BHC Behavioral Health Commission

Implementation and effectiveness of the Marcus Alert system

2025

Commission draft

Commonwealth of Virginia
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Behavioral Health Commission

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Purpose

The Commission is established in the legislative branch of state government for the purpose of studying and making recommendations for the improvement of behavioral health services and the behavioral health service system in the Commonwealth to encourage the adoption of policies to increase the quality and availability of and ensure access to the full continuum of high-quality, effective, and efficient behavioral health services for all persons in the Commonwealth. In carrying out its purpose, the Commission shall provide ongoing oversight of behavioral health services and the behavioral health service system in the Commonwealth, including monitoring and evaluation of established programs, services, and delivery and payment structures and implementation of new services and initiatives in the Commonwealth and development of recommendations for improving such programs, services, structures, and implementation.

Contents

1 Overview of the Marcus Alert system

The Mental health Awareness Response and Community Understanding Services (Marcus) Alert system was developed in response to the death of biology teacher Marcus-David Peters, who was fatally shot by law enforcement while in crisis. Peters' family and members of the community worked with members of the General Assembly to craft legislation with the intent of diverting people in a mental health crisis from law enforcement involvement. Racial equity was also a priority in developing the legislation, as Marcus-David Peters was Black.

Members of the Behavioral Health Commission (BHC) directed staff to study the implementation and effectiveness of the Marcus Alert system during their December 2024 meeting. To complete this study, BHC staff conducted interviews with state agency personnel responsible for coordinating Marcus Alert; visited Community Services Boards (CSBs) across Virginia and interviewed CSB staff, law enforcement officers, and public safety telecommunicators; reviewed the research literature and reports on 988 and co-response; surveyed CSBs and people with lived experience; and analyzed administrative data from state agencies (Appendix A).

Marcus-David Peters Act provides a framework for responding to behavioral health crises

The Marcus-David Peters Act was passed during the 2020 Special Session with the goals of improving responses to behavioral health crises and diverting individuals in crisis from law enforcement when possible. The legislation created two new sections in the *Code of Virginia*, §9.1-193 and §37.2-311.1, which collectively defined two new systems and their requirements: (1) the Marcus Alert system, and (2) a comprehensive crisis system. The two systems were intended to work in tandem to serve individuals experiencing a behavioral health crisis. While the Marcus Alert system would address primarily how to respond to behavioral health calls placed to 911, the state's comprehensive crisis system would provide access to behavioral health services for individuals calling 988, the state's mental health crisis line. State agencies and stakeholders stated that "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')."

The Marcus Alert system is defined in statute as a set of protocols to

(i) "initiate a behavioral health response to a behavioral health crisis, including for individuals experiencing a behavioral health crisis secondary to mental illness, substance abuse, developmental disabilities, or any combination thereof;

(ii) divert such individuals to the behavioral health or developmental services system whenever feasible; and

(iii) facilitate a specialized response in accordance with § 9.1-193 when diversion is not feasible".

The statutes establish requirements for state agencies and localities to develop a crisis response system and Marcus Alert protocols. Notably, the Department of Behavioral Health and Developmental Services (DBHDS) is directed to collaborate with the Department of Criminal Justice Services (DCJS) and stakeholders to develop a written plan for Marcus Alert, which must set forth specific responsibilities and requirements for state and local government entities.

§ 9.1-193 also lays out seventeen goals of law enforcement participation in comprehensive crisis services and the Marcus Alert system, and requires every locality to establish a database to be made available to 911 where individuals can voluntarily submit their relevant mental health and contact information.

Statute calls for a state plan to develop the core elements of Marcus Alert and divide responsibilities

The *Code of Virginia* directs DBHDS to work with DCJS and numerous stakeholders to develop a written plan detailing how the Marcus Alert system would be structured and implemented at both the state and local levels. The plan was required to:

(1) identify the current status of crisis incidents and services;

(2) create three protocols to guide interactions between entities at the local level;

(3) assign specific responsibilities, duties, and authorities among responsible state and local entities; and

(4) assess the effectiveness of a locality's or area's plan for community involvement.

The "State Plan for the Implementation of the Marcus-David Peters Act" was finalized in 2021 and is often referred to as "the state plan." The state plan develops the details of the Marcus Alert system and is the work of DBHDS, DCJS, other state agency partners, and a 45-member stakeholder group representing "local government, nonprofit, 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."

State entities are responsible for developing statewide guidance and training, and leading the creation of a crisis system

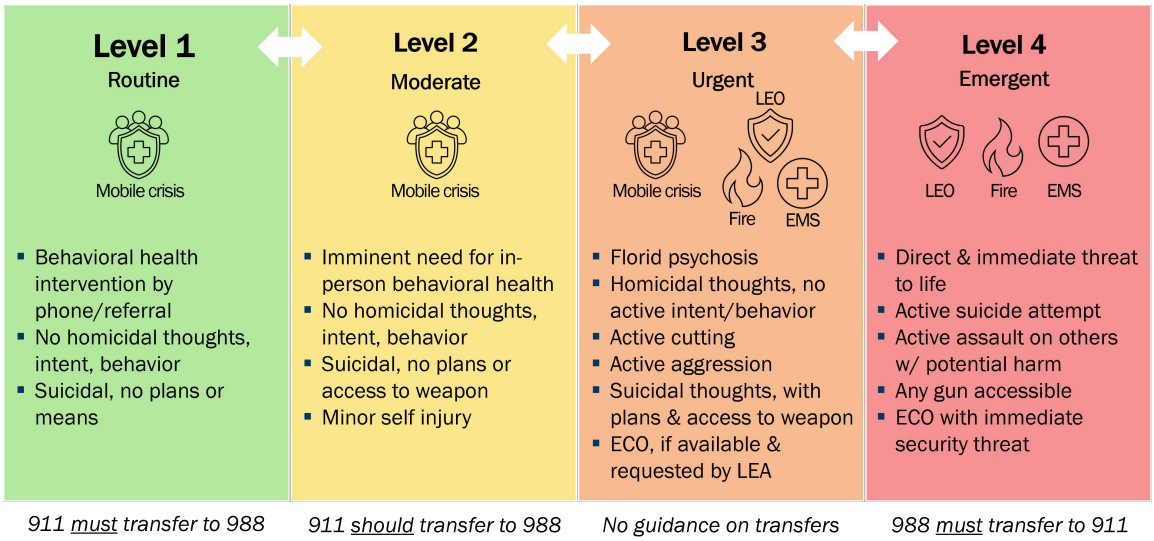
The state-level components of the Marcus Alert system include developing a four-level triage framework, achieving regional coverage using regional mobile crisis teams, leading the Equity at Intercept Zero initiative, establishing statewide training standards, and spearheading several aspects of building a crisis system. The state also has additional responsibilities for data collection and evaluation that are described in greater detail in Chapter 3.

