Virginia Department of Behavioral Health & Developmental Services

Implementation of the Marcus-David Peters Act: Requirements for Local MARCUS Alert Systems

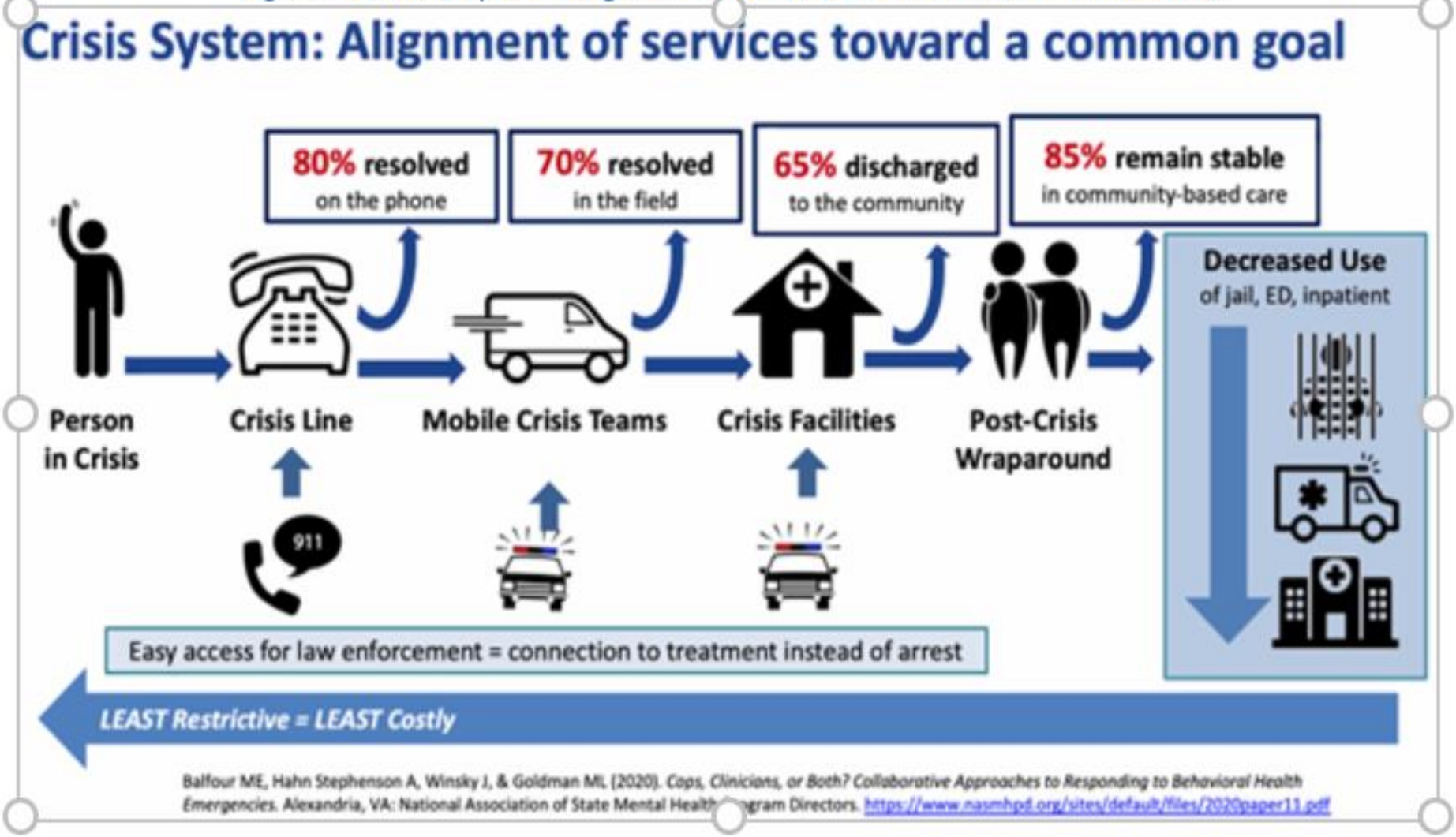
Virginia Association of Counties

DBHDS Vision: A life of possibilities for all Virginians

Overview of the Act

- Named for Marcus-David Peters, a young, Black Biology teacher who was shot and killed by Richmond Police in 2018 in the midst of a mental health crisis
- *Aims to ensure that the emergency response to a behavioral health crisis is a behavioral health response*

