Marcus Alert Local Plan Guide

Version: April 2022

This document was created by the Virginia Department of Behavioral Health and Developmental Services in collaboration with the Virginia Department of Criminal Justice Services.

Contents

How to Use This Guide

This guide is designed to assist local areas on navigating how and what to submit for Local Marcus Alert plans. There are eight (8) sections that are required for local plan submissions, they are:

- Local Agency Inventory
- Stakeholder Member List
- Marcus Alert Responses
- Protocol 1
- Protocol 2 (not required for those choosing to be exempt)
- Protocol 3 (not required for those choosing to be exempt)
- Budget
- Contact Information

You will find information under each of the section titles providing instructions on what information is needed for submission. It is recommended to provide as much detail as possible within each section, this will reduce the need for follow-up communications and additional requests for information.

As you move through this document, beginning on page 9, you will find a guided pages that have examples of the types of responses that localities may implement. The next section on page 20 you will find the blank template pages that you will submit for the local plan.

This document is a PDF, however, each section contains fillable text boxes where you will provide your information. If you need additional space for a section, in the text box found in this document type "Additional space was needed. Separate document is attached." Provide all other text for that section on the separate document, you will then submit that subsection text as a separate attachment.

Icons

Throughout this document you will find icons that indicate which entity will have the most impact/involvement in a section.

Law Enforcement

Public Safety Answering Points/Emergency Communications Centers

Behavioral Health

Frequently Asked Questions

What is the Marcus Alert System?

The Marcus Alert legislation requires behavioral health, law enforcement, and 9-1-1 call centers to work together to better respond to behavioral health calls. The legislation has three primary components 1) diverting behavioral health calls from 9-1-1 to the Regional Crisis Call Centers (9-8-8 infrastructure) 2) formalized agreements between law enforcement and mobile crisis teams and 3) a "specialized response" from law enforcement when responding to behavioral health calls. As of July 1, 2022 there is a modified version of a Marcus Alert system that does not include 2) and 3).

What is optional in the Marcus Alert?

Effective, July 1, 2022 an exemption is made to the requirement that localities 1) establish protocols for local law enforcement agencies to enter into memorandums of agreement with mobile crisis response providers regarding requests for law-enforcement back-up during mobile crisis or community care team response (Protocol 2) and 2) minimum standards, best practices, and a system for the review and approval of protocols for law-enforcement participation (Protocol 3) in the Marcus alert system. This exemption exists for localities with a population that is less than or equal to 40,000. If a law enforcement agency is exempt, there is an option to submit only Protocols 2 or 3, or opt out of both Protocols.

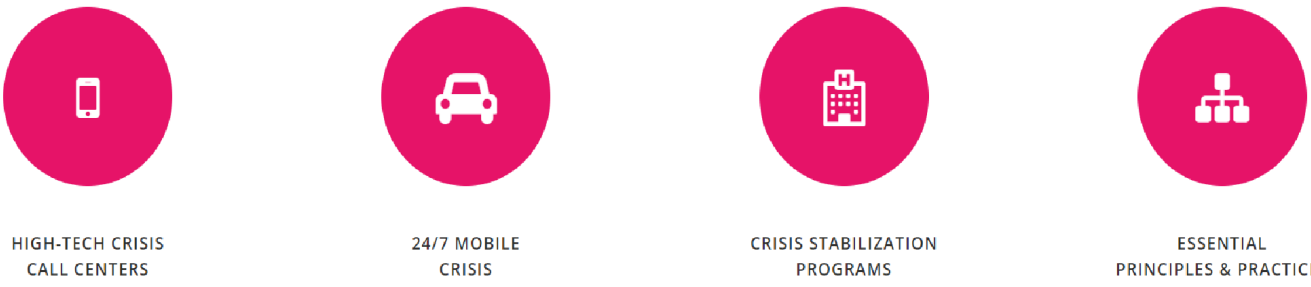
The list of localities by population can be found on Page 27.

What needs to be submitted if our partners opt-out?

For areas that have partners that qualify for and choose exemption from participation, portions of the local plan are still required. Of the eight (8) sections, only Protocols 2 and 3 are not required according to the exemption. All other sections are to be completed and submitted.

What is the vision for Virginia's behavioral health crisis system?

Virginia's behavioral health crisis system is being modeled after the national "Crisis Now" concept. This concept was created as a best practice model after systemic review of behavioral health crisis systems and their effectiveness. Crisis Now has 4 core elements which are:



The Marcus-David Peters Act requires DBHDS to transform the behavioral health system and that includes the Marcus Alert. The Marcus Alert connects 9-1-1 to the 9-8-8 Crisis Call Centers and requires formalized agreements for safety purposes for mobile crisis teams, it also ensures our law enforcement partners have appropriate policies and procedures in place that align with modern policing.

What is 9-8-8 and the Regional Crisis Call Centers?

9-8-8 is the new 3-digit code for the existing National Suicide Prevention Lifeline (800-273-TALK). The National Suicide Prevention Lifeline is made up of an expansive network of over 200 local – and state – funded crisis centers located across the United States. The counselors at these local crisis centers answer calls and chats from people in distress that the Lifeline receives every day. [1]

Calls that enter through 800-273-TALK (and 9-8-8 once launched on July 16, 2022) are routed based on area code and will go to the closest Lifeline Center. Two existing Lifeline centers have been awarded contracts to provide full coverage of all Virginia's Lifeline calls and PSAP transfers. The benefit of these contracts is these call centers can be integrated into Virginia's behavioral health system and aid in the dispatch of Mobile Crisis Teams and provide connection to local community resources. In addition, regional crisis call centers can create agreements with local 9-1-1 centers to streamline call transfers, in both directions.

DBHDS Region	**Call Center Vendor**
Region 1 Northwest	PRS Crisis Link
Region 2 Northern	PRS Crisis Link
Region 3 Southwest	Frontier Health
Region 4 Central	PRS Crisis Link
Region 5 Eastern	PRS Crisis Link

What is the Four Level Framework?

The four Marcus Alert Levels 1, 2, 3, and 4 are used to support shared communication across LE, BH, and PSAP. This framework is beneficial for planning different responses at the local level, communicating local plans to DBHDS and DCJS in a standardized fashion that can be understood across the state, and also for reporting and evaluation purposes. Each PSAP will need to integrate coding for these levels into their CAD for reporting purposes. The Four Level Framework is what local Marcus Alert systems will build their different protocols and specialized responses around. You can find the graphic of this triage framework on page 10. A blank template for planning purposes is on page 13.

[1] https://suicidepreventionlifeline.org/our-crisis-centers/

What are the next areas to implement Marcus Alert?

The second round of areas scheduled to fully implement the Marcus Alert System (Protocols and Community Coverage) by July 1, 2023 are required by legislation to be the largest population areas in their region and are:

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

For the third and following waves of implementation, DBHDS and DCJS hope to have a CSB within each region and its geographical area partners volunteer.

The Marcus Alert Resource Toolkit

A collection of Resources for Local Planning has been made available on the Department of Behavioral Health and Developmental Services website. The Toolkit provides resources for planning purposes and helpful suggestions when developing policies for the protocols. You can find the toolkit at the following link: https://dbhds.virginia.gov/marcusalert/toolkit/.

Timeline

The following timeline is based on the Marcus David Peters Act as signed into law in April 2022 (effective July 1, 2022).