Triage framework provides a shared language for Marcus Alert

The triage framework offers guidelines for classifying the urgency of the behavioral health crisis experienced by an individual who calls either 911 or 988 (Exhibit 1-1). The framework also offers a common language that can be used across sectors (behavioral health, emergency dispatch, law enforcement). The triage framework provides the basis for the acceptable response options at each level and whether it should involve emergency personnel. The response options available in a particular locality are selected by that community within boundaries set by the state plan.

- Level 1 calls feature distressed callers with no homicidal thoughts or plans for suicide who are suitable for intervention over the phone. The state plan requires 911 to transfer Level 1 calls to 988.
- Level 2 calls include situations where clinical intervention might be necessary, such as someone engaging in minor self-injurious behavior or dependence on substances.
- Level 3 calls involve an increased level of risk, such as active aggression, homicidal thoughts, or psychosis, but without direct and immediate threat to life.
- Level 4 calls are emergency situations that require immediate dispatch of first responders, such as a suicide attempt in progress.

Exhibit 1-1
Marcus Alert triage framework categorizes behavioral health calls by level of urgency, guiding response options



Source: BHC staff adaptation of triage framework in the State Plan for the Implementation of the Marcus-David Peters Act

Other state responsibilities include training, statewide crisis services, and equity

The state plan establishes new training competencies that are integrated into statewide requirements for professionals most involved in Marcus Alert, including mobile crisis providers, 988 crisis workers, and law enforcement. The plan also lays out topics for the cross-profession Advanced Marcus Alert training and identifies the need for behavioral health training for public safety telecommunicators, including the levels of urgency in the triage framework, intervention options, and education on 988.

DBHDS was also assigned responsibility for establishing statewide behavioral health services to which individuals in crisis could be diverted, including a 988 call center, regional mobile crisis teams that could be dispatched to provide in-person services, and crisis facilities for assessment and stabilization. In the state plan, regional mobile crisis teams were expected to play a key role in responding to crisis calls to 911 and 988 because planned investments in these mobile teams would eventually enable them to provide statewide coverage.

Racial equity in crisis response was a priority for the state plan stakeholder group and was addressed through the "Equity at Intercept Zero initiative." The initiative described in the state plan has two components: (1) a network of "Black-led, BIPOC led, and/or peer led" providers, non-profits, and academic partners; and (2) a statewide, Black-led Crisis Coalition responsible for reviewing Marcus Alert outcomes twice yearly and for providing written feedback to be included in the DBHDS annual report. The network of providers and partners includes five to seven "leads" who received $175,000 to assist with training, network capacity, and relationships important to Marcus Alert's goals, as well as evaluation planning and analytical support. DBHDS funded the first eighteen months of the initiative with a federal Mental Health Block Grant, but no state General Funds have been appropriated for this project.

State entities approve local plans

DBHDS and DCJS are responsible for approving local plans, which CSBs submit once they have collected the required components from the localities in their coverage area. Both state agencies review, provide feedback on, and approve the plans. DBHDS and DCJS each have one FTE for a Marcus Alert coordinator—this position assists localities with implementation and reviews and approves plans. DBHDS and DCJS also have subject matter experts whose roles are partially dedicated to Marcus Alert, including a crisis data analyst at DBHDS and an expert on Public Safety Answering Points (PSAPs) at DCJS. DCJS has authority over law enforcement certification and training as well as PSAP training, while DBHDS works with CSBs and regional hubs in line with their performance contracts.

Local entities are responsible for implementing and customizing Marcus Alert

The state plan assigns local agencies and CSBs responsibility for implementing the Marcus Alert system and for tailoring the state framework to the specific needs and resources of their communities. Local agencies and CSBs carry most of the responsibility for planning and implementing the Marcus Alert elements most visible to the public, including 911-988 interoperability and the creation of community care teams. To support this work, there are

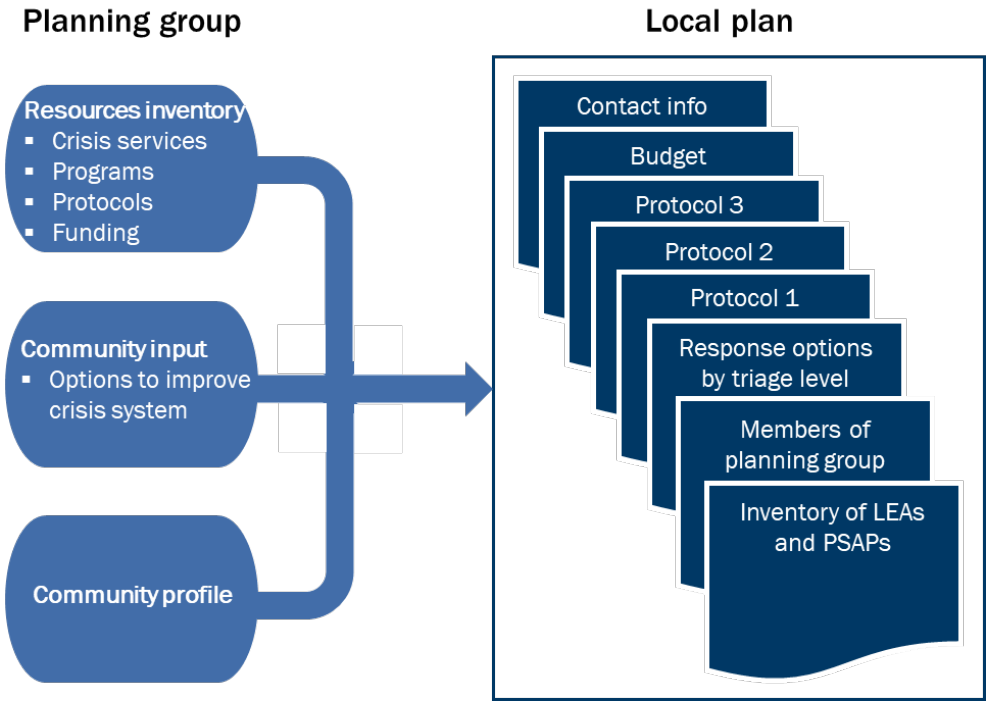
five regional coordinators, one for each of the five DBHDS regions, who are funded out of the Marcus Alert budgets of CSBs that have implemented Marcus Alert in that region. Regional coordinators do much of the liaison work between local agencies and DBHDS, and they work with CSBs to develop their local plans and submit them to DBHDS on their behalf. Region 2 (Northern Virginia) has a second regional coordinator, paid for with local funds.

CSBs and localities plan for Marcus Alert with a group of local stakeholders

CSBs and localities must develop a "local plan" that describes how they will implement three protocols, a database, and optionally, one or more community care teams. The details of each local system are described in the local plan, which is a set of documents from each locality in a CSB coverage area, as well as CSB-level components such as a budget and a list of local agencies and stakeholders. CSBs and localities complete their local plans utilizing the guidelines in a DBHDS document called the "Marcus Alert Local Plan Guide."