Figure 34. Crisis System Alignment toward Decreased Use of Institutions

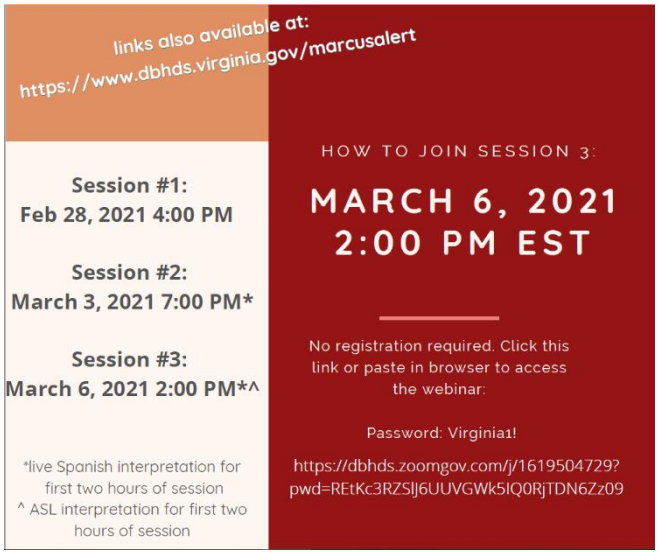


Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.* Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

State Stakeholder Group

- DBHDS, with DCJS and stakeholders, shall develop a plan developing a Marcus alert system by July 1, 2021
- Marcus Alert Stakeholder Group and listening sessions
- Plan focuses on the state framework (i.e., not each local implementation), with 10 components:

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



For more info: www.dbhds.virginia.gov/marcusalert

State Plan

- ✓ Available at www.dbhds.Virginia.gov/marcusalert/
  - ✓ 20 pg version recommended to get an overview
  - ✓ Longer version with full catalog recommended as a reference document for specifics and data
- ✓ State plan for implementation is broader than the local requirements:
  - ✓ State components
  - ✓ Local components

Coordination at Every Level

Federal: 988 Integration required by July 2022

State: coordinated technological infrastructure to ensure that an "Air Traffic Control" function and "safety net to the safety net" is possible whether call center is state or regional

Regional: STEP-VA funded with sustainability (Medicaid) mobile crisis teams with specialized teams for youth, developmental disability and other special populations. Regional hubs hold contracts with all mobile crisis teams within the region and serve as the single point of coordination with dispatch

Local: Marcus alert protocols and coordination with law enforcement, law enforcement reforms, magistrates, emergency services, and other first responders