December 1, 2021	5 Initial Areas required to implement Marcus Alert Protocols.
5 Months	Localities are required to submit Marcus Alert Local Plans at least 5 months before implementation.
February 1, 2023	Second Implementing Areas (CSBs, PSAPs, and LEAs) are required to submit Marcus Alert Local Plans.
July 1, 2023-2028	Implementation of the Marcus Alert local plan is phased in for localities a minimum of one (1) locality per DBHDS region each year through 2026, all implemented by 2028

How to Submit a Local Plan

The Department of Behavioral Health and Developmental Services recently transitioned its website to a new platform and the web portal is in the early development stage. Once this project is complete, directions will be provided on how to submit/upload the forms.

Contact Us

General Marcus Alert inquiries can be sent to marcusalert@dbhds.virginia.gov

Virginia Department of Behavioral Health and Developmental Services

Alexandria Robinson
Marcus Alert Program Coordinator
Alexandria.Robinson@dbhds.virginia.gov
804-291-8022

An Major *effective 5/10/2022
Community Crisis Data Analyst

Virginia Department of Criminal Justice Services

Dallas Leamon
Marcus Alert Program Coordinator
Dallas.Leamon@dcjs.virginia.gov

New Position to Be Filled:
Marcus Alert Communications (PSAP) Coordinator

Regional Marcus Alert Coordinators

These Positions are locally staffed and provide support to LE, BH, and PSAPs

Region 1 Northwest	Erika Vesely, evesely@rrcsb.org 540-718-3569
Region 2 Northern	Jean Post, Acting, Virginia.post@fairfaxcounty.gov
Region 3 Southwest	Chris Parks, cparks@highlandscsb.org
Region 4 Central	Amy Erb, Acting, erba@rbha.org 804-819-4187
Region 5 Eastern	Todd McGehee, TMcgehee@vbgov.com 757-404-8204

Best Practices Checklist

Does your Local Marcus Alert Plan include any of the following? This checklist is a tool for planning purposes and is not required to be submitted.

Protocol #1	
☐	Level 1 calls are fully diverted to 9-8-8.
☐	Level 2 calls are fully diverted to 9-8-8 and
☐	Level 3 calls involving youth are coordinated with 9-8-8 and specialized children's mobile crisis teams.
☐	Level 3 calls involving individuals with ID/DD are coordinated with 9-8-8 and specialized developmental disability mobile crisis teams/REACH program training.
Protocol #3	
☐	Community Policing policies and initiatives are agency-wide.
☐	There is guardian vs. warrior training or approach at the agency level.
☐	De-escalation is required prior to use of force (as a separate policy or built into use of force policy).
☐	The use of force policy addresses individuals in behavioral health crisis.
☐	Implicit bias trainings and policies are agency-wide.
☐	Bias-based policing policy addresses individuals in behavioral health crisis and individuals with substance use disorder, mental health disorders, or developmental disabilities.
☐	There are officer wellness supports and policies for behavioral health crisis responses.
Training	
☐	Officer wellness or peer support programs are available to all officers.
☐	All officers complete eight-hour mental health first aid.
☐	There is ongoing de-escalation training for all officers, including basic and intermediate training.
☐	Officers receive interactive, scenario-based de-escalation training, including mental health scenarios, at least yearly.
☐	Advanced workshop-based trainings on cultural humility, anti-racism, and cultural competence are available.

☐	Agencies have coverage on each shift by an appropriate amount of officers who have completed 40-hour CIT training in the 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.
Quality Improvement	
☐	CIT programs adopt other CIT best practices.
☐	There is a plan for a high level engagement by each area (mental health, law enforcement, 911 centers, and other entities) in cross-sector quarterly meetings and a commitment to data-driven quality improvement processes at the local level.

Future Elements

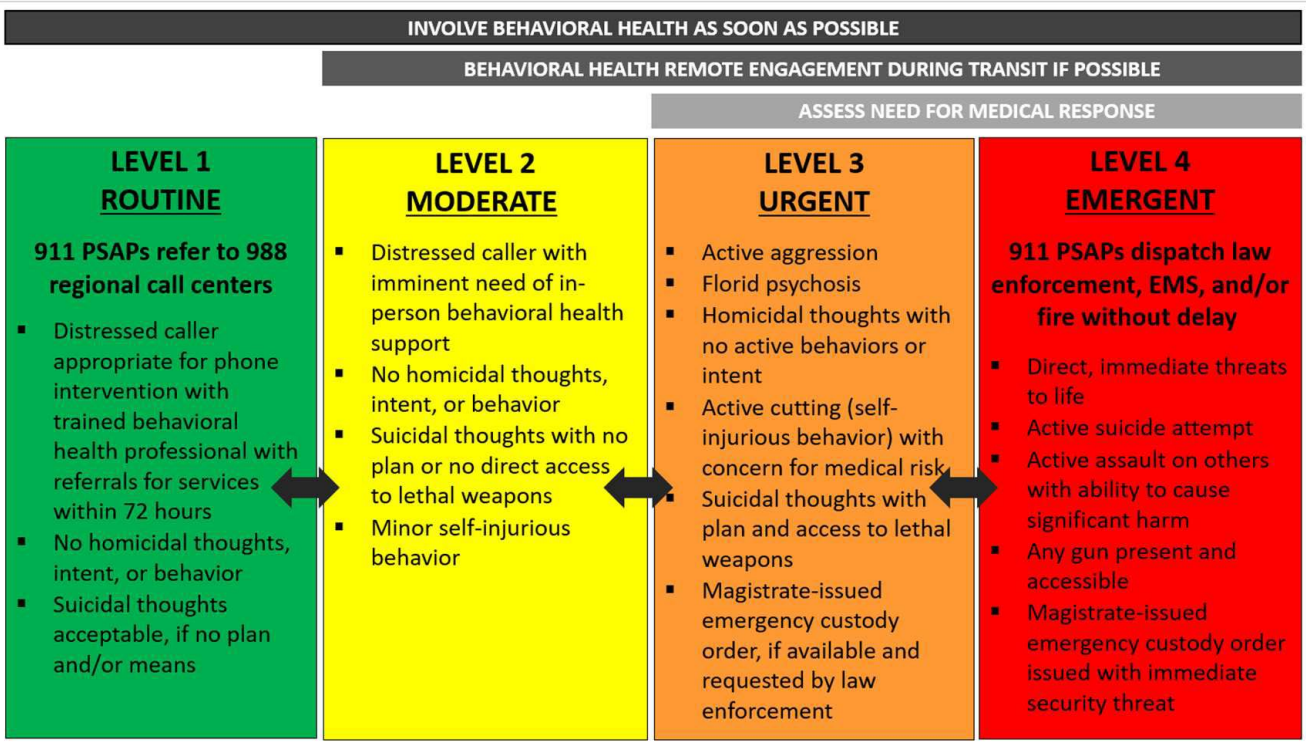
Some elements of the Marcus Alert local plan are dependent on state-level components of the plan.

☐	Back-up officers sent under agreements with regional hubs will be voluntarily CIT trained and have received the advanced Marcus Alert.
☐	Agencies have coverage each shift by an appropriate amount of officers who have completed the advanced/intersectional Marcus Alert training.

