodnax Police Department
Brookneal Police Department
Buena Vista Police Department
Burkeville Police Department
BWXT Police Department
Cape Charles Police Department
Cedar Bluff Police Department
Charlottesville Albemarle Airport PD
Charlottesville Police Department
Chase City Police Department
Chatham Police Department
Chesapeake Bay Bridge-Tunnel Police
Chesapeake Police Department
Chesterfield County Police Department
Chilhowie Police Department
Chincoteague Police Department
Christiansburg Police Department
Clarksville Police Department
Clifton Forge Police Department
Clinchco Police Department
Clintwood Police Department
Coeburn Police Department
Colonial Beach Police Department
Colonial Heights Police Department
Courtland Police Department
Covington Police Department
Craigsville Police Department
Crewe Police Department
Csx Transportation Police
Culpeper Police Department
Damascus Police Department
Danville Police Department
Dayton Police Department

Division of Capitol Police
Drakes Branch Police Department
Dublin Police Department
Dumfries Police Department
Eastville Police Department
Elkton Police Department
Emporia Police Department
Exmore Police Department
Fairfax City Police Department
Fairfax County Police Department
Falls Church Police Department
Farmville Police Department
Franklin Police Department
Fredericksburg Police Department
Front Royal Police Department
Galax Police Department
Gate City Police Department
Glade Spring Police Department
Glasgow Police Department
Glen Lyn Police Department
Gordonsville Police Department
Gretna Police Department
Grottoes Police Department
Grundy Police Department
Halifax Police Department
Hampton Police Department
Harrisonburg Police Department
Haysi Police Department
Henrico County Division of Police
Herndon Police Department
Hillsville Police Department
Honaker Police Department
Hopewell Police Department
Hurt Police Department
Independence Police Department
James City County Police Department
Jonesville Police Department
Kenbridge Police Department
Kilmarnock Police Department
Kings Dominion Police Department
Kingsmill Police Department
La Crosse Police Department
Lake Monticello Police Department
Lawrenceville Police Department
Lebanon Police Department
Leesburg Police Department
Lexington Police Department
Louisa Police Department
Luray Police Department
Lynchburg Police Department
Lynchburg Regional Airport Police Department
Manassas City Police Department
Manassas Park City Police Dept.
Marion Police Department
Martinsville Police Department
Mckenney Police Department
Metro Washington Airport Authority Pd
Middleburg Police Department
Middletown Police Department
Mount Jackson Police Department
Narrows Police Department
New Market Police Department
Newport News Police Department
Newport News/Williamsburg Int`l Airport
Norfolk International Airport PD
Norfolk Police Department
Norfolk Southern Railway Police
Norton Police Department
Occoquan Police Department
Onancock Police Department
Onley Police Department
Orange Police Department
Parksley Police Department
Pearisburg Police Department
Pembroke Police Department
Pennington Gap Police Department
Petersburg Police Department
Pocahontas Police Department
Poquoson Police Department
Portsmouth Police Department
Pound Police Department
Prince George County Police Department
Prince William County Police Department
Pulaski Police Department
Purcellville Police Department
Quantico Police Department
Radford Police Department
Remington Police Department
Rich Creek Police Department
Richlands Police Department
Richmond International Airport Police
Richmond Police Department
Roanoke City Police Department
Roanoke County Police Department
Roanoke Regional Airport Commission
Rocky Mount Police Department

Rural Retreat Police Department
Saint Paul Police Department
Salem Police Department
Saltville Police Department
Scottsville Police Department
Shenandoah Police Department
Smithfield Police Department
South Boston Police Department
South Hill Police Department
Stanley Police Department
Staunton Police Department
Stephens City Police Department
Strasburg Police Department
Suffolk Police Department
Tappahannock Police Department
Tazewell Police Department
Timberville Police Department
Victoria Police Department
Vienna Police Department
Vinton Police Department
Virginia Alcoholic Beverage Control PD
Virginia Beach Police Department
Virginia Port Authority Police Dept.
Virginia State Police
Warrenton Police Department
Warsaw Police Department
Washington Metro Virginia State Police Area Transit PD
Waverly Police Department
Waynesboro Police Department
Weber City Police Department
West Point Police Department
White Stone Police Department
Williamsburg Police Department
Winchester Police Department
Windsor Police Department
Wintergreen Police Department
Wise Police Department
Woodstock Police Department
Wytheville Police Department
Accomack County Sheriff's Office
Albemarle County Sheriff`s Office
Alexandria City Sheriff's Office
Alleghany County Sheriff`s Office
Amelia County Sheriff's Office
Amherst County Sheriff's Office
Appomattox County Sheriff`s Office
Arlington County Sheriff`s Office
Augusta County Sheriff's Office
Bath County Sheriff's Office
Bedford County Sheriff's Office
Bland County Sheriff's Office
Botetourt County Sheriff`s Office
Bristol City Sheriff's Office
Brunswick County Sheriff`s Office
Buchanan County Sheriff's Office
Buckingham County Sheriff`s Office
Buena Vista Sheriff's Office
Campbell County Sheriff's Office
Caroline County Sheriff's Office
Carroll County Sheriff's Office
Charles City County Sheriff`s Office
Charlotte County Sheriff`s Office
Charlottesville City Sheriff’s Office
Chesapeake City Sheriff's Office
Chesterfield County Sheriff`s Office
City of Richmond Sheriff`s Office
Clarke County Sheriff's Office
Colonial Heights City Sheriff`s Office
Craig County Sheriff's Office
Culpeper County Sheriff's Office
Cumberland County Sheriff`s Office
Danville City Sheriff's Office
Dickenson County Sheriff`s Office
Dinwiddie County Sheriff`s Office
Emporia City Sheriff's Office
Essex County Sheriff`s Office
Fairfax County Sheriff's Office
Falls Church City Sheriff`s Office
Fauquier County Sheriff's Office
Floyd County Sheriff's Office
Fluvanna County Sheriff's Office
Franklin County Sheriff's Office
Frederick County Sheriff`s Office
Fredericksburg City Sheriff`s Office
Giles County Sheriff's Office
Gloucester County Sheriff`s Office
Goochland County Sheriff`s Office
Grayson County Sheriff's Office
Greene County Sheriff's Office
Greensville County Sheriff`s Office
Halifax County Sheriff's Office
Hampton City Sheriff's Office
Hanover County Sheriff's Office
Henrico County Sheriff's Office
Henry County Sheriff's Office