Crisis Now Model

FOUR CORE ELEMENTS FOR TRANSFORMING CRISIS SERVICES

HIGH-TECH CRISIS CALL CENTERS

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

24/7 MOBILE CRISIS

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

CRISIS STABILIZATION PROGRAMS

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

ESSENTIAL PRINCIPLES & PRACTICES

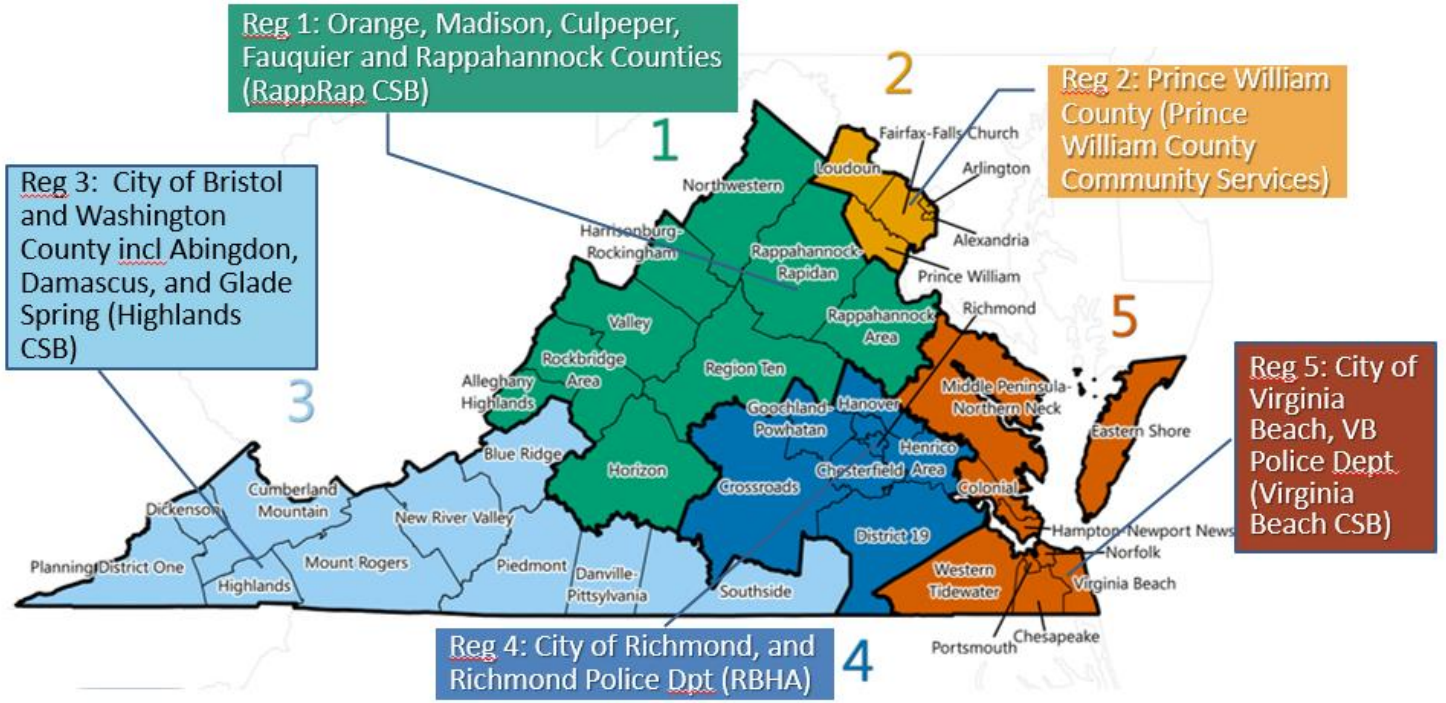
These must include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

Someone to call

Someone to come to you

A place to go

First Five Marcus Alert Programs



5 State/Regional Components

- 4 level framework for **urgency**
  - Standard definitions at the state level, cross walks are used to integrate it and further specify at local level
- STEP-VA/BRAVO mobile crisis teams
  - 1 hour response time
- Equity at Intercept 0 Initiative
  - Includes network leads and coalition development
- Statewide training standards
- Public service campaign focused on calling 988

Training State Plan

Training Component	Agency	Approach
Basic LE training	DCJS	Will be integrated into new curriculums
In service LE training	DCJS	Will be integrated into new curriculums
Basic BH training	DBHDS	Will be required of all teams dispatched from regional hubs/billing for the service
Basic 911 training	DCJS, VDEM, VDH…	Content will be developed as an add-on to the 988 training curriculum; dissemination plan TBD
Advanced Marcus Alert Training	DBHDS & DCJS	Cross sector approach that builds on basic trainings and CIT (but CIT not a pre-requisite)

8 Local Area Components

- Voluntary database
- Required planning process with local stakeholder group
- Local technical specs/definitions crosswalked to state triage
- Protocol #1 (routing calls to 988)
- Protocol #2 (establishing relationship between local LE and mobile crisis hub)
- Protocol #3 (specialized response protocols)
- Community coverage options and plans
- Process for submitting plans