Guided Pages for Local Plans

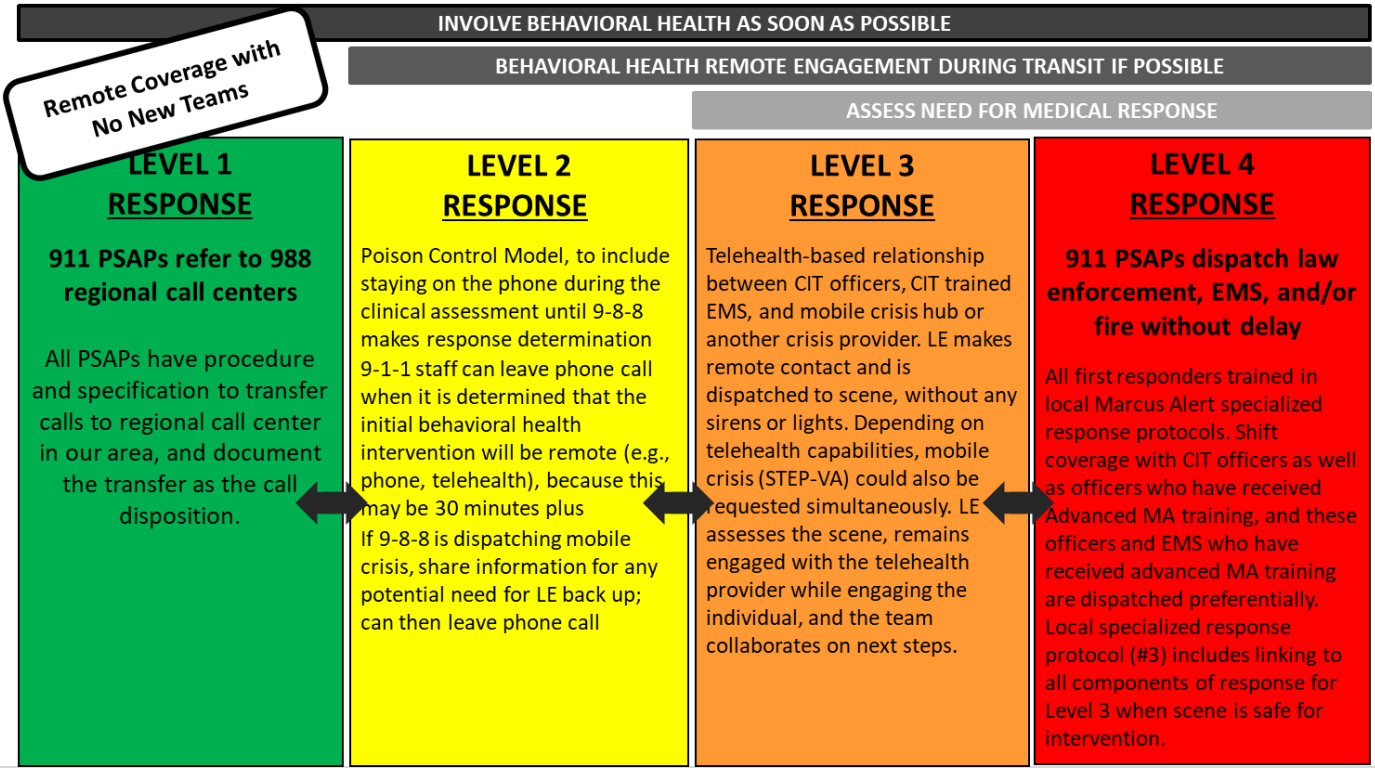
The next section contains guided answers and planning tools to the Marcus Alert Response Options and Protocols 1, 2, and 3. There are also embedded links that direct you to training materials and a sample MOU.

Four Level Triage Framework – Urgency Determination



Four Level Triage Framework – Response Options for Community Coverage

Achieving community coverage is possible through a variety of team composition samples demonstrated in the below graphics. These are tools for planning purposes only and can be adapted for localities.



Additional Local MCTs

INVOLVE BEHAVIORAL HEALTH AS SOON AS POSSIBLE

BEHAVIORAL HEALTH REMOTE ENGAGEMENT DURING TRANSIT IF POSSIBLE

ASSESS NEED FOR MEDICAL RESPONSE

LEVEL 1 RESPONSE	LEVEL 2 RESPONSE	LEVEL 3 RESPONSE	LEVEL 4 RESPONSE
911 PSAPs refer to 988 regional call centers All PSAPs have procedure and specification to transfer calls to regional call center in our area, and document the transfer as the call disposition.	Mobile crisis response, using modified Poison Control Model, to include staying on the phone during the clinical assessment until 9-8-8 makes response determination (particularly focused on whether mobile crisis is recommended for dispatch). 9-8-8 dispatches mobile crisis utilizing local or regional teams (all under MOU with hub), 9-1-1 monitors/flags so that information gathered initially is provided to any calls for back up law enforcement involvement later in the situation.	Mobile crisis response, utilizing local teams for "preferred customer" response (e.g., local goal may be 30 minute response). Remote engagement in transit, including sharing any information about who will arrive, when, and for what type of support. LE aware of location and call (if very close by) or dispatched simultaneously to serve in back up capacity or secure the safety of the scene prior to the mobile crisis team beginning their intervention. CIT officers with advanced training always dispatched preferentially (local goal= 100% of the time). LE may be asked to remain on the scene or released.	**911 PSAPs dispatch law enforcement, EMS, and/or fire without delay** All first responders trained in local Marcus Alert specialized response protocols. Shift coverage with CIT officers as well as officers who have received Advanced MA training, and these officers and EMS who have received advanced MA training are dispatched preferentially. Mobile crisis (local 30 minute response goal) dispatched simultaneously but kept continually informed in transit and does not arrive or approach scene until considered safe and appropriate to do so by LE and EMS.

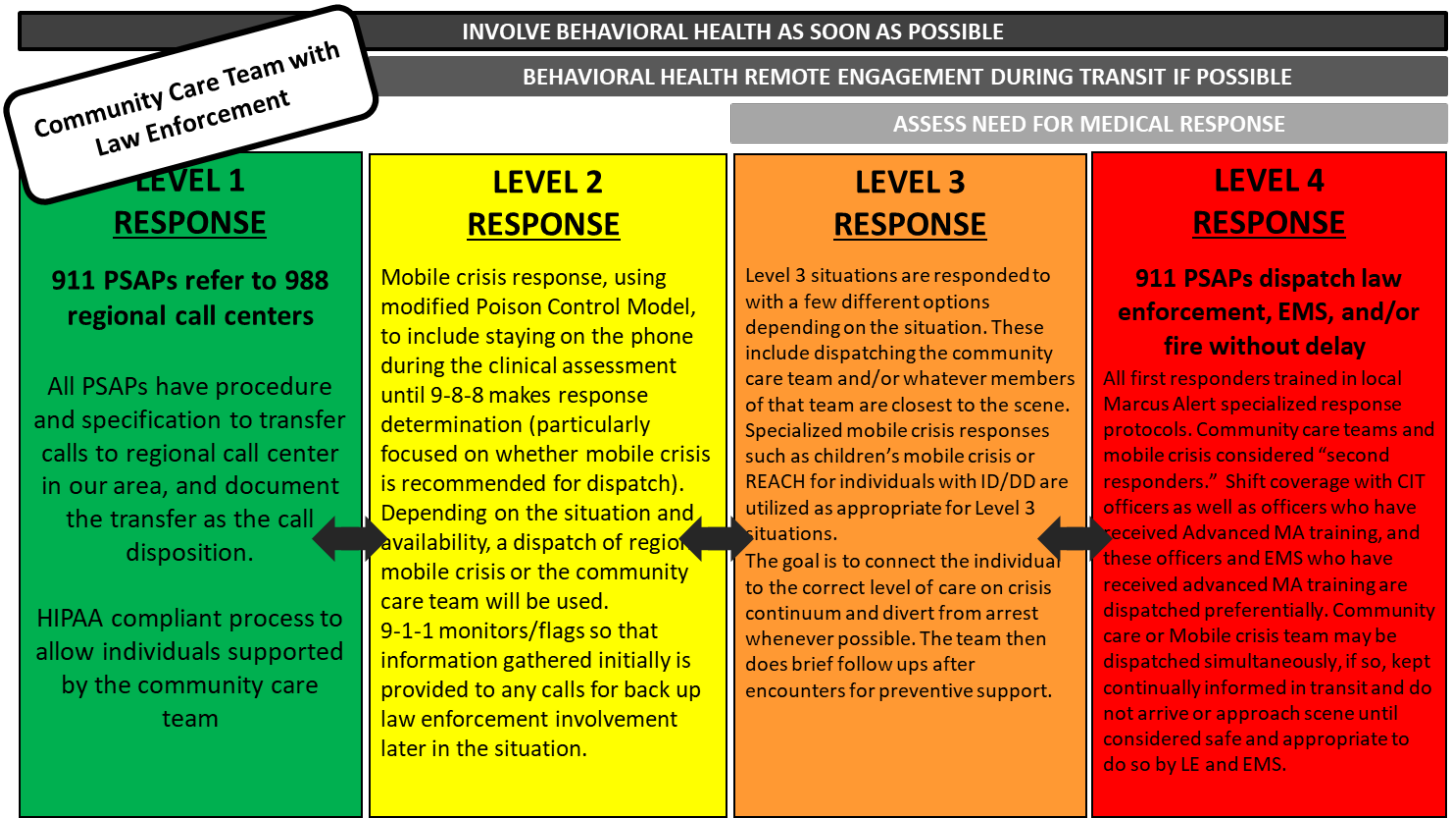
Community Care Team without LE ("CAHOOTS" style)