Highland County Sheriff's Office
Hopewell City Sheriff's Office
King & Queen County Sheriff`s Office
King George County Sheriff`s Office
King William County Sheriff`s Office
Lancaster County Sheriff`s Office
Lee County Sheriff's Office
Loudoun County Sheriff's Office
Louisa County Sheriff's Office
Lunenburg County Sheriff`s Office
Lynchburg City Sheriff's Office
Madison County Sheriff's Office
Martinsville Sheriff's Office
Mathews County Sheriff's Office
Mecklenburg County Sheriff`s Office
Middlesex County Sheriff`s Office
Montgomery County Sheriff`s Office
Nelson County Sheriff's Office
New Kent County Sheriff's Office
Newport News City Sheriff`s Office
Norfolk City Sheriff's Office
Northampton County Sheriff`s Office
Northumberland County Sheriff`s Office
Norton City Sheriff's Office
Nottoway County Sheriff's Office
Orange County Sheriff's Office
Page County Sheriff's Office
Patrick County Sheriff's Office
Petersburg City Sheriff's Office
Pittsylvania County Sheriff`s Office
Portsmouth City Sheriff's Office
Powhatan County Sheriff's Office
Prince Edward County Sheriff`s Office
Prince George County Sheriff`s Office
Prince William County Sheriff`s Office
Pulaski County Sheriff's Office
Radford City Sheriff's Office
Rappahannock County Sheriff`s Office
Richmond County Sheriff's Office
Roanoke City Sheriff's Office
Roanoke County Sheriff's Office
Rockbridge County Sheriff`s Office
Rockingham Co. Sheriff's Office
Russell County Sheriff's Office
Salem City Sheriff's Office
Scott County Sheriff's Office
Shenandoah County Sheriff`s Office
Smyth County Sheriff's Office
Southampton County Sheriff`s Office
Spotsylvania County Sheriff`s Office
Stafford County Sheriff's Office
Staunton City Sheriff's Office
Suffolk City Sheriff's Office
Surry County Sheriff's Office
Sussex County Sheriff's Office
Tazewell County Sheriff's Office
Virginia Beach City Sheriff`s Office
Warren County Sheriff's Office
Washington County Sheriff`s Office
Waynesboro City Sheriff's Office
Westmoreland County Sheriff`s Office
Williamsburg-James City County Sheriff`s Office
Winchester City Sheriff's Office
Wise County Sheriff's Office
Wythe County Sheriff's Office
York - Poquoson Sheriff`s Office
Bridgewater College Police Department
Central Virginia Community College PD
Christopher Newport University PD
College Of William & Mary Campus PD
Eastern Shore Community College PD
Eastern Virginia Medical School PD
Emory & Henry College Police Department
Ferrum College Police Department
George Mason University Police Dept.
Germanna Community College PD
Hampden - Sydney College Police
Hampton University Police Dept.
J. Sargeant Reynolds Community College PD
James Madison University PD
Liberty University Police Department
Longwood University Police Department
Lord Fairfax Community College PD
Mt. Empire Community College Campus PD
Norfolk State University Police Department
Northern Va Community College PD
Old Dominion University Police Dept.
Patrick Henry Community College PD
Piedmont Virginia Community College Campus PD
Radford University Police Department
Regent University Police Department
Richard Bland College Police Department
Southwest Virginia Comm. College PD
Thomas Nelson Comm. College PD

University of Mary Washington Police Department
University of Richmond Police Department
University of Virginia College at Wise PD
University of Virginia Police Department
Virginia Commonwealth University PD
Virginia Highlands Community College PD
Virginia Military Institute Police Department
Virginia School for the Deaf and Blind Campus PD
Virginia State University Police Dept
Virginia Tech PD
Virginia Union University PD
Virginia Western Community College PD
Wilson Workforce and Rehabilitation Center
Wytheville Community College PD
Virginia State Police Area 1
Virginia State Police Area 2
Virginia State Police Area 3
Virginia State Police Area 4
Virginia State Police Area 5
Virginia State Police Area 6
Virginia State Police Area 7
Virginia State Police Area 8
Virginia State Police Area 9
Virginia State Police Area 10
Virginia State Police Area 11
Virginia State Police Area 12
Virginia State Police Area 13
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Virginia State Police Area 35
Virginia State Police Area 36
Virginia State Police Area 37
Virginia State Police Area 38
Virginia State Police Area 39
Virginia State Police Area 40
Virginia State Police Area 41
Virginia State Police Area 42
Virginia State Police Area 43
Virginia State Police Area 44
Virginia State Police Area 45
Virginia State Police Area 46
Virginia State Police Area 47
Virginia State Police Area 48
Virginia State Police Area 49

Public Safety Answering Points

Alexandria (FCC ID: 7079)
Alleghany (FCC ID: 7080)
Amelia (FCC ID: 7081)
Amherst (FCC ID: 7082)
Appomattox (FCC ID: 7083)
Arlington (FCC ID: 7084)
Augusta (FCC ID: 7085)
Bath (FCC ID: 7086)
Bedford (FCC ID: 7087)
Bland (FCC ID: 7089)
Botetourt (FCC ID: 7090)
Bristol (FCC ID: 7091)
Brunswick (FCC ID: 7092)
Buchanan (FCC ID: 7093)
Buckingham (FCC ID: 7094)
Campbell (FCC ID: 7095)
Caroline (FCC ID: 7096)
Charles City (FCC ID: 7098)
Charlotte (FCC ID: 7099)
Charlottesville-UVA-Albemarle (FCC ID: 7101)
Chesapeake (FCC ID: 7102)
Chesterfield (FCC ID: 7103)
Clarke (FCC ID: 7107)
Colonial Heights (FCC ID: 7110)
Covington (FCC ID: 7111)
Craig (FCC ID: 7113)
Culpeper (FCC ID: 7114)
Cumberland (FCC ID: 7115)