Local plans are developed by a planning group that includes CSB staff, law enforcement, and staff from 911 call centers, also known as PSAPs. The group can also include private mental health providers, social and racial justice organizations, fire and rescue, social services, individuals with lived experience, local government, and other community representatives. The planning group is responsible for convening stakeholders and aggregating information, which is then used to create a local plan that is submitted to DBHDS and DCJS for review (Exhibit 1-2).

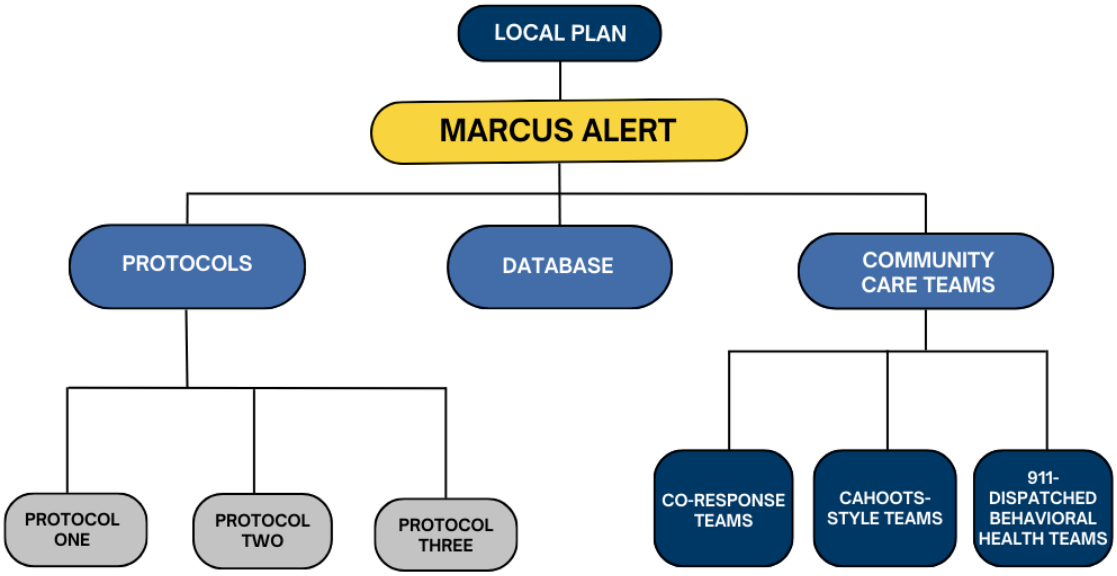
Exhibit 1-2
Planning groups aggregate information to create local plans



Source: BHC staff analysis of the State Plan for the Implementation of the Marcus-David Peters Act and the Marcus Alert Local Plan Guide

The Marcus Alert system includes the three protocols, the database, and one or more community care teams, if necessary (Exhibit 1-3). A completed local plan contains documentation on how each PSAP in the CSB's coverage area will implement, including Protocol 1 and whether and how community care teams will be utilized. For localities participating in Protocol 2 and Protocol 3, documentation will also be included for the fulfillment of those protocols. As a result of legislation passed during the 2022 General Assembly session, law enforcement in localities with a population less than or equal to 40,000 as of the 2020 Census are not required to participate in Protocol 2 or Protocol 3. As of August 2025, localities were not required to submit their plans for a database; however, they were still required to establish a database by July 1, 2023 per statute.

Exhibit 1-3
Local Marcus Alert systems have multiple components



Source: BHC staff analysis of the State Plan for the Implementation of the Marcus-David Peters Act and the Marcus Alert Local Plan Guide

Protocol 1 creates most of the infrastructure for Marcus Alert

Protocol 1 requires local planning teams to adapt the state triage framework to fit their community's needs and to develop response options for each level of urgency. Some state requirements exist for whether and where calls should be transferred between 911 and 988, and for what can be included as response options (Table 1-1).

Protocol 1 also requires that PSAPs develop processes for transferring calls from 911 PSAPs to 988 call centers. This may require changes to the software and systems PSAPs utilize to triage and dispatch calls. There are also data collection requirements for PSAPs that may require further changes to their computer automated dispatch (CAD) systems in order to efficiently collect and report data, as discussed further in Chapter 3.

Table 1-1
Transfers and response options to 911 calls vary by level of urgency in state plan

Level of urgency	Call transfers	Recommended in-person response options
Level 1	Required transfer to 988	None
Level 2	Recommended coordination with 988	Behavioral health-only teams ▪ Regional mobile crisis teams ▪ Community care teams without law enforcement
Level 3	No guidance in state plan	▪ Regional mobile crisis teams, law enforcement backup ▪ Community care teams ▪ Co-response teams – CAHOOTS-style teams – CSB behavioral health-only teams ▪ CIT-trained officers (public safety risk) with telehealth link
Level 4	No transfer	▪ Community care teams ▪ CIT-trained officers ▪ Law enforcement officers or emergency personnel

Source: BHC staff analysis of the State Plan for the Implementation of the Marcus-David Peters Act and the Marcus Alert Local Plan Guide

Protocols 2 and 3 aim to improve and specialize law enforcement responses

Protocols 2 and 3 directly engage law enforcement through relationships, education, training, and departmental policies in localities with greater than 40,000 residents and are optional for localities with populations of 40,000 or fewer. Protocol 2 requires a signed Memorandum of Understanding (MOU) between the regional crisis hub (which dispatches regional mobile crisis teams from 988) and any law enforcement agencies that may be providing back-up to mobile crisis teams, as well as the local PSAPs. The state plan anticipates that 988 will receive a higher volume of calls from every level of acuity over time, and some dispatches of mobile crisis will require law enforcement backup. The MOUs are intended to increase understanding between behavioral health and law enforcement regarding each other's job functions and professional ethics; clarify technical elements of back-up such as procedures for communicating between mobile crisis teams and law enforcement, and agreements on the kinds of training required of officers who are performing mobile crisis backup.