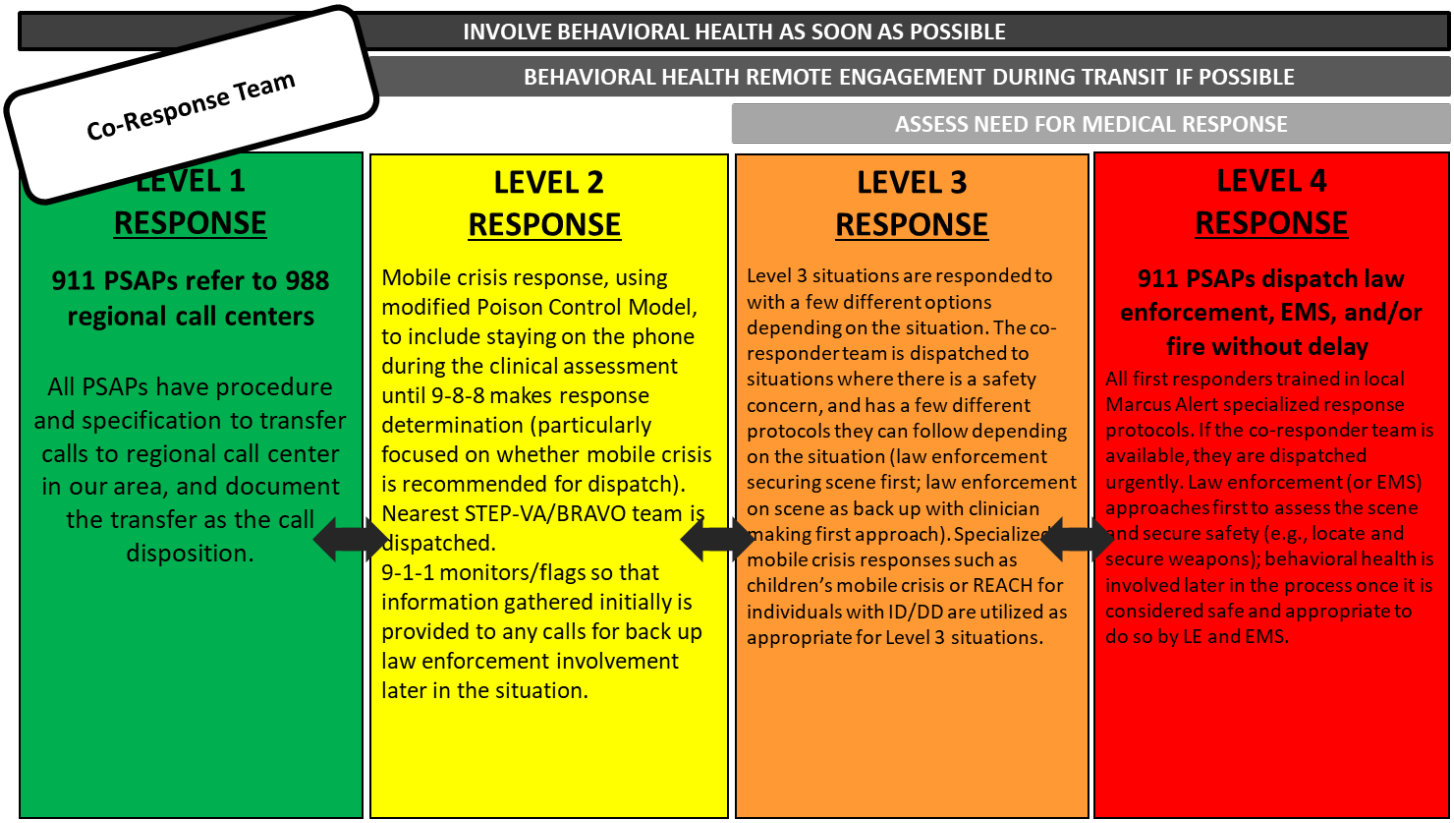
INVOLVE BEHAVIORAL HEALTH AS SOON AS POSSIBLE

BEHAVIORAL HEALTH REMOTE ENGAGEMENT DURING TRANSIT IF POSSIBLE

ASSESS NEED FOR MEDICAL RESPONSE

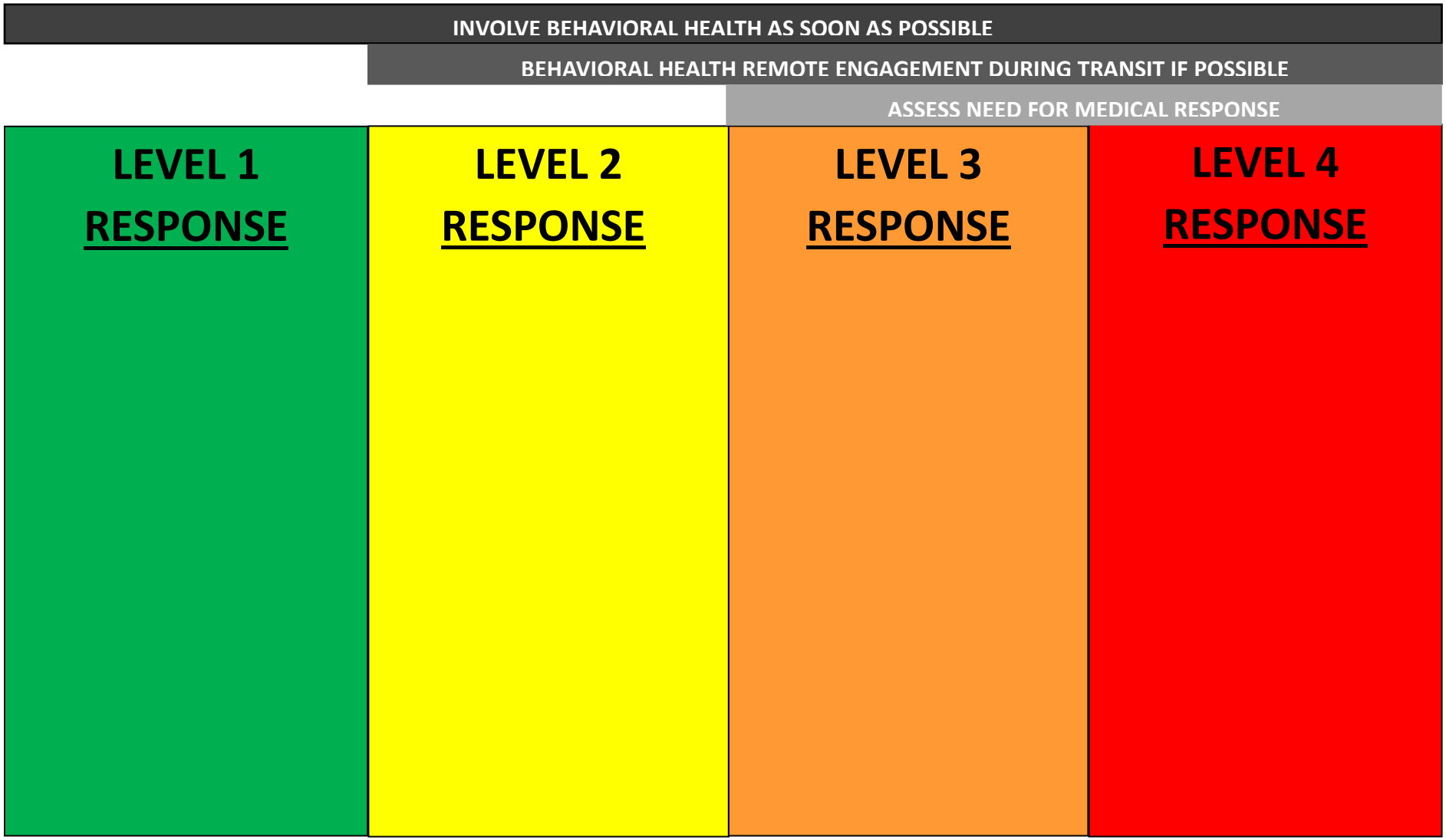
LEVEL 1 RESPONSE	LEVEL 2 RESPONSE	LEVEL 3 RESPONSE	LEVEL 4 RESPONSE
911 PSAPs refer to 988 regional call centers All PSAPs have procedure and specification to transfer calls to regional call center in our area, and document the transfer as the call disposition.	Mobile crisis response, using modified Poison Control Model, to include staying on the phone during the clinical assessment until 9-8-8 makes response determination (particularly focused on whether mobile crisis is recommended for dispatch). Depending on the situation and availability, a dispatch of regional mobile crisis or local community care team will be used. 9-1-1 monitors/flags so that information gathered initially is provided to any calls for back up law enforcement involvement later in the situation.	Community care team response utilizing a "CAHOOTS" style two person team (EMS/Peer, Peer/QMHP, etc.) respond to the scene. Coordination with 9-8-8 as needed to determine next steps (e.g., transport to crisis receiving center, connect to clinician). LE aware of location and prepared to serve as back up as needed. CIT officers with advanced training always dispatched preferentially (local goal= 100% of the time). LE may be asked to remain on the scene or released. Goal is to connect the individual to the correct level of care on crisis continuum as quickly as possible. Team also does brief follow ups after encounters for preventive support.	**911 PSAPs dispatch law enforcement, EMS, and/or fire without delay** All first responders trained in local Marcus Alert specialized response protocols. Community care teams and mobile crisis considered "second responders." Shift coverage with CIT officers as well as officers who have received Advanced MA training, and these officers and EMS who have received advanced MA training are dispatched preferentially. Community care or Mobile crisis team may be dispatched simultaneously, if so, kept continually informed in transit and do not arrive or approach scene until considered safe and appropriate to do so by LE and EMS.


Community Care Team with Law Enforcement
INVOLVE BEHAVIORAL HEALTH AS SOON AS POSSIBLE
BEHAVIORAL HEALTH REMOTE ENGAGEMENT DURING TRANSIT IF POSSIBLE
ASSESS NEED FOR MEDICAL RESPONSE
LEVEL 1 RESPONSE
911 PSAPs refer to 988 regional call centers
All PSAPs have procedure and specification to transfer calls to regional call center in our area, and document the transfer as the call disposition.
HIPAA compliant process to allow individuals supported by the community care team
LEVEL 2 RESPONSE
Mobile crisis response, using modified Poison Control Model, to include staying on the phone during the clinical assessment until 9-8-8 makes response determination (particularly focused on whether mobile crisis is recommended for dispatch). Depending on the situation and availability, a dispatch of regional mobile crisis or the community care team will be used.