Danville (FCC ID: 7116)
Dickenson (FCC ID: 8222)
Dinwiddie (FCC ID: 8457)
Eastern Shore (FCC ID: 7119)
Emporia (FCC ID: 7120)
Essex (FCC ID: 7121)
Fairfax (FCC ID: 7123)
Falls Church (FCC ID: 7124)
Farmville (FCC ID: 7125)
Fauquier (FCC ID: 7126 / 7221)
Floyd (FCC ID: 7127)
Fluvanna (FCC ID: 7128)
Franklin City (FCC ID: 7130)
Franklin County (FCC ID: 7129)
Frederick (FCC ID: 7131)
Fredericksburg (FCC ID: 7132)
Giles (FCC ID: 7134)
Gloucester (FCC ID: 7135)
Goochland (FCC ID: 7136)
Greene (FCC ID: 7138)
Greensville (FCC ID: 7140)
Halifax (FCC ID: 7141)
Hampton (FCC ID: 7142)
Hanover (FCC ID: 7143)
Harrisonburg-Rockingham (FCC ID: 7144)
Henrico (FCC ID: 7145)
Highland (FCC ID: 7146)
Hopewell (FCC ID: 7147)
Isle of Wight (FCC ID: 7148)
James City (FCC ID: 7150)
King and Queen (FCC ID: 7151)
King George (FCC ID: 7152)
King William (FCC ID: 7153)
Lancaster (FCC ID: 7154)
Lee (FCC ID: 7156)
Loudoun (FCC ID: 7157)
Louisa (FCC ID: 7158)
Lunenburg (FCC ID: 7159)
Lynchburg (FCC ID: 7160)
Madison (FCC ID: 7161)
Manassas (FCC ID: 7162)
Manassas Park (FCC ID: 7163)
Martinsville-Henry (FCC ID: 7164)
Mathews (FCC ID: 7165)
Mecklenburg (FCC ID: 7166)
Middlesex (FCC ID: 7167)
MWAA (FCC ID: 8567)
Nelson (FCC ID: 7169)
New Kent (FCC ID: 7170)
New River Valley (FCC ID: 8501)
Newport News (FCC ID: 7171)
Norfolk (FCC ID: 7172)
Northumberland (FCC ID: 7173)
Norton (FCC ID: 7174)
Nottoway (FCC ID: 7175)
Orange (FCC ID: 7176)
Page (FCC ID: 7177)
Patrick (FCC ID: 7179)
Petersburg (FCC ID: 7180)
Pittsylvania (FCC ID: 7181)
Portsmouth (FCC ID: 7183)
Powhatan (FCC ID: 7184)
Prince George (FCC ID: 7185)
Prince William (FCC ID: 7186)
Pulaski (FCC ID: 7187)
Radford (FCC ID: 7188)
Rappahannock (FCC ID: 7189)
Richmond Ambulance Authority (FCC ID: RAA)
Richmond City (FCC ID: 7191)
Richmond County (FCC ID: 7190)
Roanoke City (FCC ID: 7192)
Roanoke County (FCC ID: 7193)
Rockbridge (FCC ID: 7194)
Russell (FCC ID: 7195)
Salem (FCC ID: 7196)
Scott (FCC ID: 7197)
Shenandoah (FCC ID: 7198)
Smyth (FCC ID: 7200)
Southampton (FCC ID: 7202)
Spotsylvania (FCC ID: 7203)
Stafford (FCC ID: 7204)
Staunton (FCC ID: 7211)
Suffolk (FCC ID: 7106)
Surry (FCC ID: 7212)
Sussex (FCC ID: 7213)
Tazewell (FCC ID: 7214)
Twin County (FCC ID: 7215)
Virginia Beach (FCC ID: 7218)
Warren (FCC ID: 7220)
Washington (FCC ID: 7222)
Waynesboro (FCC ID: 7223)
Westmoreland (FCC ID: 7225)
Winchester (FCC ID: 7228)
Wise (FCC ID: 7229)
Wythe (FCC ID: 8407)
York-Poquoson-Williamsburg (FCC ID: 7232)

Appendix D. Community Input Survey Results

A survey was designed to solicit feedback from individuals who have had or who could have contact with Virginia's behavioral health system—particularly the crisis response system. The survey was made available in English and in Spanish through an online platform from March 22, 2021 through April 5, 2021. Potential respondents were made aware of the survey by disseminating the link to the online survey through the Marcus Alert Stakeholder Workgroup members' affiliated organizations and the DBHDS social media account. In total, a convenience sample of 681 individuals responded to the survey.

The survey was structured such that questions were not displayed if they were not applicable to respondents. For instance, a respondent with no family experience would not be asked a question regarding a loved one's diagnoses. Moreover, respondents were not required to answer all survey questions: They could skip them at will if they did not feel comfortable divulging information. Note that percentages were calculated based on the total number of respondents within the subpopulation, regardless of whether they answered the question. Some tables indicate the percentage of respondents who declined to answer. "Other" write-in responses that fit within predefined response options were not recoded. As the data are based on a convenience sample, care should be taken in making generalizations based on the results.

Respondent Demographics

At the beginning of the survey, respondents were asked to identify their experience with the behavioral health system. They had the option to select any of the following options that they felt characterized them: a family member, loved one, or advocate for an individual who has experienced a behavioral health crisis, an individual who has experienced a behavioral health crisis, a peer recovery specialist, a family support partner, a licensed behavioral health professional (LBA, LCSW, LCP, LMFT, LPC), a certified pre-admission screening clinician, and none of the above. Based on their responses, respondents were grouped into experience groups for the analysis, those who opted not to respond to this question were not grouped. Note that there is overlap in group membership given that respondents could select more than one option.

- Family Experience
    - Family member, loved one, or advocate for an individual who has experienced a behavioral health crisis
    - Family support partner
- Personal Experience
    - Individual who has experienced a behavioral health crisis
    - Peer recovery specialist
- Professional Experience
    - Certified pre-admission screening clinician
    - Family support partner
    - Licensed behavioral health professional
    - Peer recovery specialist
- Potential User
    - None of the above

Respondent Subpopulations

Subpopulation	Count	Percentage
Family Experience with Behavioral Health Crisis	418	61%
Personal Experience with Behavioral Health Crisis	235	35%
Professional Experience with Behavioral Health Crisis	165	24%
Potential Experience with Behavioral Health Crisis	74	11%

Racial Breakdown of All Respondents

Race	Count	Percentage
Asian	6	1%
Black or African American	76	11%
Native American or American Indian or Alaska Native	13	2%
Native Hawaiian or Pacific Islander	3	0%
White or Caucasian	371	54%
Other	28	4%

Racial Breakdown of Respondents with Individual Experience

Race	Count	Percentage
Asian	1	0%
Black or African American	31	13%
Native American or American Indian or Alaska Native	8	3%
Native Hawaiian or Pacific Islander	1	0%
White or Caucasian	131	56%
Other	13	6%

Racial Breakdown of Respondents with Family Experience

Race	Count	Percentage
Asian	2	0%
Black or African American	44	11%
Native American or American Indian or Alaska Native	8	2%
Native Hawaiian or Pacific Islander	2	0%
White or Caucasian	243	58%
Other	20	5%

Racial Breakdown of Peer Recovery Specialists

Race	Count	Percentage
Black or African American	8	16%
Native American or American Indian or Alaska Native	3	6%
White or Caucasian	29	59%
Other	2	4%

Racial Breakdown of Respondents with Professional Experience

Race	Count	Percentage
Asian	1	1%
Black or African American	22	13%
Native American or American Indian or Alaska Native	6	4%

Native Hawaiian or Pacific Islander	1	1%
White or Caucasian	91	55%
Other	7	4%

Ethnic Racial Breakdown of All Respondents

Response	Count	Percentage
Hispanic/Latino/Latina/Latinx	30	4%
Not Hispanic/Latino/Latina/Latinx	430	63%
Declined to Answer	221	32%

Age Distribution of All Respondents

Age Category	Count	Percentage
16 to 23 years old	13	2%
24 to 30 years old	44	6%
31 to 37 years old	52	8%
38 to 44 years old	68	10%
45 to 51 years old	80	12%
52 to 59 years old	77	11%
60 to 65 years old	58	9%
66 to 72 years old	36	5%
73 to 79 years old	19	3%
80 to 86 years old	5	1%