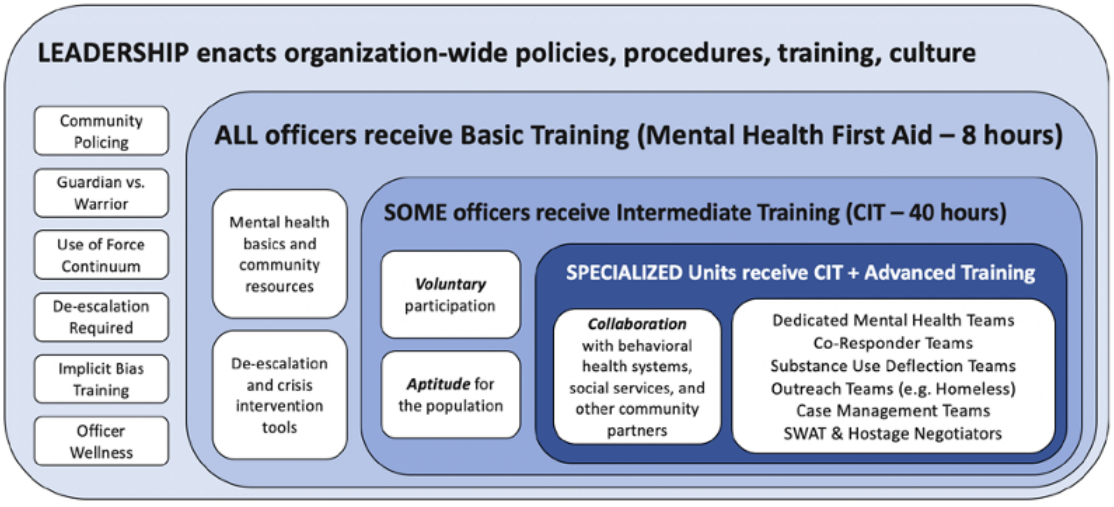
Protocol 3 pertains to mandatory training and departmental policies for law enforcement agencies. Local law enforcement agencies must commit to having at least 20 percent of their officers trained in CIT and to prioritize deploying them over other officers. Officers on co-response teams must attend Advanced Marcus Alert Training, which is developed by DBHDS and DCJS, and all officers are required to complete Mental Health First Aid or equivalent training.

This protocol also requires local law enforcement agencies to submit copies of certain agency policies, which are reviewed for compliance by DCJS:

- Use of force policy (that should include de-escalation techniques)
- Officer wellness policy
- Training policy, including implicit bias training
- Policies on Marcus Alert responses to calls identified as Marcus Alert calls
- Active community policing efforts that are occurring in their communities
- List of law enforcement agencies that are actively participating in the CIT Program (submitted by local CIT Program)

The state plan's approach to Protocol 3 adopts an organizational approach from a 2020 report by the National Association of State Mental Health Program Directors, which cites the Tucson Police Department's work towards a systemic, rather than single-policy, approach to serving community members with behavioral health needs (Exhibit 1-4).

Exhibit 1-4
Protocol 3 draws from the policies of the Tucson (AZ) Police Department



Source: State Plan for the Implementation of the Marcus-David Peters Act

Database is specified in statute

The database is one of the few elements of Marcus Alert that is explicitly laid out in Code without requiring further development in the state plan. § 9.1-193 requires that every locality

"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." Information may be submitted to the database by the individual with a mental health condition or by their parent or guardian if the individual is under the age of 18. The statute specifies the information on juveniles will be removed from the database when they turn 18, unless they or their guardian request otherwise. The state plan mentions that the stakeholder group was interested in a single, statewide database; however, this option would have been at odds with the statute, which places the responsibility on localities.

Community care teams supplement a locality's community coverage

Community care teams are locally based teams that include at least one behavioral health service provider and are designed to address gaps in the crisis continuum. DBHDS does not consider regional mobile crisis to be a community care team, but local CSB behavioral health-only teams may be community care teams. Community care teams are often—but not always—dispatched by PSAPs. Other members of community care teams can include law enforcement, certified peer recovery specialists, EMS providers, and other professions relevant to the needs of that community. Some of the most common types of community care teams are:

- Co-response teams: behavioral health provider + law enforcement
- CAHOOTS-style teams: behavioral health provider + EMS
- CSB behavioral health-only teams: behavioral health provider + behavioral health provider or CPRS

Co-response teams are the most common form of community care team in Virginia, but not every implementing CSB creates a co-response team; sometimes a different structure of community care team better fits the needs and the available resources in that community. Community care teams are not required as a part of Marcus Alert, but it is a frequent use for allocated Marcus Alert funding and a good coverage option for communities with little or no community coverage at Level 3 (see Chapter 3).

Implementation is phased-in, with all localities required to implement by 2028

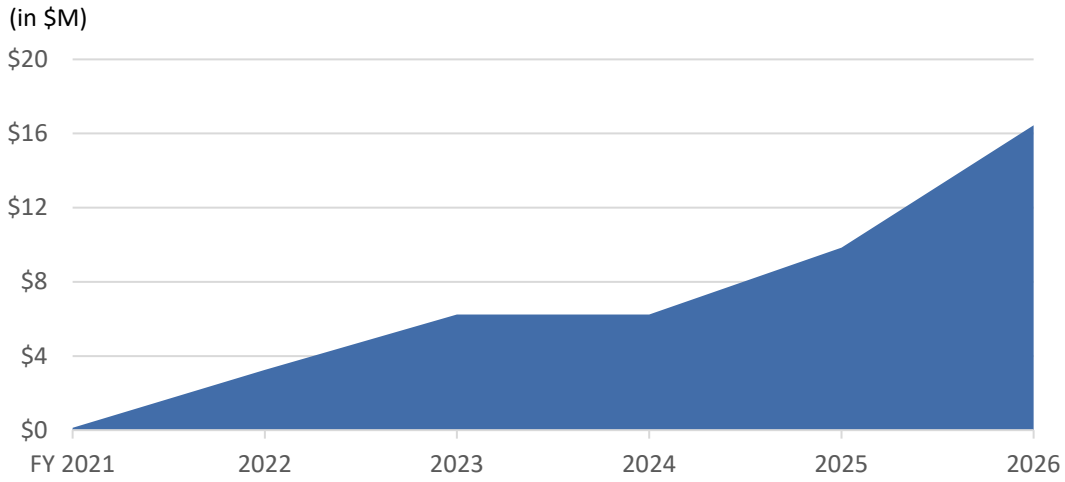
Marcus Alert implementation is phased over several years, but all localities are required to implement a Marcus Alert system by July 1, 2028. In December 2021, the first cohort of localities implemented, one in each of the five DBHDS regions. Another cohort followed in July 2023 and another in July 2024 (Appendix B). No new localities implemented in 2025 because no new funding was allocated in FY24; CSBs receive funding one year before their implementation date to allow for planning costs.

Currently, seventeen of the forty CSBs have implemented Marcus Alert in their coverage area. Another ten have received planning funds and will implement Marcus Alert on July 1, 2026. Thirteen CSBs have not yet received any planning funding.

General Assembly has allocated at least $42 million to Marcus Alert since FY 2021

The General Assembly has allocated at least $42 million to Marcus Alert since the system's inception in FY21 (Figure 1-1). The majority of this funding flows to implementing CSBs through DBHDS-Grants to Localities, but the sum also includes funds for Marcus Alert coordinators and analyst positions at DBHDS and DCJS. Since FY22, the budget has set a fixed allocation of $600,000 per implementing CSB.