9-1-1 monitors/flags so that information gathered initially is provided to any calls for back up law enforcement involvement later in the situation.
LEVEL 3 RESPONSE
Level 3 situations are responded to with a few different options depending on the situation. These include dispatching the community care team and/or whatever members of that team are closest to the scene. Specialized mobile crisis responses such as children's mobile crisis or REACH for individuals with ID/DD are utilized as appropriate for Level 3 situations.
The goal is to connect the individual to the correct level of care on crisis continuum and divert from arrest whenever possible. The team then does brief follow ups after encounters for preventive support.
LEVEL 4 RESPONSE
911 PSAPs dispatch law enforcement, EMS, and/or fire without delay
All first responders trained in local Marcus Alert specialized response protocols. Community care teams and mobile crisis considered "second responders." Shift coverage with CIT officers as well as officers who have received Advanced MA training, and these officers and EMS who have received advanced MA training are dispatched preferentially. Community care or Mobile crisis team may be dispatched simultaneously, if so, kept continually informed in transit and do not arrive or approach scene until considered safe and appropriate to do so by LE and EMS.


Co-Response Team
INVOLVE BEHAVIORAL HEALTH AS SOON AS POSSIBLE
BEHAVIORAL HEALTH REMOTE ENGAGEMENT DURING TRANSIT IF POSSIBLE
ASSESS NEED FOR MEDICAL RESPONSE
LEVEL 1 RESPONSE
911 PSAPs refer to 988 regional call centers
All PSAPs have procedure and specification to transfer calls to regional call center in our area, and document the transfer as the call disposition.
LEVEL 2 RESPONSE
Mobile crisis response, using modified Poison Control Model, to include staying on the phone during the clinical assessment until 9-8-8 makes response determination (particularly focused on whether mobile crisis is recommended for dispatch). Nearest STEP-VA/BRAVO team is dispatched.
9-1-1 monitors/flags so that information gathered initially is provided to any calls for back up law enforcement involvement later in the situation.
LEVEL 3 RESPONSE
Level 3 situations are responded to with a few different options depending on the situation. The co-responder team is dispatched to situations where there is a safety concern, and has a few different protocols they can follow depending on the situation (law enforcement securing scene first; law enforcement on scene as back up with clinician making first approach). Specialized mobile crisis responses such as children's mobile crisis or REACH for individuals with ID/DD are utilized as appropriate for Level 3 situations.
LEVEL 4 RESPONSE
911 PSAPs dispatch law enforcement, EMS, and/or fire without delay
All first responders trained in local Marcus Alert specialized response protocols. If the co-responder team is available, they are dispatched urgently. Law enforcement (or EMS) approaches first to assess the scene and secure safety (e.g., locate and secure weapons); behavioral health is involved later in the process once it is considered safe and appropriate to do so by LE and EMS.