Gender Identity of All Respondents

Gender Identity	Count	Percentage
Female	387	57%
Male	94	14%
Nonbinary or gender nonconforming	9	1%
Transgender female	2	0%
Transgender male	2	0%
Other	1	0%

Sexual Orientation of All Respondents

Response	Count	Percentage
Straight	394	58%
Bisexual	36	5%
Pansexual	13	2%
Lesbian	10	1%
Asexual	7	1%
Gay	5	1%

Household Composition of All Respondents

Members of Household	Count	Percentage
Children (adopted, biological, foster)	228	33%
Spouse	214	31%
None of the above: I live alone.	78	11%

Significant other	53	8%
Parent(s)	48	7%
Roommate(s)	26	4%
Extended family (aunts, uncles, cousins)	14	2%
Grandchildren	13	2%
Grandparent(s)	4	1%

Health Insurance among All Respondents

Insurance	Count	Percentage
Employer-sponsored insurance	277	41%
Medicaid	86	13%
Medicare	110	16%
No insurance coverage	20	3%
Tricare	26	4%
Other	38	6%

Self-Reported Diagnostic Category among Respondents with Personal Experience

Diagnostic Category	Count	Percentage
Mental health disorder (schizophrenia, depression, anxiety, bipolar, etc.)	31	13%
Substance use disorder (alcohol use disorder, opioid use disorder, etc.)	15	6%
None of the above	4	2%
Physical disability (cerebral palsy, spina bifida, etc.)	3	1%
Developmental disability or intellectual disability (autism, Down's syndrome, etc.)	1	0%

Loved Ones' Reported Diagnostic Category

Respondents with family experience indicated which category of diagnoses their loved ones' have received.

Diagnostic Category	Count	Percentage
Mental health disorder (schizophrenia, depression, anxiety, bipolar, etc.)	207	50%
Developmental disability or intellectual disability (autism, Down's syndrome, etc.)	88	21%
Substance use disorder (alcohol use disorder, opioid use disorder, etc.)	67	16%
Physical disability (cerebral palsy, spina bifida, etc.)	33	8%
None of the above	31	7%

Self-Reported Treatments Used among Respondents with Personal Experience

Treatments Tried	Count	Percentage
Individual psychotherapy or counseling	28	12%
Medication	23	10%
Peer support	20	9%
Group psychotherapy or counseling	17	7%
Case management	14	6%
Other	6	3%
Supported employment	5	2%
Home care	3	1%
Physical therapy (PT)	3	1%

None of the above	3	1%
Occupational therapy (OT)	2	1%
Speech therapy	1	0%
None of the above	1	0%

Loved Ones' Reported Treatments Used

Respondents with family experience indicated which treatments their loved ones' have used to manage their diagnoses, regardless of diagnosis.

Loved One Treatments Tried	Count	Percentage
Medication	208	50%
Individual psychotherapy or counseling	179	43%
Case management	125	30%
Group psychotherapy or counseling	85	20%
Occupational therapy (OT)	55	13%
Home care	53	13%
Peer support	41	10%
Speech therapy	41	10%
Physical therapy (PT)	35	8%
Other	29	7%
Supported employment	26	6%
None of the above	26	6%
Home care	1	0%
None of the above	1	0%

Reported Treatment Used by Loved Ones with Mental Health Diagnoses

Respondents with family experience indicated which treatments their loved ones' with mental health diagnoses have used to manage their diagnoses. Note that loved ones could also have other diagnoses.

Loved One MH Treatments Tried	Count	Percentage
Medication	180	87%
Individual psychotherapy or counseling	160	77%
Case management	94	45%
Group psychotherapy or counseling	75	36%
Home care	35	17%
Occupational therapy (OT)	34	16%
Peer support	33	16%
Speech therapy	22	11%
Physical therapy (PT)	21	10%
Supported employment	20	10%
Other	19	9%
None of the above	5	2%
Home care	1	0%

Reported Treatment Used by Loved Ones with Developmental Disability Diagnoses

Respondents with family experience indicated which treatments their loved ones' with developmental disability diagnoses have used to manage their diagnoses. Note that loved ones could also have other diagnoses.

Loved One DD Treatments Tried	Count	Percentage
Medication	65	74%

Case management	61	69%
Individual psychotherapy or counseling	52	59%
Occupational therapy (OT)	35	40%
Speech therapy	34	39%
Home care	30	34%
Physical therapy (PT)	22	25%
Group psychotherapy or counseling	20	23%
Supported employment	19	22%
Peer support	14	16%
Other	13	15%
None of the above	2	2%

Primary Emotional Support

*Who would you call first if **you** were feeling overwhelmed emotionally?*

First Choice for Support among All Respondents

Response	Count	Percentage
Family member	202	30%
Friend	141	21%
Spouse	95	14%
Private therapist or behavioral health provider	57	8%
Crisis hotline	28	4%
Family support partner	19	3%
Case manager	15	2%
9-1-1	11	2%
Religious or spiritual leader (priest, pastor, rabbi, imam, etc.)	10	1%
Peer recovery specialist	9	1%
Community services board (CSB)	7	1%
Mobile crisis team	5	1%

First Choice for Support among Respondents with Personal Experience

Response	Count	Percentage
Family member	63	27%
Friend	50	21%
Spouse	32	14%
Private therapist or behavioral health provider	23	10%
Crisis hotline	11	5%
Family support partner	9	4%
Peer recovery specialist	9	4%
Case manager	7	3%
9-1-1	4	2%
Religious or spiritual leader (priest, pastor, rabbi, imam, etc.)	4	2%
Community services board (CSB)	2	1%

Mobile crisis team	2	1%

*Who would you call first if **your loved one** were feeling overwhelmed emotionally?*

First Choice to Support Overwhelmed Loved Ones among All Respondents with Family Experience

Respondents with family experience indicated who they would call first to support loved ones who were feeling emotionally overwhelmed.

Response	Count	Percentage
Family member	87	21%
Private therapist or behavioral health provider	79	19%
Friend	40	10%
Crisis hotline	37	9%
9-1-1	22	5%
Case manager	21	5%
Community services board (CSB)	13	3%
Family support partner	13	3%
Religious or spiritual leader (priest, pastor, rabbi, imam, etc.)	13	3%
Spouse	9	2%
Mobile crisis team	7	2%
Peer recovery specialist	3	1%

Early Intervention

This question provides some insights into willingness to use the 988 regional crisis call centers.