Voluntary Database

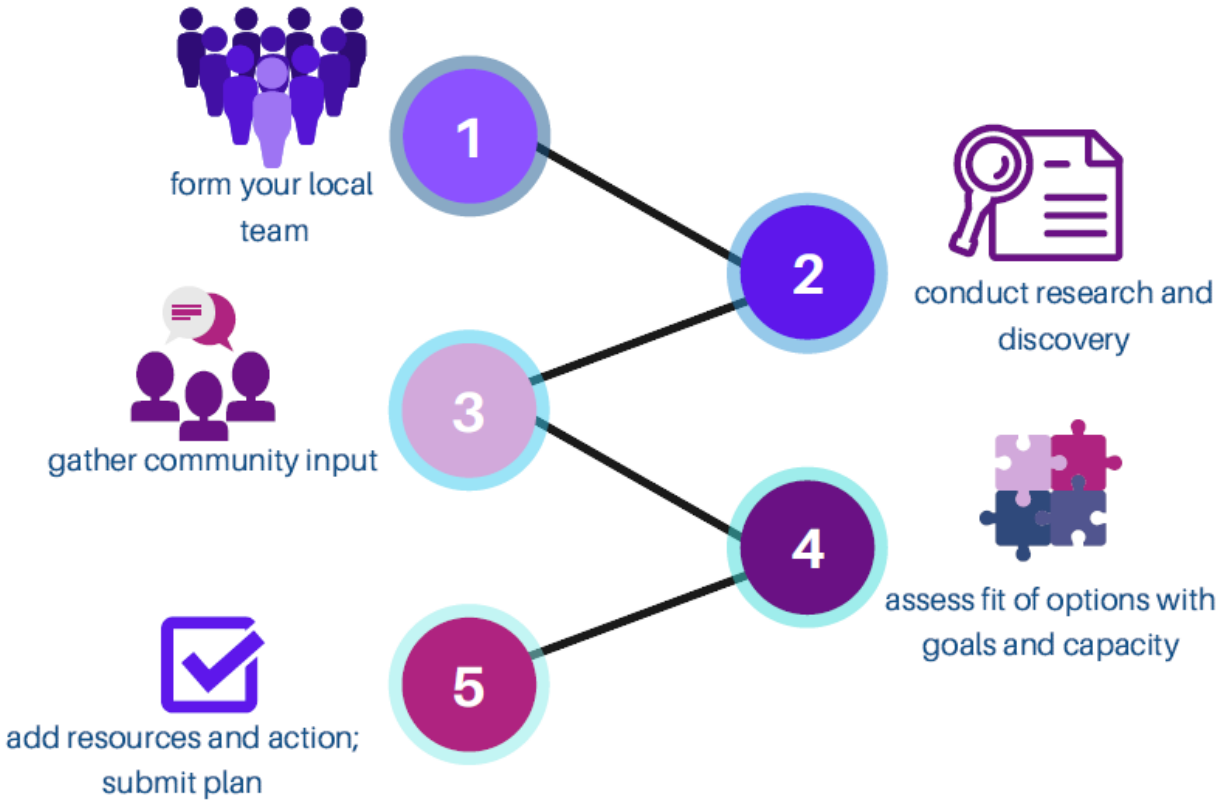
F. By July 1, 2021, every locality shall establish a voluntary database to be made available to the 9-1-1 alert system and the Marcus alert system to provide relevant mental health information and emergency contact information for appropriate response to an emergency or crisis. Identifying and health 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.

Voluntary Database Solutions

- ✓ *Off-the-shelf solutions*
- ✓ *Building on an existing 911 database*
- ✓ *Build a new database (high tech or low tech)*

Local Planning Process

The roadmap has five components, which are pictured and described below:



Authorities and Responsibilities for Planning

- Local government official: responsibility to stay informed, support needs across entities/departments, be aware of timeline, be aware (or select) local planning lead and/or lead at each agency, stay updated and connect with regional mobile crisis hub, track compliance and process dates.
- First steps:
  - Has your area developed a voluntary database?
  - Have you determined the geographic area for your stakeholder group?
  - Who is convening the stakeholder group?
    - CSB or existing coalition is recommended but not required
  - Does the stakeholder group have proper representation?

Planning Outputs

Output/Product of Planning	Local Entity Most Impacted
Local protocol #1 (transfer calls to 988 from 911)	911 center
Local protocol #2 (coordinate to serve as back up)	Law enforcement
Local protocol #3 (law enforcement policies/procedures)	Law enforcement
Plan for community coverage at each triage level	All (stakeholder group lead process)

Planning Take Aways

- Start stakeholder group soon, identify convening agency and consider resources
- Coordinate within DBHDS region for protocols #1 & 2
- Use local planning roadmap document
  - Don’t skip the research phase
- Ensure representation on stakeholder group
- Ensure community input on all protocols throughout process
- Identify a lead, and delegate responsibility for submitting the plan to a specific person
- Submit plan with 4-6 weeks for review; compliance required July 1, 2022

Community Coverage

- As STEP-VA/BRAVO mobile crisis teams will provide statewide coverage, each locality is not required to form distinct, Marcus Alert teams
- Yet, local teams are expected to be formed in some localities, to complete community coverage across all four levels of the urgency framework
- The Plan outlines coverage approaches included telehealth/remote options, additional STEP-VA/BRAVO teams, and three community care team options, with and without law enforcement, including coresponder teams