Four Level Triage Framework – Community Coverage Response Options

Use this blank template to help plan community coverage.



Marcus Alert Response Options 

This section will define the responses available at each of the Marcus Alert levels.

A. Community Coverage

In detail describe the Marcus Alert response options (including Mobile Crisis, Co-Response, Youth Mobile Crisis, REACH, CIT officers, etc.) and any other response teams in your area, for each level of urgency. *24/7 community coverage is phased in and not required at the time the local plan is due, but instead is required by the phased in date which varies based on locality.

Level 1:

It is required that Level 1 calls are transferred from the 9-1-1 call center to the Regional Crisis Call Center (9-8-8 infrastructure).

Sample Answer: Level 1 calls are fully diverted to the Regional Crisis Call Center and no dispatch is made.

Level 2:

It is recommended for Level 2 calls that mobile crisis or other non-law enforcement community care/response teams are dispatched. Coverage for this level can be met by STEP-VA Mobile Crisis. Are there private providers in your community that offer mobile crisis services? If a behavioral health only team does not exist in your area, consider co-response teams between behavioral health and CIT trained fire, ems, or law enforcement. Co-response teams do not require licensed behavioral health personnel, consider staffing experienced Peer Recovery Specialists alongside first responders. It is important to adopt procedures that behavioral health takes the lead during level 2 calls and first responders should only engage with the individuals unless they are needed.

Sample Answer: Level 2 response options are Mobile Crisis Teams (available 10am- 10pm M-F), REACH teams (available 24/7), Youth Mobile Crisis (available 10am -8pm daily) – if no behavioral health only team is available for dispatch, CIT trained officers will be preferentially deployed to the scene with technology in hand for telehealth with a behavioral health clinician.

Level 3:

It is also required that you consider a "behavioral health - only" option for Level 3 calls. One of the criteria for this level is "suicidal thoughts with a plan and access to lethal weapons". Consider the person has a plan for suicide and it involves a handgun that does exist in the house, but the call center agent has determined that the gun is still in a locked safe and the individual has not removed it. In this situation, there is access to a lethal weapon, but the individual needs behavioral health intervention rather than law enforcement. It may be wise for a behavioral health team to be deployed and CIT

trained law enforcement stages. Also, it is required to consider using specialized teams such as REACH for developmental disabilities or Youth Mobile Crisis when dealing with these populations.

Sample Answer: Level 3 response options are Mobile Crisis Teams (available 10am- 10pm M-F), REACH teams (available 24/7), Youth Mobile Crisis (available 10am -8pm daily) – if no behavioral health only team is available for dispatch, CIT trained officers will be preferentially deployed to the scene with technology in hand for telehealth with a behavioral health clinician.

Level 4:

It is required that Level 4 calls involve either law enforcement or EMS. The best practice recommendation is for these first responders to be CIT trained and also take the advanced level Marcus Training once it is available. Remember Marcus Alert Level 4 calls are still behavioral health calls, but there is a need for an immediate emergency response. First responders should be dispatched and approach the scene first, consider simultaneously dispatching and staging behavioral health until scene safety is determined.

Sample Answer: Level 4 response is EMS, Fire, or Police are dispatched per standard PSAP protocols, also if determined appropriate adult, youth, or REACH mobile crisis teams will be alerted to dispatch and be asked to stage the scene.

Protocol 1: 9-1-1 Diversion 

This section will clarify the technical, workflow, and operations of how calls will be triaged, coordinated, and or transferred from 9-1-1 call centers to the Regional Crisis Call Center (Frontier or PRS CrisisLink).

A. Urgency Determination

In detail describe what methods tele-communicators (criteria, questions, key words, chief complaints, etc.) will use to classify the call as a Marcus Alert type call (If all Psychiatric/Behavioral Problem calls are classified as Marcus Alert, please include this information).

Marcus Alert type call:

The Washington County PSAP kindly has provided their Marcus Alert EMD Guide Cards that were created by APCO as an example of how their tele-communicators are determining urgency. Other agencies such as Prince William County kindly shared internal training they have created in collaboration with their CSB to educate 9-1-1 personnel on how to classify calls to the 4 Marcus Alert levels.

B. Technical Changes to integrate data collection into the CAD

Please be as descriptive as possible. If a direct cost was associated with these changes please include this information here AND in the final budget.

There is no sample text for this section.

C. Tools

In detail describe the training that has been provided to tele-communicators on the handling of calls. Attach training materials and new policies and procedures that are developed for Marcus Alert implementation. Attach a guide card or other script that has been created.

There is no sample text for this section.

D. Workflow processes on transferring/receiving calls to Regional Crisis Call Center

Provide a detailed workflow process for each level (text or flow chart images can be used). The workflow should begin with a call's first point of contact, through dispatch, and end with the resolution.

Level 1:

It is required that Level 1 calls are transferred from the 9-1-1 call center to the Regional Crisis Call Center (9-8-8 infrastructure) and recommended to be via a PSAP specific priority line (created by the Regional Crisis Call Center). The best practice recommendation is when calls are transferred, the 9-1-1 call center agent will provide all relevant details that have been obtained over the phone such as the person's name and address/location, the determined Marcus Alert Level, and other pertinent information. The Crisis Call Center agent will dismiss the 9-1-1 call center agent once all information is received, this should take less than one minute (30-45 seconds).

Level 2:
It is recommended that Level 2 calls would be provided a behavioral health mobile crisis response, which is dispatched by the Regional Crisis Call Center. The best practice recommendation is when calls are transferred, the 9-1-1 call center agent will provide all relevant details that have been obtained over the phone such as the person's name and address/location, the determined Marcus Alert Level, and other pertinent information. The Crisis Call Center agent will dismiss the 9-1-1 call center agent once all information is received, this should take less than one minute (30-45 seconds). In addition, the PSAP should create workflows in union with the Regional Crisis Call Center/Mobile Crisis Dispatch Hub on how they will notify 9-1-1 dispatch that a mobile crisis unit is being dispatched and provided updates.

Level 3:
It is recommended that Level 3 calls are coordinated with the Regional Crisis Call Center, though first responders may be dispatched to the scene if the locality requires co-dispatching behavioral health teams, coordination between the Regional Crisis Call Center and the 9-1-1 Call Center is needed.

Level 4:
First responders are the primary dispatch for Level 4 calls. If it is determined by the local planning group that behavioral health will be notified of all Level 4 dispatches, this should be coordinated with the Regional Crisis Call Center.

E. Agreements with Regional Crisis Call Center

Attach any formal agreements developed between the PSAP and the Regional Crisis Call Center that have been developed.

There is no sample text for this section.

F. Barrier Statement

Implementation of this protocol will have unique obstacles and barriers from other protocols. Please provide details of barriers that should be taken into consideration. This information will also be used to inform General Assembly reports and funding requests.

There is no sample text for this section.

Protocol 2: Mobile Crisis Back-Up 

Attach formal agreements between the Regional Mobile Crisis Hub and local law enforcement agencies (drafts are acceptable, once signed please send for review).