*Imagine there is a three-digit number like 1-2-3 that you could call whenever **you** feel emotionally overwhelmed. They provide assessment over the phone and connect to you to services based on the type of situation. Based on the situation, services could be providing immediate over-the-phone support, sending a mobile crisis team to you within about an hour, or connecting you to a provider for a next-day appointment. How often would you use this number?*

Use of Three-Digit Code among All Respondents

Response	Count	Percentage
Less than once a year	165	24%
Never	119	17%
Several times a year	119	17%
Once a year	74	11%
Declined to Answer	67	10%
Once a month	50	7%
Several times a month	42	6%
Once a week	22	3%

Several times a week	17	2%
Every day	6	1%

Use of Three-Digit Code among All Respondents by Racial Group

Response	Count	Percentage	Race
Several times a year	3	50%	_asian
Never	2	33%	_asian
Less than once a year	1	17%	_asian
Several times a year	12	16%	_black
Once a year	11	14%	_black
Less than once a year	10	13%	_black
Never	10	13%	_black
Once a month	10	13%	_black
Several times a month	8	11%	_black
Several times a week	6	8%	_black
Once a week	4	5%	_black
Declined to Answer	4	5%	_black
Every day	1	1%	_black
Never	1	33%	_hawaiian
Once a month	1	33%	_hawaiian
Several times a month	1	33%	_hawaiian
Less than once a year	8	27%	_latinx
Several times a year	8	27%	_latinx
Several times a month	5	17%	_latinx
Several times a week	3	10%	_latinx
Once a month	2	7%	_latinx
Once a year	2	7%	_latinx
Never	1	3%	_latinx
Once a week	1	3%	_latinx
Less than once a year	2	15%	_native_american
Never	2	15%	_native_american
Once a month	2	15%	_native_american
Once a year	2	15%	_native_american
Several times a year	2	15%	_native_american
Once a week	1	8%	_native_american
Several times a month	1	8%	_native_american
Several times a week	1	8%	_native_american
Several times a year	7	25%	_other
Less than once a year	6	21%	_other
Never	4	14%	_other
Once a year	4	14%	_other
Several times a month	3	11%	_other
Several times a week	2	7%	_other
Once a month	1	4%	_other
Once a week	1	4%	_other
Less than once a year	105	28%	_white

Never	77	21%	_white
Several times a year	72	19%	_white
Once a year	40	11%	_white
Once a month	31	8%	_white
Several times a month	17	5%	_white
Once a week	10	3%	_white
Declined to Answer	9	2%	_white
Several times a week	6	2%	_white
Every day	4	1%	_white

Use of Three-Digit Code among Respondents with Personal Experience

Response	Count	Percentage
Several times a year	53	23%
Less than once a year	48	20%
Once a year	33	14%
Never	25	11%
Several times a month	22	9%
Once a month	20	9%
Once a week	13	6%
Several times a week	12	5%
Declined to Answer	7	3%
Every day	2	1%

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*Imagine there is a three-digit number like 1-2-3 that you could call whenever **your loved one** feels emotionally overwhelmed. They provide assessment over the phone and connect to your loved one to services based on the type of situation. Based on the situation, services could be providing immediate over-the-phone support, sending a mobile crisis team to your loved one within about an hour, or connecting your loved one to a provider for a next-day appointment. How often would you use this number?*

Use of Three-Digit Code for Loved Ones

Respondents with family experience indicated the frequency with which they would use the three-digit code for their loved ones. Racial group refers to the respondents' self-identified race, which may not match their loved ones' race.

Response	Count	Percentage
Several times a year	117	28%
Less than once a year	60	14%
Declined to Answer	58	14%
Several times a month	51	12%
Once a year	48	11%
Once a month	29	7%
Several times a week	22	5%
Never	17	4%

Once a week	9	2%
Every day	7	2%

Common Stressors

Select all that apply: In the last 12 months, I have felt emotionally overwhelmed because of…

Stressors within Last 12 Months among All Respondents

Stressor	Count	Percentage
…relationship stress or family issues	315	46%
…stress over managing my or a loved one's mental health diagnosis	238	35%
…parenting stress or concerns about my kids	197	29%
…stress over managing my or a loved one's intellectual or developmental disability	152	22%
…the cost of medication(s) and treatment(s)	152	22%
…utility bills (water, gas, electricity, TV, internet, phone)	138	20%
Other	118	17%
…housing	107	16%
None of the above	102	15%
…lack of health insurance	63	9%
…lack of transportation access	58	9%
…court date or court fees	55	8%
…lack of food access	40	6%
…lack of phone access	18	3%

Stressors within Last 12 Months among All Respondents by Racial Group

Stressor	Count	Percentage	Race
…parenting stress or concerns about my kids	4	67%	_asian
…relationship stress or family issues	4	67%	_asian
…the cost of medication(s) and treatment(s)	3	50%	_asian
…utility bills (water, gas, electricity, TV, internet, phone)	3	50%	_asian
Other	2	33%	_asian
…court date or court fees	1	17%	_asian
…lack of health insurance	1	17%	_asian
…stress over managing my or a loved one's intellectual or developmental disability	1	17%	_asian
…relationship stress or family issues	41	54%	_black
…stress over managing my or a loved one's mental health diagnosis	22	29%	_black
…housing	21	28%	_black
…stress over managing my or a loved one's intellectual or developmental disability	20	26%	_black
…utility bills (water, gas, electricity, TV, internet, phone)	19	25%	_black

Other	19	25%	_black
…the cost of medication(s) and treatment(s)	18	24%	_black
…parenting stress or concerns about my kids	16	21%	_black
…lack of transportation access	13	17%	_black
…court date or court fees	12	16%	_black
None of the above	7	9%	_black
…lack of health insurance	6	8%	_black
…lack of food access	5	7%	_black
…lack of phone access	1	1%	_black
…parenting stress or concerns about my kids	2	67%	_hawaiian
…relationship stress or family issues	2	67%	_hawaiian
…utility bills (water, gas, electricity, TV, internet, phone)	2	67%	_hawaiian
…court date or court fees	1	33%	_hawaiian
…housing	1	33%	_hawaiian
…lack of food access	1	33%	_hawaiian
…lack of transportation access	1	33%	_hawaiian
…stress over managing my or a loved one's intellectual or developmental disability	1	33%	_hawaiian
…stress over managing my or a loved one's mental health diagnosis	1	33%	_hawaiian
…the cost of medication(s) and treatment(s)	1	33%	_hawaiian
Other	1	33%	_hawaiian
…relationship stress or family issues	22	73%	_latinx
…stress over managing my or a loved one's mental health diagnosis	15	50%	_latinx
…the cost of medication(s) and treatment(s)	13	43%	_latinx
…parenting stress or concerns about my kids	11	37%	_latinx
…stress over managing my or a loved one's intellectual or developmental disability	11	37%	_latinx
…utility bills (water, gas, electricity, TV, internet, phone)	11	37%	_latinx
…lack of health insurance	8	27%	_latinx
…housing	6	20%	_latinx
…lack of transportation access	6	20%	_latinx
…court date or court fees	4	13%	_latinx
…lack of food access	4	13%	_latinx
…lack of phone access	2	7%	_latinx
Other	2	7%	_latinx
None of the above	1	3%	_latinx
…relationship stress or family issues	7	54%	_native_american
…stress over managing my or a loved one's mental health diagnosis	7	54%	_native_american
…the cost of medication(s) and treatment(s)	5	38%	_native_american
…utility bills (water, gas, electricity, TV, internet, phone)	5	38%	_native_american
…parenting stress or concerns about my kids	4	31%	_native_american
Other	4	31%	_native_american
…housing	3	23%	_native_american