Figure 1-1
General funds for Marcus Alert have increased almost yearly since FY21



Source: BHC staff analysis of 2020-2025 Appropriation Acts

The General Assembly also allocated a portion of federal American Rescue Plan Act of 2021 (ARPA) funds to Marcus Alert in FY22, FY23, and FY24 to support a technical assistance position at DCJS. DBHDS has also supported the implementation of some Marcus Alert sites using federal funds, including a Mental Health Block Grant and funding from the Bipartisan Safer Communities Act.

2 Implementation status of the Marcus Alert system

The Marcus Alert implementation process is underway for many, but not all, Virginia localities. One-third of localities in Virginia have implemented a Marcus Alert system, and the remaining localities have until July 1, 2028 to plan and implement theirs. The planning process is a collaboration between local stakeholders, local government entities, and guidance from state and regional coordinators. Plans are structured at the level of a Community Services Board (CSB) coverage area, but localities within the same coverage area can exercise flexibility in some elements of their local plans.

The 2028 deadline creates some urgency for the remaining localities and CSBs. The local planning process typically takes one year, and decisions made by the General Assembly during the 2026 session will shape whether and how remaining localities implement Marcus Alert over the next two years. This chapter describes the breadth of implementation so far and variations between localities and CSBs, summarizes facilitators and barriers to implementation, and recommends improvements that could be made to help ensure a robust system is in place statewide by the 2028 deadline.

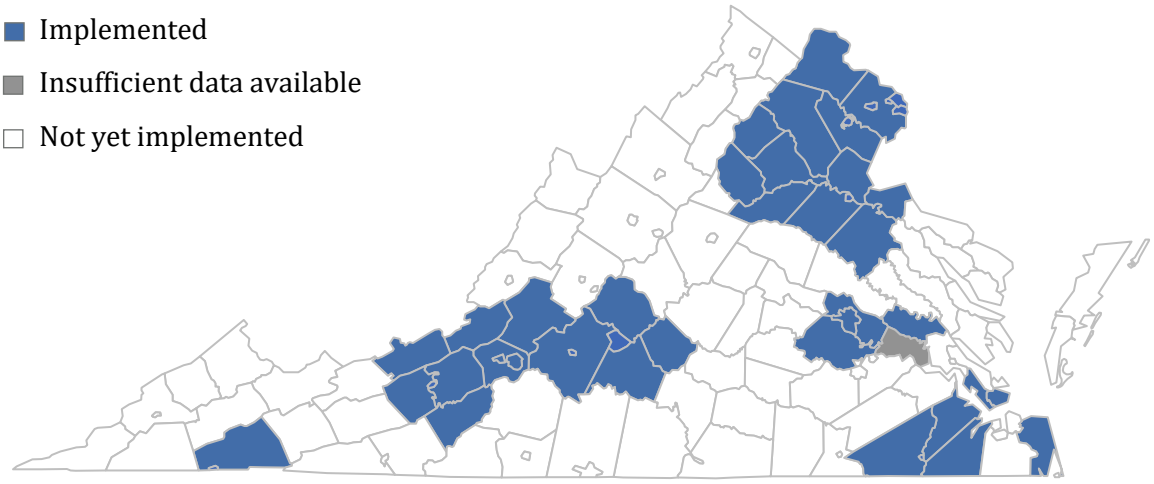
Marcus Alert system has been implemented across parts of Virginia

Marcus Alert implementation is progressing but remains incomplete. One-third of localities representing two-thirds of the Virginia population have now implemented a Marcus Alert system, and although there are statutorily required similarities between their programs, there are also differences that reflect both the regional needs of a population and the priorities of CSB staff and stakeholders in those areas.

One-third of Virginia localities have implemented Marcus Alert as of FY25

Seventeen Marcus Alert systems were operational in 2025, representing 48 localities across Virginia (36 percent of the state's 133 localities)(Exhibit 2-1). The localities that have already implemented Marcus Alert include many higher-population areas, such that they represent two-thirds of the Virginia population. Localities in only one CSB coverage area had received final approval for its Marcus Alert plan, and sixteen areas were operational but had not yet received approval from the Department of Behavioral Health and Developmental Services (DBHDS). Ten additional CSBs were in the planning process but had not yet submitted their plans to DBHDS.

Exhibit 2-1
48 localities in 17 CSB areas have implemented Marcus Alert



Source: BHC staff analysis of all Marcus Alert local plans submitted to DBHDS

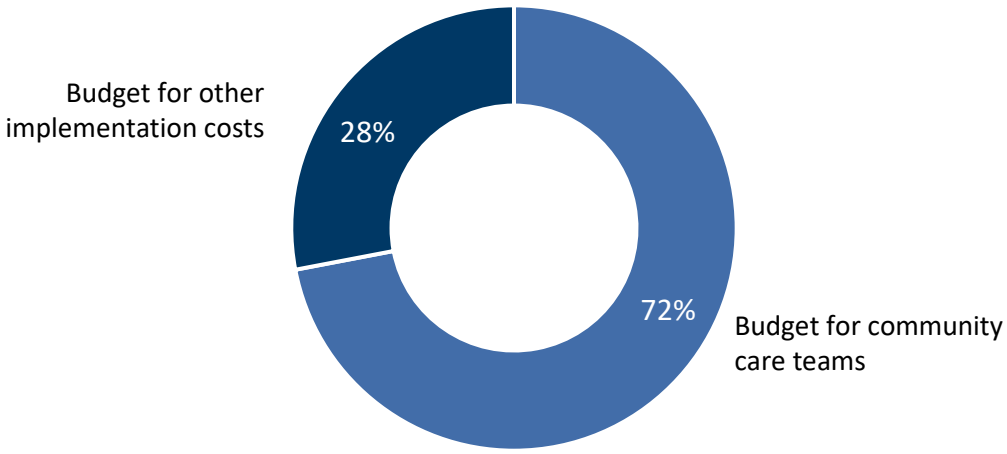
Marcus Alert implementation varies significantly across localities

The Marcus Alert state plan and Local Plan Guide establish requirements for local implementation, but localities retain discretion in shaping their Marcus Alert systems. Local plans vary particularly with respect to the use of community care teams, accountability plans (see Chapter 3), and reliance on regional mobile crisis teams. The degree of interagency collaboration also varies among localities, including differences in relationships between CSBs and law enforcement, CSB support for Public Safety Answering Points (PSAPs), and the willingness or ability of PSAPs to transfer Marcus Alert calls to 988 (see Chapter 3). Five CSBs expressly noted receiving additional funds from their local government, ranging from $52,000 in one-time funds to $1.0 million in annual funding. Most of the CSBs with additional local funds hired an above-average number of Marcus Alert personnel.

CSBs used funds on a mix of community care teams (co-response teams, behavioral health + EMS teams, or other local behavioral health teams) and other funding priorities, with 72 percent of funding going to community care teams, on average (Figure 2-1). Three CSBs spent 100 percent of their funds on co-response, while one CSB spent 100 percent on behavioral health-only teams that can be dispatched by PSAPs.