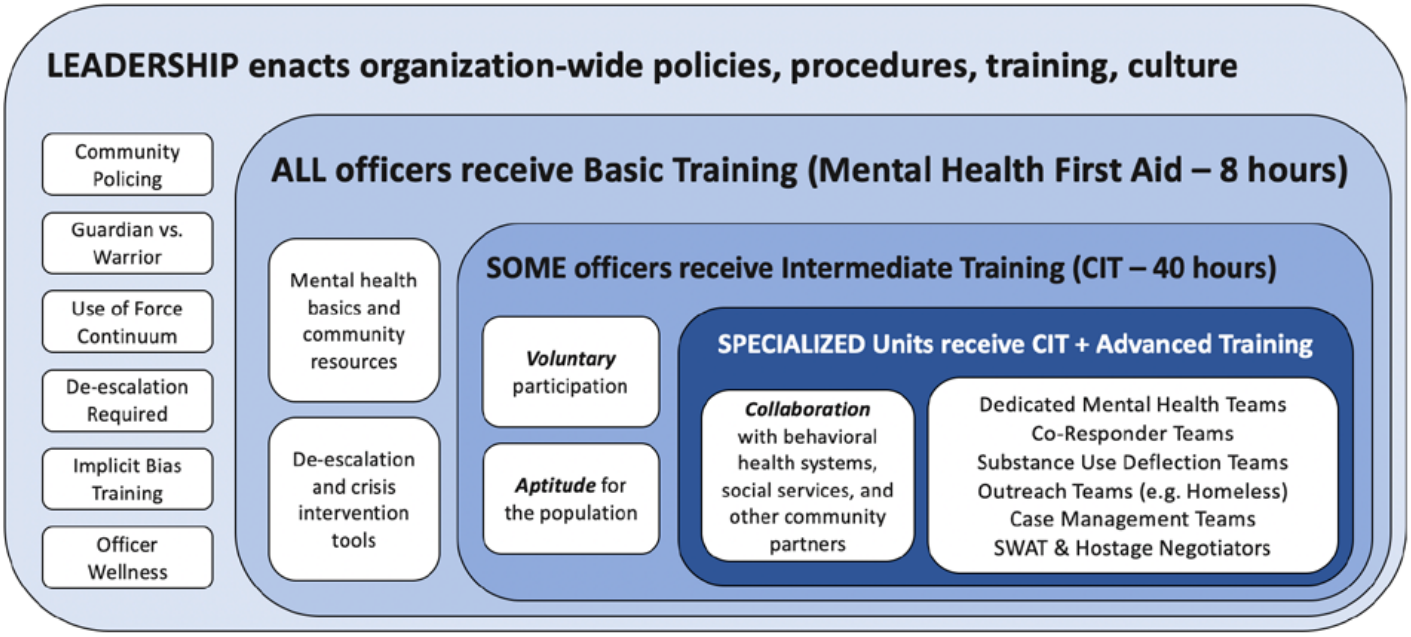
For the actual submission of this section, you will submit policies and procedures. For planning purposes, the partners in Highlands Community Services' service area have kindly provided a sample Memorandum of Understanding (MOU). This MOU includes a "Mutual Aid and Jurisdictional Authorization" section that allows law enforcement agencies to share resources across jurisdictional lines. The City of Virginia Beach and their partners have also shared their Memorandum of Understanding. Highlands is an example of a more rural community bringing a large number of law enforcement agencies together covering a large geographical area and Virginia Beach is a more population dense, Urban/Suburban locality.

Protocol 3: Specialized Law Enforcement Response

This section seeks to learn what changes in policy and procedure are being instituted to ensure those being sent to behavioral health calls are being best served by the best law enforcement has to offer.

For the actual submission of this section, you will submit policies and procedures. For planning purposes, it is helpful to view the below graphic which comes from the paper "Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies". This paper highlights national best practice law enforcement approaches to behavioral health emergencies.

Figure: Organizational approach to serving community members with BH needs.



Another digital resource for developing law enforcement specialized responses is the Police-Mental Health Collaboration (PMHC) Toolkit.

Blank Template Pages for Submission

This section contains the template pages for the eight (8) sections that are required for local plan submissions.

- Local Agency Inventory
- Stakeholder Member List
- Marcus Alert Responses
- Protocol 1
- Protocol 2 (not required for those choosing to be exempt)
- Protocol 3 (not required for those choosing to be exempt)
- Budget
- Contact Information

Local Agency Inventory

Please List All Law Enforcement agencies and 9-1-1 Call Centers within the CSB Catchment Area.

	Choose one the below options for each agency		
Law Enforcement Agency Name	**Protocols are included in this local plan**	**Choosing to not participate (as authorized by law for localities with a population of <40,000)**	**Will participate but need additional assistance with planning, protocols are not included in this plan**
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

	Choose one the below options for each agency	
9-1-1 Agency Name	**Protocols are included in this local plan**	**Will participate but need additional assistance with planning, protocols are not included in this plan**
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Stakeholder Members

Name	Role (choose one)		Area of Expertise (choose one)							
	Professional	Community Member	MH	DD/ID	Public Safety	CIT	Social Justice	Gov't	SUD	Other
1.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If more than 25 members of the stakeholder group, attach an additional page to your local plan submission.

Marcus Alert Response Options 

This section will define the responses available at each of the Marcus Alert levels.

A. Community Coverage

In detail describe the Marcus Alert response options (including Mobile Crisis, Co-Response, Youth Mobile Crisis, REACH, CIT officers, etc.) and any other response teams in your area, for each level of urgency. *24/7 community coverage is phased in and not required at the time the local plan is due, but instead is required by the phased in date which varies based on locality.

Level 1:

Level 2:

Level 3:

Level 4:

Protocol 1: 9-1-1 Diversion 

This section will clarify the technical, workflow, and operations of how calls will be triaged, coordinated, and or transferred from 9-1-1 call centers to the Regional Crisis Call Center (Frontier or PRS CrisisLink).

A. Urgency Determination

In detail describe what methods tele-communicators (criteria, questions, key words, chief complaints, etc.) will use to classify the call as a Marcus Alert type call (If all Psychiatric/Behavioral Problem calls are classified as Marcus Alert, please include this information).

Marcus Alert type call:

Level 1:

Level 2:

Level 3:

Level 4:

B. Technical Changes to integrate data collection into the CAD

Please be as descriptive as possible. If a direct cost was associated with these changes please include this information here AND in the final budget.

C. Tools

In detail describe the training that has been provided to tele-communicators on the handling of calls. Attach training materials and new policies and procedures that are developed for Marcus Alert implementation. Attach a guide card or other script that has been created.

D. Workflow processes on transferring/receiving calls to Regional Crisis Call Center

Provide a detailed workflow process for each level (text or flow chart images can be used). The workflow should begin with a call's first point of contact, through dispatch, and end with the resolution.

Level 1:

Level 2:

Level 3:

Level 4:

E. Agreements with Regional Crisis Call Center

Attach any formal agreements developed between the PSAP and the Regional Crisis Call Center that have been developed.

F. Barrier Statement

Implementation of this protocol will have unique obstacles and barriers from other protocols. Please provide details of barriers that should be taken into consideration. This information will also be used to inform General Assembly reports and funding requests.

Protocol 2: Mobile Crisis Back-Up 

Attach formal agreements between the Regional Mobile Crisis Hub and local law enforcement agencies (drafts are acceptable, once signed please send for review). See the Marcus Alert Toolkit for a sample MOU and things that should be considered.

A. Barrier Statement

Implementation of this protocol will have unique obstacles and barriers from other protocols. Please provide details of barriers that should be taken into consideration. This information will also be used to inform General Assembly reports and funding requests.

Protocol 3: Specialized Law Enforcement Response 

This section seeks to learn what changes in policy and procedure are being instituted to ensure those being sent to behavioral health calls are being best served by the best law enforcement has to offer.