…lack of food access	3	23%	_native_american
…lack of transportation access	3	23%	_native_american
…stress over managing my or a loved one's intellectual or developmental disability	3	23%	_native_american
…court date or court fees	2	15%	_native_american
None of the above	2	15%	_native_american
…lack of health insurance	1	8%	_native_american
…lack of phone access	1	8%	_native_american
…relationship stress or family issues	15	54%	_other
…stress over managing my or a loved one's mental health diagnosis	12	43%	_other
…parenting stress or concerns about my kids	8	29%	_other
…stress over managing my or a loved one's intellectual or developmental disability	8	29%	_other
…the cost of medication(s) and treatment(s)	8	29%	_other
…utility bills (water, gas, electricity, TV, internet, phone)	8	29%	_other
…court date or court fees	6	21%	_other
Other	5	18%	_other
…housing	4	14%	_other
…lack of health insurance	4	14%	_other
None of the above	4	14%	_other
…lack of transportation access	3	11%	_other
…lack of food access	2	7%	_other
…lack of phone access	1	4%	_other
…relationship stress or family issues	190	51%	_white
…stress over managing my or a loved one's mental health diagnosis	153	41%	_white
…parenting stress or concerns about my kids	125	34%	_white
…the cost of medication(s) and treatment(s)	93	25%	_white
…stress over managing my or a loved one's intellectual or developmental disability	87	23%	_white
…utility bills (water, gas, electricity, TV, internet, phone)	78	21%	_white
Other	70	19%	_white
…housing	62	17%	_white
None of the above	59	16%	_white
…lack of health insurance	41	11%	_white
…lack of transportation access	31	8%	_white
…court date or court fees	28	8%	_white
…lack of food access	22	6%	_white
…lack of phone access	15	4%	_white

Stressors within Last 12 Months among Respondents with Personal Experience

Stressor	Count	Percentage
…relationship stress or family issues	153	65%
…stress over managing my or a loved one's mental health diagnosis	99	42%
…utility bills (water, gas, electricity, TV, internet, phone)	82	35%

…the cost of medication(s) and treatment(s)	81	34%
…housing	64	27%
…parenting stress or concerns about my kids	62	26%
Other	60	26%
…stress over managing my or a loved one's intellectual or developmental disability	42	18%
…lack of transportation access	41	17%
…lack of health insurance	35	15%
…court date or court fees	30	13%
…lack of food access	28	12%
None of the above	16	7%
…lack of phone access	14	6%

Warning Signs

I can always tell when I am going to experience a behavioral health emergency.

Existence of Warning Signs among Respondents with Personal Experience

Response	Count	Percentage
Agree	77	33%
Disagree	44	19%
Neutral	59	25%
Strongly Agree	34	14%
Strongly Disagree	14	6%
Declined to Answer	7	3%

*I can always tell when **my loved one** is going to experience a behavioral health emergency.*

Existence of Warning Signs for Loved Ones among Respondents with Family Experience

Response	Count	Percentage
Agree	133	32%
Disagree	75	18%
Neutral	95	23%
Strongly Agree	41	10%
Strongly Disagree	13	3%
Declined to Answer	61	15%

*What signs let you know that **you** are going to experience a behavioral health emergency? Select all that apply.*

Warning Signs among Respondents with Personal Experience

Warning Sign	Count	Percentage
Too many stressors at once	172	73%
Can't sleep	156	66%
Difficulty concentrating	155	66%
Disordered thoughts	130	55%
Change in eating habits	98	42%
Issues with family members get worse	80	34%
Drinking more alcohol or using more substances than usual	51	22%
Other	29	12%
Don't want to take my medicine	24	10%
Visual hallucinations	20	9%
Auditory hallucinations	18	8%
None of the above: I do not have any warning signs.	11	5%

*What signs let you know that **your loved one** is going to experience a behavioral health emergency? Select all that apply.*

Warning Signs for Loved Ones among Respondents with Family Experience

Warning Sign	Count	Percentage
Too many stressors at once	192	46%
Can't sleep	182	44%
Disordered thoughts	179	43%
Issues with family members get worse	168	40%
Difficulty concentrating	160	38%
Change in eating habits	118	28%
Don't want to take my medicine	97	23%
Drinking more alcohol or using more substances than usual	92	22%
Auditory hallucinations	50	12%
Other	49	12%
Visual hallucinations	33	8%
None of the above: They do not have any warning signs.	30	7%

Reluctance to Seek Help

Select all that apply: In the past, I have been reluctant to seek behavioral health care for myself for fear of poor treatment because of my…

Reasons Reluctant to Seek Help among All Respondents

Reason for Reluctance	Count	Percentage
None of the above: I have never felt that I need behavioral health care.	208	31%
Other	187	27%
…mental health diagnosis	116	17%

…recreational substance use	38	6%
…race	31	5%
…spirituality or religious beliefs	28	4%
…traumatic brain injury	28	4%
…ethnicity	27	4%
…physical disability	26	4%
…sexual orientation	26	4%
…intellectual or developmental disability	23	3%
…criminal history	20	3%
…gender identity and expression	18	3%
…use of alternative and augmentative communication (AAC)	9	1%
…probation status	8	1%
…citizenship status	2	0%
…limited English proficiency	2	0%
…immigration status	1	0%
…parole status	1	0%

Reasons Reluctant to Seek Help among Respondents with Personal Experience

Reluctance	Count	Percentage
…mental health diagnosis	89	38%
Other	78	33%
…recreational substance use	25	11%
None of the above: I have never felt that I need behavioral health care.	25	11%
…traumatic brain injury	23	10%
…physical disability	20	9%
…sexual orientation	19	8%
…spirituality or religious beliefs	18	8%
…ethnicity	15	6%
…criminal history	14	6%
…race	13	6%
…gender identity and expression	11	5%
…intellectual or developmental disability	10	4%
…use of alternative and augmentative communication (AAC)	8	3%
…probation status	7	3%
…limited English proficiency	1	0%
…parole status	1	0%

*Select all that apply: In the past, I have been reluctant to seek behavioral health care for **my loved one** for fear of poor treatment because of their…*

Reasons Reluctant to Seek Help for Loved Ones among Respondents with Family Experience

Reluctance	Count	Percentage
None of the above	139	33%
…mental health diagnosis	83	20%

Other	72	17%
…intellectual or developmental disability	62	15%
…recreational substance use	34	8%
…criminal history	30	7%
…race	29	7%
…ethnicity	19	5%
…spirituality or religious beliefs	14	3%
…gender identity and expression	13	3%
…sexual orientation	13	3%
…traumatic brain injury	13	3%
…physical disability	12	3%
…limited English proficiency	9	2%
…probation status	8	2%
…use of alternative and augmentative communication (AAC)	8	2%
…parole status	7	2%
…immigration status	6	1%
…citizenship status	5	1%

Avoiding Help in Crises

Which of the following reasons have kept you from seeking help for yourself or your loved one during a behavioral health emergency in the past? Select all that apply.