Community Coverage = Your Plan for Levels 1,2,3,and 4

INVOLVE BEHAVIORAL HEALTH AS SOON AS POSSIBLE

BEHAVIORAL HEALTH REMOTE ENGAGEMENT DURING TRANSIT IF POSSIBLE

ASSESS NEED FOR MEDICAL RESPONSE

EXAMPLE LOCAL COVERAGE (remote coverage with no new teams)

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

Poison Control Model, to include staying on the phone during the clinical assessment until 9-8-8 makes response determination
9-1-1 staff can leave phone call when it is determined that the initial behavioral health intervention will be remote (e.g., phone, telehealth), because this may be 30 minutes plus
If 9-8-8 is dispatching mobile crisis, share information for any potential need for LE back up; can then leave phone call

LEVEL 3 RESPONSE

Telehealth-based relationship between CIT officers, CIT trained EMS, and mobile crisis hub or another crisis provider. LE makes remote contact and is dispatched to scene, without any sirens or lights. Depending on telehealth capabilities, mobile crisis (STEP-VA) could also be requested simultaneously. LE assesses the scene, remains engaged with the telehealth provider while engaging the individual, and the team collaborates on next steps.

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. 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. Local specialized response protocol (#3) includes linking to all components of response for Level 3 when scene is safe for intervention.

INVOLVE BEHAVIORAL HEALTH AS SOON AS POSSIBLE

BEHAVIORAL HEALTH REMOTE ENGAGEMENT DURING TRANSIT IF POSSIBLE

ASSESS NEED FOR MEDICAL RESPONSE

EXAMPLE LOCAL COVERAGE (additional local mobile crisis teams)

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). 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.

LEVEL 3 RESPONSE

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.

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. 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.

EXAMPLE LOCAL COVERAGE
(community care- no law enforcement "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

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). 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.

LEVEL 3 RESPONSE

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.

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.

EXAMPLE LOCAL COVERAGE
(preventive community care 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.

EXAMPLE LOCAL COVERAGE
(co-responder 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.

Funding the Marcus Alert

- The most expensive and far reaching part is the stand-up of the mobile crisis system, which is state funded
  - Regional mobile crisis teams current funding: $7.8 m STEP-VA in 2020 (majority to children's mobile crisis), additional $6.1 m beginning July, 2021 ($13.9 m total)
  - Call center staff funding: $4.7 m
  - Call center data and dispatch platform: $5 million, one time, $500,000 ongoing
  - New 5% set aside on mental health Block Grant
  - New Medicaid rates (December, 2021) for 4 services
  - Crisis Receiving Centers/place to go: $7 million in one time funds (building on current CITACs and CSUs)
  - $10m in ARPA state funds received, can be used for mobile crisis or crisis receiving centers
  - 9-8-8 cell phone fee (similar to 9-1-1 fee)

Funding the Marcus Alert

- DCJS training funding:
  - Byrne/JAG monies from the DOJ
  - ARPA money $1 million for CIT related trainings state wide

Funding the Marcus Alert

- Costs associated with other components of the system and standing up the local system
  - $600,000 per area is initial grant amount
    - Only first 5 areas currently funded
    - Expected to cover significant portion, but will not fund co-responder program in each area
  - State ARPA request for local planning grants was not funded
  - Consider requesting local ARPA
  - Consider applying for other grants

What's Next?

- Data and Evaluation Task Force forming
- Training RFPs in development
- Detail work with initial 5 areas
- Select Equity at Intercept 0 awardees
- Compliance rubric to be developed for localities
- One stop shop/website improvements
- Potential February Summit or Conference

Big Picture

- This requires a lot of coordination and cooperation
  - Build on existing work, don't recreate the wheel, but integrate into the new technologies (e.g., regional call center dispatch)
- Will not work if we don't work together at state, regional, and local level
- Will not be built overnight
- Significant workforce issues must be addressed
- Any larger changes such as related to custody would require legislative changes
- Includes a lot of hard work, as well as broader cultural shift
- *….and this is an incredibly important initiative and will be well worth the effort.*

Questions and Concerns

Questions, comments, or requests for local technical assistance send to: Marcusalert@dbhds.Virginia.gov