Some of the top uses of funds were clinician salaries—especially for co-response teams—co-response equipment, and marketing. CSBs hired an average of 6.6 new positions, ranging from a low of 3.0 FTEs to a high of 13.0. On average, personnel accounted for 91 percent of local plan budgets, including additional local funds. A frequent use of funds outside of personnel and community care teams was for promotion and marketing. Very few budgets included any costs specific to the required protocols, and none included funding for the database.

Figure 2-1
Community care teams account for most ongoing Marcus Alert budgeted spending



Source: BHC staff analysis of all Marcus Alert local plans submitted to DBHDS

Although 16 (94 percent of) implementing CSBs have at least one co-response team in their coverage area, there can be significant variation in the makeup of those teams and how they respond to calls (Case study 1). The one CSB that does not utilize law enforcement co-response instead utilizes a CAHOOTS-style team composed of a paramedic and a behavioral health provider who respond to 911 calls.

Case study 1
Types of co-response teams

- **Arlington County CSB has a** Mobile Outreach Support Team featuring a clinician and a peer in their own vehicle. They respond to 911 calls in the county either alone or with a first responder, depending on the acuity of the call.
- **Highlands Community Services** has a co-response team composed of a Highlands clinician and a dedicated deputy from the Washington County sheriff's office. They ride together in a vehicle and respond to calls both in Washington County and the city of Bristol.
- **Blue Ridge Behavioral Healthcare** has co-response clinicians that ride in their own vehicle and will respond alongside any law enforcement agency in Roanoke, Roanoke County, Salem, and Botetourt County. For calls in Craig County, they respond via telehealth.

Source: BHC staff interviews with Arlington County CSB, Highlands Community Services, and DCJS

Strong, pre-existing relationships and dedicated regional coordinators appear to facilitate implementation

In interviews with CSBs, staff frequently credited pre-existing relationships between CSB staff and local law enforcement for the success of their area's Marcus Alert implementation. In particular, the relationships forged through Crisis Intervention Teams (CIT) and CIT training appear to have contributed to positive relationships between CSB staff and law enforcement. PSAPs typically do not participate in CIT programs, although some PSAPs send their telecommunicators to CIT training designed specifically for PSAP staff. CSBs and law enforcement may also have pre-existing relationships through the Emergency Custody Order (ECO) and Temporary Detention Order (TDO) process, because TDO pre-screeners often interact with law enforcement who have custody of individuals under an ECO.

Local Marcus Alert coordinators may improve PSAP support and system effectiveness, but many CSBs have not hired dedicated coordinators

Some PSAPs with good relationships with their CSBs credit the work of the CSB's local Marcus Alert coordinator for supporting them during implementation. Most CSBs that have implemented Marcus Alert have chosen not to hire a dedicated coordinator and instead rely on existing CSB staff and assistance from their regional coordinator. A few CSBs, primarily in Region 2 (Northern Virginia), have used Marcus Alert funds to hire their own coordinators who work exclusively on implementation and on building effectiveness once the system is operational.

Local Marcus Alert coordinators interviewed for this study took the lead on designing Marcus Alert trainings for PSAP staff and provide regular ongoing trainings and support at their PSAPs. Staff with non-Marcus Alert job responsibilities may find this more challenging to accomplish. Many local coordinators also gather data on their system's effectiveness, usually measured through arrest diversion and TDO diversion. Marcus Alert funds are limited, and many CSBs understandably prioritize hiring additional personnel for community care teams, but ensuring Protocol 1 effectiveness through PSAP support should be an equally high priority. DBHDS should encourage implementing CSBs to consider hiring a local coordinator to ensure that PSAPs receive effective support and that CSBs have access to valuable data for future local planning.

RECOMMENDATION 1

DBHDS should amend the Marcus Alert Local Plan Guide to strongly encourage CSBs to hire a local Marcus Alert coordinator with implementation funds if they do not already employ staff in this role.

Several factors have created barriers to implementation

Multiple operational, financial, and organizational barriers are slowing Marcus Alert implementation and limiting system effectiveness across CSBs, law enforcement agencies, and PSAPs. These challenges span personnel shortages, funding misalignment, stakeholder

confusion about requirements, and lack of statewide training and guidance. The breadth and complexity of these barriers may require multifaceted solutions, but addressing them is critical for meeting the 2028 statutory deadline and achieving system goals.

Personnel shortages and recruitment challenges have hindered the deployment of necessary staff in multiple agencies

Staffing shortages across CSBs, law enforcement agencies, and PSAPs create barriers to implementing Marcus Alert and limit the system's ability to provide 24/7 coverage through community care teams. Most local plans (15 out of 17) cited staffing as a barrier, and stakeholders reinforced this concern during interviews. CSBs face staffing shortages that limit their ability to offer mobile crisis response 24/7 and to supply clinicians to co-response teams. Among 20 CSBs with co-response teams, 12 (60 percent) reported on a BHC survey that they had unfilled behavioral health positions on their co-response team. Hiring clinicians for co-response teams proves especially challenging because the role is often more dangerous and strenuous than working in a traditional practice. Law enforcement agencies also face officer shortages that prevent them from operating co-response programs.

Limited staffing also affects PSAPs' ability to complete "warm handoffs" to 988, where telecommunicators stay on the line for some or all of the call with 988. PSAPs report high turnover rates, resulting in staff who often lack experience and context using the complex Marcus Alert triage process.

"Marcus Alert" name is perceived as divisive by some stakeholders

The "Marcus Alert" name reflects the legislation's history; however, some stakeholders associate the name with the political atmosphere of 2020, including increased scrutiny of law enforcement practices. Law enforcement, PSAP, CSB, and state agency staff brought up the name "Marcus Alert" in multiple interviews and commented that the Marcus Alert system, as developed, would not have prevented the death of its namesake. Staff from state agencies also commented on the effect of the system's name on law enforcement participation. A contractor hired by DBHDS to develop the Marcus Alert advanced training had similar findings after discussions with law enforcement, PSAP staff, and behavioral health specialists. In a presentation to the Marcus Alert stakeholder group in August 2024, they reported that "Marcus Alert" is a "loaded moniker" that is sometimes associated with misguided punishment for law enforcement.

Population-based exemption may limit crisis response options in localities that need them most

The 2022 General Assembly amended the Marcus Alert statute to exempt localities with a population of 40,000 or fewer from implementing Protocols 2 and 3, which are the Marcus Alert elements most directly associated with law enforcement. So-called "exempt" localities, which account for two-thirds of all Virginia localities (89 out of 133), must nonetheless implement Protocol 1, provide adequate community coverage, and have the database.