Reasons to Avoid Emergency Help among Respondents with Personal Experience

Reason to Avoid Help	Count	Percentage
I or my loved one fear the uncertainty and the lack of control: not knowing what type of response will happen after reaching out for help.	100	43%
I or my loved one do not want to be forced to be hospitalized.	100	43%
I or my loved one have had negative experiences with behavioral health professionals.	91	39%
I or my loved one do not want to be handcuffed.	73	31%
I or my loved one have had negative experiences as a result of calling 9-1-1 for help with a behavioral health emergency.	64	27%
I or my loved one are afraid of not being able to have a chosen supporter (parent, friend, spouse, etc.) who will be able to help communicate need and advocate for appropriate accommodations.	61	26%
I or my loved one do not believe follow-up care will be proved to help prevent another behavioral health emergency.	58	25%
I or my loved one are afraid of receiving a criminal charge.	56	24%
Some sources of help are not safe for people like me or my loved one.	48	20%
I or my loved one have had negative experiences with contacting Emergency Medical Services (EMS) for help with a behavioral health emergency.	41	17%
None of the above	40	17%
I or my loved one have had emergency room/department (ER/ED) staff call the police in response to a behavioral health emergency.	38	16%

I or my loved one believe that the community services board (CSB) is an extension of the system, not a safe source of help.	34	14%

Reasons to Avoid Emergency Help among Respondents with Family Experience

Reason to Avoid Help	Count	Percentage
I or my loved one fear the uncertainty and the lack of control: not knowing what type of response will happen after reaching out for help.	156	37%
I or my loved one do not want to be forced to be hospitalized.	137	33%
I or my loved one have had negative experiences with behavioral health professionals.	127	30%
I or my loved one do not want to be handcuffed.	115	28%
I or my loved one have had negative experiences as a result of calling 9-1-1 for help with a behavioral health emergency.	107	26%
I or my loved one do not believe follow-up care will be proved to help prevent another behavioral health emergency.	101	24%
I or my loved one are afraid of not being able to have a chosen supporter (parent, friend, spouse, etc.) who will be able to help communicate need and advocate for appropriate accommodations.	95	23%
I or my loved one are afraid of receiving a criminal charge.	83	20%
Some sources of help are not safe for people like me or my loved one.	78	19%
None of the above	64	15%
I or my loved one have had emergency room/department (ER/ED) staff call the police in response to a behavioral health emergency.	53	13%
I or my loved one have had negative experiences with contacting Emergency Medical Services (EMS) for help with a behavioral health emergency.	53	13%
I or my loved one believe that the community services board (CSB) is an extension of the system, not a safe source of help.	48	11%

Criminalizing Mental Health

I have had a criminal charge pressed as a result of calling 9-1-1 for a behavioral health emergency.

Criminal Charges among Respondents with Personal Experience

Response	Count	Percentage
No	176	75%
Yes	16	7%
Declined to Answer	43	18%

*My **loved one** has had a criminal charge pressed as a result of calling 9-1-1 for a behavioral health emergency.*

Loved Ones' Criminal Charges among Respondents with Family Experience

Respondents with family experience indicated whether loved ones have ever received a criminal charge as a result of seeking help for a behavioral health emergency.

Response	Count	Percentage
No	263	63%
Yes	42	10%
Declined to Answer	113	27%

Preferred Response

*If **you** were to experience a behavioral health emergency next week, what would be your preferred option for handling the crisis, if all of these options were available to you?*

Preferred Response among Respondents with Personal Experience

Response	Count	Percentage
Call a hotline where a trained behavioral health professional (social worker, counselor, peer recovery specialist, etc.) can speak for at least 30 minutes over the phone	45	19%
Declined to Answer	44	19%
Call and receive an immediate telehealth appointment with a behavioral health professional	43	18%
Call a hotline and receive a same-day, in-person appointment with a therapist	32	14%
Call a hotline and talk with a peer recovery specialist over the phone	29	12%
Walk into a 23-hour crisis stabilization center	14	6%
Call 9-1-1 and have a mobile crisis team provide a behavioral health-only response	11	5%
Call 9-1-1 and have a co-response between a paramedic and a behavioral health professional	10	4%
Go to an ER/ED and receive an assessment	6	3%
Call 9-1-1 and have a co-response between a police officer and a behavioral health professional	1	0%

*If **your loved one** were to experience a behavioral health emergency next week, what would be your preferred option for handling the crisis, if all of these options were available?*

Preferred Response for Loved Ones among Respondents with Family Experience

Response	Count	Percentage
Declined to Answer	110	26%
Call a hotline where a trained behavioral health professional (social worker, counselor, peer recovery specialist, etc.) can speak for at least 30 minutes over the phone	51	12%
Call and receive an immediate telehealth appointment with a behavioral health professional	50	12%

Call a hotline and receive a same-day, in-person appointment with a therapist	47	11%
Call 9-1-1 and have a mobile crisis team provide a behavioral health-only response	42	10%
Call 9-1-1 and have a co-response between a paramedic and a behavioral health professional	33	8%
Walk into a 23-hour crisis stabilization center	23	6%
Go to an ER/ED and receive an assessment	21	5%
Call 9-1-1 and have a co-response between a police officer and a behavioral health professional	20	5%
Call a hotline and talk with a peer recovery specialist over the phone	17	4%
Call 9-1-1 and have a police officer come to assist you	3	1%
Call 9-1-1 and have a paramedic come to assist you	1	0%

Increasing Likelihood to Seek Help

Select all that apply: I would be more likely to seek help for myself or my loved one before the peak of a behavioral health emergency if…

Factors to Increase Likelihood of Seeking Help among Respondents with Personal Experience