- Local LE Agencies submit copy of the agency's policy that outline Marcus Alert Response to calls identified as Marcus Alert Call Types.
- Local LE Agencies commit to have appropriate coverage (greater than 20% and preferential deployment of CIT Trained Officers.
- Local LE Agencies commit to sending officers that are members of a Co-Response / Community Response to Advanced Marcus Alert Training.
- Local LE Agencies should submit active community policing efforts that are occurring in their communities.
- Local LE Agencies should submit a copy of the agency's use of force policy that should include de-escalation techniques within the policy.
- Local LE Agencies should submit a copy of the agency's training policy that includes Implicit Bias Training as well as continued training on Implicit Bias.
- Local LE Agencies should submit the agency's Officer Wellness Policy. What mental health resources does your agency provide for your officers?
- Local LE Agencies should require officers to complete Mental Health First Aid or equivalent training.
- Local CIT Program should submit list of LE Agencies that are actively participating in the CIT Program.

Barrier Statement

Implementation of this protocol will have unique obstacles and barriers from other protocols. Please provide details of barriers that should be taken into consideration. This information will also be used to inform General Assembly reports and funding requests.

Budget 

The Budget is an important part of the Local Plan because this information provides a realistic picture of what funds are needed in the various regions and team compositions. This information will be used to instruct the State's annual report on Marcus Alert implementation due to the General Assembly. Be as detailed and upfront about incurred expenses as possible.

There is an option to either utilize the template provided below or to submit a locally developed budget. Regardless of the budget template used, be sure to attach the document here.

Barrier Statement

Please provide details of how the $600,000 provided by the General Assembly is used and what additional funding sources are used/needed to support the Marcus Alert. This information will also be used to inform General Assembly reports and funding requests.

Marcus Alert Locality Budget

Program Operating Costs

A. Personnel Expenses

Position Title - Employee Name	Annual Salary/ Wage	State General Funds	Locality Share	Total Amount
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
Category Totals		$ -	$ -	$ -

B. Supplies

Supply Type / Purpose	Qty x Unit Cost	State General Funds	Locality Share	Total Amount
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -

		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
Category Totals		$ -	$ -	$ -

C. Contractual

Purpose - Calculation	Vendor(s) / Supplier(s)	State General Funds	Locality Share	Total Amount
C. 1 Goods/Services Contract		$ -	$ -	$ -
C. 2 Consultants		$ -	$ -	$ -
C. 3 Trainers		$ -	$ -	$ -
C. 4 Evaluators		$ -	$ -	$ -
C. 6 Other Contractual		$ -	$ -	$ -
Category Totals		$ -	$ -	$ -

D. Other Operating Costs

Purpose - Calculation	Description	State General Funds	Locality Share	Total Amount
D. 1 Printing Services		$ -	$ -	$ -
D. 2 Other Operating Costs		$ -	$ -	$ -
D. 3 Other Operating Costs		$ -	$ -	$ -

D. 4 Other Operating Costs		$ -	$ -	$ -
D. 5 Other Operating Costs		$ -	$ -	$ -
D. 6 Other Operating Costs		$ -	$ -	$ -
Category Totals		$ -	$ -	$ -

Program Operating Costs - Subtotal

	State General Funds	Locality Share	Total Amount
Subtotal	$ -	$ -	$ -

Contact Information

Please provide contact information for an overall lead, one lead CSB contact, one lead PSAP contact, and one lead law enforcement contact. Potential questions and follow up on this plan, from DBHDS or DCJS, will be directed to the respective contacts listed here.

Primary Contact for Local Plan
Name:
Phone Number:
Email Address:
Agency and Role:

Primary Community Services Board Contact
Name:
Phone Number:
Email Address:
Agency and Role:

Primary PSAP Contact
Name:
Phone Number:
Email Address:
Agency and Role:

Primary Law Enforcement Contact
Name:
Phone Number:
Email Address:
Agency and Role:

Localities with Populations Less Than 40,000 per 2020 Census Data

Locality	*2020 Census*
Accomack County	33,413
Alleghany County	15,223
Amelia County	13,265
Amherst County	31,307
Appomattox County	16,119
Bath County	4,209
Bland County	6,270
Botetourt County	33,596
Bristol City	17,219
Brunswick County	15,849
Buchanan County	20,355
Buckingham County	16,824
Buena Vista City	6,641
Caroline County	30,887
Carroll County	29,155
Charles City County	6,773
Charlotte County	11,529
Clarke County	14,783
Colonial Heights City	18,170
Covington City	5,737
Craig County	4,892
Cumberland County	9,675
Dickenson County	14,124
Dinwiddie County	27,947
Emporia City	5,766
Essex County	10,599
Fairfax City	24,146
Falls Church City	14,658
Floyd County	15,476
Fluvanna County	27,249
Franklin City	8,180
Fredericksburg City	27,982
Galax City	6,720
Giles County	16,787
Gloucester County	38,711
Goochland County	24,727

Grayson County	15,333
Greene County	20,552
Greensville County	11,391
Halifax County	34,022
Highland County	2,232
Hopewell City	23,033
Isle of Wight County	38,606
King and Queen County	6,608
King George County	26,723
King William County	17,810
Lancaster County	10,919
Lee County	22,173
Lexington City	7,320
Louisa County	37,596
Lunenburg County	11,936
Madison County	13,837
Manassas Park City	17,219
Martinsville City	13,485
Mathews County	8,533
Mecklenburg County	30,319
Middlesex County	10,625
Nelson County	14,775
New Kent County	22,945
Northampton County	12,282
Northumberland County	11,839
Norton City	3,687
Nottoway County	15,642
Orange County	36,254
Page County	23,709
Patrick County	17,608
Petersburg City	33,458
Poquoson City	12,460
Powhatan County	30,333
Prince Edward County	21,849
Pulaski County	33,800
Radford City	16,070
Rappahannock County	7,348
Richmond County	8,923
Rockbridge County	22,650
Russell County	25,781
Salem City	25,346

Scott County	21,576
Smyth County	29,800
Southampton County	17,996
Staunton City	25,750
Surry County	6,561
Sussex County	10,829
Waynesboro City	22,196
Westmoreland County	18,477
Williamsburg City	15,425
Winchester City	28,120
Wise County	36,130
Wythe County	28,290

Localities with Populations More Than 40,000 per 2020 Census Data

Locality	*2020 Census*
Albemarle County	112,395
Alexandria City	159,467
Arlington County	238,643
Augusta County	77,487
Bedford County	79,462
Campbell County	55,696
Charlottesville City	46,553
Chesapeake City	249,422
Chesterfield County	364,548
Culpeper County	52,552
Danville City	42,590
Fairfax County	1,150,309
Fauquier County	72,972
Franklin County	54,477
Frederick County	91,419
Hampton City	137,148
Hanover County	109,979
Harrisonburg City	51,814
Henrico County	334,389
Henry County	50,948
James City County	78,254
Loudoun County	420,959

Lynchburg City	79,009
Manassas City	42,772
Montgomery County	99,721
Newport News City	186,247
Norfolk City	238,005
Pittsylvania County	60,501
Portsmouth City	97,915
Prince George County	43,010
Prince William County	482,204
Richmond City	226,610
Roanoke City	100,011
Roanoke County	96,929
Rockingham County	83,757
Shenandoah County	44,186
Spotsylvania County	140,032
Stafford County	156,927
Suffolk City	94,324
Tazewell County	40,429
Virginia Beach City	459,470
Warren County	40,727
Washington County	53,935
York County	70,045