The population-based criteria emerged as a compromise between legislators when negotiating the scope of local exemptions during the 2022 General Assembly session, and

does not appear to accurately represent a locality's ability to implement Marcus Alert. For example, the city of Falls Church (14,658 people in 2020) is exempt despite being located in an urban area and having the second-highest median household income of any Virginia locality. Falls Church has voluntarily implemented Protocols 2 and 3. Tazewell County (40,429 people in 2020) is not exempt despite having the twelfth-lowest median household income in Virginia and a more rural location.

Protocols 2 and 3 may be beneficial for smaller, exempt localities because implementing these protocols can help build relationships between local law enforcement agencies and the 988 regional hub. Smaller localities frequently lack a community care team and could benefit from using regional mobile crisis teams to achieve community coverage, especially for Level 3 calls. When Level 3 calls pose a risk to public safety, the state plan indicates that CIT-trained officers should work with Emergency Medical Services and the regional mobile crisis hub, which can provide telehealth-based support. This type of response is less likely to be a viable option if law enforcement opts out of participating in Marcus Alert and does not have an opportunity to build the necessary relationships. Without telehealth support from regional mobile crisis teams, a behavioral health response at Level 3 is often not available in areas that need it most—small localities without community care teams.

Local plans do not always align with the state plan

Nearly one-third of localities have submitted response options to Level 3 calls that do not adhere to state plan requirements. Ten localities, mostly smaller localities exempt from Protocols 2 and 3, did not include response options for some or all of the four Marcus Alert triage levels. Fifteen of the 48 localities (31 percent) submitted Level 3 response options that were either absent or not consistent with the state plan. Among those that did provide response options, five localities indicated that they planned to send CIT-trained officers to Level 3 crises without engaging behavioral health support.

The result is that individuals in those fifteen localities are unlikely to receive a behavioral health response if their call is categorized as Level 3. The state plan allows CIT officers to be dispatched to Level 3 calls if no community care team is available, but behavioral health support must still be present via a telehealth relationship with the regional hub. Some CIT-only plans indicated that they would transfer the caller to 988 if they felt they could defuse the situation; however, this is not the same as providing behavioral health services to the person in crisis.

DBHDS and DCJS could address this by including guidance in the local plan guide making clear that a CIT officer alone, without support from mobile crisis or the regional hub, is not an acceptable Level 3 response. The challenge is that collaboration between CIT officers and behavioral health requires law enforcement participation and buy-in. If law enforcement does not want to participate in planning and if they are exempted from doing so due to population size, CSBs and PSAPs cannot create a response option that requires law enforcement participation.

A policy option in Chapter 3 recommends the initiation of the Marcus Alert Evaluation Task Force, as described in the state plan. Once the task force is engaged in evaluating Marcus Alert,

they could examine alternative possibilities for providing a behavioral health response at Level 3 in communities with no community care team.

There are no enforcement mechanisms for local agency compliance

Most local agencies have chosen to become compliant with Marcus Alert requirements, but state agencies have little power to enforce requirements when agencies do not comply. Staff from DBHDS and DCJS reported that they have tried to persuade PSAPs and law enforcement to develop required protocols, but nothing in statute gives them the power to penalize the agency if the agency refuses. Some local agencies consider the contents of the state plan to be guidance rather than carrying the force of law, even though § 9.1-193 directs localities to implement the protocols in accordance with the state plan. CSB and state agency staff reported that one locality has not cooperated with Protocol 1, despite being located in a CSB coverage area that implemented Marcus Alert in 2024. No state or local entity appears to have the ability to compel them to implement that protocol if they choose not to do so. Subsection H of § 9.1-193 directs localities to implement Protocol 1 in accordance with the state plan, but it contains a typo that could further hinder enforcement: the subsection currently references "clause (iv) of subdivision B 2 of § 37.2-311.1"—a clause on reviewing the prevalence of crisis situations—rather than clause (vi)—the clause that references the implementation of Protocol 1.

Local agencies also have few financial incentives to participate, because the current funding structure provides CSBs with $600,000 regardless of compliance with the state plan. Identifying the proper incentive structure to achieve compliance without unintended consequences will require the input of numerous stakeholders. The Marcus Alert Evaluation Task Force recommended in Chapter 3, if convened, could give consideration to possible enforcement mechanisms or incentives for local agency participation.

RECOMMENDATION 2

The General Assembly may wish to consider amending § 9.1-193 (H) to change the Code reference from "clause (iv) of subdivision B 2 of § 37.2-311.1", to "clause (vi) of subdivision B 2 of § 37.2-311.1".

Scope and requirements of the Marcus Alert system are not well understood in the absence of statewide training

Many stakeholders from different types of local agencies appeared confused about which components of Marcus Alert they were required to implement. Meanwhile, no statewide training has been provided to alleviate this and other areas of confusion. The Marcus Alert state plan provides extensive documentation, but it can be challenging to use as a planning resource due to its length of 164 pages and complexity.

Stakeholders are sometimes confused about Marcus Alert requirements

Confusion about Marcus Alert requirements has led some CSBs and law enforcement agencies to believe they cannot implement the system without co-response teams. Co-response teams

are one way to achieve community coverage, but they are not required for any locality implementing Marcus Alert. However, CSB and law enforcement staff used the terms "co-response teams" and "Marcus Alert system" interchangeably in numerous interviews for this study and expressed concern that they would be unable to implement Marcus Alert if they could not produce a required co-response team. Those who understood the distinction reported that other local stakeholders often strongly believe that co-response is a necessary element or the only element of a Marcus Alert system. Some CSBs and PSAPs expressed in interviews and in the BHC survey that most state messaging around Marcus Alert has centered on co-response teams that include law enforcement officers. CSBs also indicated a desire for greater clarity from state agencies, especially regarding local vs. regional vs. state responsibilities.

No statewide training has been provided to ensure effective Marcus Alert implementation

According to the state plan, DBHDS has a responsibility to develop an Advanced Marcus Alert training. Despite the state plan being finalized in 2021, the Advanced Marcus Alert training was still not available as of September 2025. Every CSB and nearly every PSAP interviewed for this study mentioned this lack of training as a serious problem to adequately implementing Marcus Alert.

Several CSBs have felt responsible for educating their local partners (such as law enforcement and PSAPs) on Marcus Alert and have had to create their own training materials to do so. Creating and conducting training requires a lot of staff time from CSB employees, especially with limited state guidance. Training was a frequently budgeted item in local plans.

PSAPs expressed similar concerns, and PSAP managers described significant hours dedicated to teaching themselves the triage framework so that they could create trainings for their staff. One PSAP manager described getting calls from confused sheriff deputies who saw “Marcus Alert” dispositions in the computer automated dispatch (CAD) system and didn’t know what it meant, so he created a training for the sheriffs as well.

DBHDS staff indicated it began its “train the trainer” sessions in May 2025 and anticipate that the full Advanced Marcus Alert training will be available soon, although the release of the training has been postponed several times. Even when the statewide training is available, only clinicians and law enforcement officers who serve on a co-response team will be required to attend. DBHDS staff expressed hope that behavioral health providers, PSAP staff, and other law enforcement would attend as well. DBHDS is also in the process of creating an interoperability training for PSAP and 988 call center employees.