Reason to Seek Help	Count	Percentage
…a chosen supporter (parent, friend, spouse, etc.) could stay to help communicate needs wherever I or my loved one went.	117	50%
…a behavioral health response not involving a police officer was guaranteed.	116	49%
…handcuffs or shackles would not be used.	109	46%
…there was access to a quiet, private area wherever I or my loved one was taken.	103	44%
…follow-up care to ensure linkages and referrals were made was guaranteed.	84	36%
…a peer support professional (peer recovery specialist, family support partner) would be part of the response.	81	34%
…a police car would not be used for transportation.	79	34%
…the police officers who responded had completed Crisis Intervention Team (CIT) training and were wearing CIT pins.	79	34%
…a shower in a private bathroom was available wherever I or my loved one went.	77	33%
…snacks were provided wherever I or my loved one was taken.	77	33%
…outdoor space was available wherever I or my loved one went.	74	31%
…the police officers who responded had specific rules about using force during a behavioral health emergency compared to a criminal situation.	74	31%
…a psychiatric advanced directive would be respected.	72	31%
…the police officers who responded had received training on interacting with individuals with intellectual and developmental disabilities in a crisis situation and assisting with their specific needs.	71	30%
…the evaluation waiting space looked like a living room with comfortable chairs and a TV.	70	30%
…the police officers who responded would not turn on their sirens and lights.	69	29%

…a secure place to store belongings was available wherever I or my loved one went.	67	29%
…the police officers who responded would not carry guns.	64	27%
…a behavioral health professional was always available over the phone during a police response, even if the professional could not be physically present.	63	27%
…a peer support professional was always available over the phone during a police response, even if the specialist could not be physically present.	49	21%
…the police officers who responded were wearing plain clothes (polo and pants) rather than a standard uniform.	49	21%
…inpatient hospitalization was not an option.	48	20%
…the police officers who responded would come in an unmarked car.	47	20%
…smoke breaks were allowed wherever I or my loved one went.	45	19%
…a chaplain or other spiritual leader would be part of the response.	28	12%
…temporary guardianship could easily be received.	22	9%
…the police officers who responded would be older.	13	6%
None of the above	12	5%

Factors to Increase Likelihood of Seeking Help among Respondents with Family Experience

Racial group refers to the respondents' self-identified race, which may not match their loved ones' race.

Reason to Seek Help	Count	Percentage
…a chosen supporter (parent, friend, spouse, etc.) could stay to help communicate needs wherever I or my loved one went.	186	44%
…a behavioral health response not involving a police officer was guaranteed.	160	38%
…follow-up care to ensure linkages and referrals were made was guaranteed.	150	36%
…handcuffs or shackles would not be used.	148	35%
…there was access to a quiet, private area wherever I or my loved one was taken.	143	34%
…the police officers who responded had completed Crisis Intervention Team (CIT) training and were wearing CIT pins.	139	33%
...the police officers who responded had received training on interacting with individuals with intellectual and developmental disabilities in a crisis situation and assisting with their specific needs.	136	33%
…the police officers who responded had specific rules about using force during a behavioral health emergency compared to a criminal situation.	128	31%
…a police car would not be used for transportation.	126	30%
…the police officers who responded would not turn on their sirens and lights.	120	29%
…a behavioral health professional was always available over the phone during a police response, even if the professional could not be physically present.	117	28%
…a peer support professional (peer recovery specialist, family support partner) would be part of the response.	111	27%
…outdoor space was available wherever I or my loved one went.	104	25%
…the evaluation waiting space looked like a living room with comfortable chairs and a TV.	103	25%
…snacks were provided wherever I or my loved one was taken.	102	24%
…a shower in a private bathroom was available wherever I or my loved one went.	97	23%
…the police officers who responded would not carry guns.	94	22%

…a psychiatric advanced directive would be respected.	92	22%
…the police officers who responded would come in an unmarked car.	86	21%
…the police officers who responded were wearing plain clothes (polo and pants) rather than a standard uniform.	83	20%
…a secure place to store belongings was available wherever I or my loved one went.	80	19%
…a peer support professional was always available over the phone during a police response, even if the specialist could not be physically present.	68	16%
…temporary guardianship could easily be received.	64	15%
…a chaplain or other spiritual leader would be part of the response.	57	14%
…smoke breaks were allowed wherever I or my loved one went.	51	12%
…inpatient hospitalization was not an option.	42	10%
None of the above	21	5%
…the police officers who responded would be older.	15	4%

Voluntary Database

Have you heard about services like Smart911 or Rave 911 that allow people to create safety profiles so that 9-1-1 call takers already have information about you if you call?

Awareness of Voluntary Database Services among All Respondents

Response	Count	Percentage
No	428	63%
Yes	78	11%
Declined to Answer	175	26%

*When the voluntary registry is created, I will most likely provide information about **me** so that first responders know about my needs.*

Willingness to Contribute to Voluntary Database among Respondents with Personal Experience

Response	Count	Percentage
Agree	47	20%
Disagree	19	8%
Neutral	58	25%
Strongly Agree	35	15%
Strongly Disagree	24	10%
Declined to Answer	52	22%

*When the voluntary registry is created, I will most likely provide information about **my loved one** so that first responders know about their unique needs.*

Willingness to Contribute Loved Ones' Information to Voluntary Database among Respondents with Family Experience

Response	Count	Percentage
Agree	102	24%
Disagree	17	4%
Neutral	69	17%
Strongly Agree	77	18%
Strongly Disagree	21	5%
Declined to Answer	132	32%

Enhancing the Workforce

Ensuring that there is a robust, healthy workforce of behavioral health professional is essential for ensuring that the comprehensive crisis response system has sufficient capacity to make the Marcus Alert system a success. With that end in mind, respondents who indicated they were behavioral health professionals were asked about their opinions regarding their training and ability to maintain their own mental well-being.

I know how to protect my own recovery and avoid trauma echoes.

Ability to Avoid Trauma Echoes among Peer Recovery Specialists

Response	Count	Percentage
Agree	22	45%
Disagree	2	4%
Neutral	5	10%
Strongly Agree	10	20%
Strongly Disagree	2	4%
Declined to Answer	8	16%

I could benefit from more training to handle behavioral health emergencies.

Need for Additional Training among Respondents with Professional Experience

Response	Count	Percentage
Agree	33	20%

Disagree	21	13%
Neutral	24	15%
Strongly Agree	20	12%
Strongly Disagree	4	2%
Declined to Answer	63	38%

Awareness of Resources

Which resources have you heard about? Select all that apply.

Resource Awareness among All Respondents

Resources	Count	Percentage
National Suicide Prevention Lifeline and Crisis Textline	314	46%
Virginia Community Service Boards: Emergency Services	274	40%
Virginia Community Services Boards: Same Day Access to Mental Health Services	182	27%
2-1-1 Virginia	141	21%
Veterans Administration Crisis Line	117	17%
The Infant and Toddler Connection	86	13%
None of the above	77	11%
Veterans Administration Women's Call Center	25	4%
Real Warriors	19	3%
Marine Corps DSTRESS Line	17	2%
Defense Center for Excellence for Psychological Health Outreach	11	2%
inTransition	5	1%
Coaching into Care	2	0%