RECOMMENDATION 3

DBHDS and DCJS should complete “train the trainer” sessions for the Advanced Marcus Alert training no later than December 31, 2025. DBHDS and DCJS should ensure that Advanced Marcus Alert training is made available to staff at CSBs, PSAPs, and law enforcement agencies no later than April 1, 2026.

Funding level per CSB is arbitrary and not aligned with need

Each CSB coverage area receives $600,000 annually for Marcus Alert regardless of their size or fiscal situation. Allocating funding equally across CSBs does not accommodate the variation that exists among Marcus Alert local plans: $600,000 is likely insufficient for 24/7 community care coverage, and it may be excessive for a CSB that is not developing a new community care team. This funding level first appeared in the Conference Report of the 2020 Special Session I and has remained the same since that time.

This amount was loosely based on a fiscal impact statement produced by the Department of Planning and Budget (DPB), but the funding amount appropriated was significantly lower than the DPB estimate. DPB assumed that the primary cost of implementing Marcus Alert would be to create a co-response team, which would cost approximately $970,000 ($1.02M for Northern Virginia), and that one co-response team would be sufficient to provide 24/7 coverage. No provisions were made for additional expenditures such as training, PSAP technology updates, or Marcus Alert regional coordinators.

Community care teams (such as co-response, CAHOOTS, or 911-dispatched behavioral health teams) are encouraged by DBHDS and DCJS, but they are not mandatory. The state plan theorizes that CSB areas could achieve community coverage using a combination of mobile crisis response teams dispatched by 988 and specially trained law enforcement officers, although this would require additional collaboration between law enforcement and mobile crisis to provide a behavioral health response at Level 3. Additionally, some localities may achieve coverage through an existing co-response or other community care team. So far, every CSB that has implemented Marcus Alert has developed a community care team. Seventy-two percent of Marcus Alert funds are utilized on these community care teams, according to an analysis of the budgets submitted in local Marcus Alert plans.

According to interviews with staff at DBHDS, some smaller CSBs have indicated that they do not plan to form a community care team as a part of their future Marcus Alert implementation, either due to lack of interest among first responder agencies or due to hiring difficulties in their area. With the current budget structure, those CSBs would be funded at $600,000 annually even though their Marcus Alert expenses may be significantly lower. Staff at DBHDS cite the prescribed funding model as a barrier that is slowing down the implementation process. Because of the fixed funding amount per CSB, there is a fixed number of CSBs that can implement Marcus Alert in any given budget cycle.

The cost of a Marcus Alert system with no new community care team is driven primarily by upgrades required to PSAP technology, which are difficult to estimate because they vary widely. This cost would likely be under $100,000 per year in most CSB coverage areas, based on an analysis of local plan budgets and interviews with PSAP staff.

Marcus Alert funding to CSBs has seldom flowed to PSAPs, which must update their systems to comply with the program's requirements. PSAPs incur costs to update their emergency dispatch protocols or CAD systems to accommodate Marcus Alert's triage framework and reporting requirements. Four CSBs provided funds to their PSAPs for these changes, but most did not. Most PSAP staff interviewed said they were able to make changes to their systems in-house without relying on costly vendor services, but many of those in-house changes were difficult and laborious. PSAPs with access to Information Technology departments were more

successful with in-house changes, but many smaller departments may benefit from the ability to contract with a vendor or purchase system updates. PSAPs also noted challenges associated with data reporting (see Chapter 3), continual training of new staff, and quality assurance of calls. No local plans have allocated funds to hiring new PSAP staff, but a dedicated Marcus Alert position shared between an area's PSAPs may provide additional needed support.

OPTION 1

The General Assembly may wish to consider amending the budget language related to Marcus Alert implementation to remove the fixed $600,000 allocation per CSB, grant DBHDS discretion to distribute available Marcus Alert funds based on the needs of each community, and stipulate that funding must be provided to PSAPs for necessary system updates, training, and related expenses.

Statewide implementation by 2028 is possible, but will require funding, agency flexibility, and communication

Twenty-three CSBs that represent 85 localities and 34 percent of the Virginia population have not yet implemented Marcus Alert. Implementing Marcus Alert across all remaining localities by the July 2028 statutory deadline requires overcoming significant funding and operational challenges. New state funding would provide the most optimal path forward, but CSBs should be prepared to comply with the mandate even without guaranteed funding. State and local agencies must also proactively address operational barriers including staff recruitment and interagency coordination.

The most effective strategy for full implementation by July 2028 requires funding for the sites that have not yet received planning funds. Most of the sites that have implemented thus far have received funding to support a one-year planning process prior to the full launch of their Marcus Alert system. In order for all remaining sites to implement in FY28 utilizing the same schedule, funds for their planning year would have to be available in FY27, which would require legislative budgetary action during the 2026 General Assembly session.

Without state funding, remaining CSBs may be unable to create community care teams that would enable them to provide a behavioral health response to Level 3 calls and achieve more robust outcomes (see Chapter 3). Even if no additional funding is appropriated by the General Assembly, CSBs, localities, and state agencies are required to implement Marcus Alert by the 2028 deadline. DBHDS, DCJS, and the remaining CSBs should develop contingency plans for how to comply with the statutory deadline in the absence of additional state funding. Marcus Alert implementation may still be possible in those circumstances: community care teams, though desirable, are not required by statute, and CSBs that have already received Marcus Alert money may be willing to continue funding the full salaries of regional coordinators. However, PSAPs in unimplemented localities will be left to finance the required technology upgrades from their own budgets if additional state funding is not appropriated for Marcus Alert.

Even if funding is appropriated for all remaining sites, there will likely still be some challenges to achieving full implementation by the deadline. Of CSBs that had not yet implemented any Marcus Alert protocols, 62.5 percent (10) indicated on the BHC survey that they would be able to implement all required protocols in their localities by 2028. However, 37.5 percent (six) said they would be able to implement "some, but not all protocols." Of the six CSBs that anticipated problems implementing Marcus Alert by 2028, four cited the "inability to recruit or retain necessary staff" as their top concern, followed by "interagency coordination." Based on the experience of communities that have already implemented Marcus Alert, localities may be most impacted by staffing issues if they plan to utilize co-response teams to provide coverage for Level 3 responses. CSBs that elect not to form new community care teams may be less affected by recruiting challenges, but they may still encounter barriers in coordinating with their local agencies.

DBHDS should take a lead role in contingency planning and communicating with CSBs about which elements of Marcus Alert are required. CSBs that have not yet begun Marcus Alert planning should also be made aware of the range of options for community care teams, including CAHOOTS-style teams and 911-dispatched mobile crisis teams, that do not require law enforcement participation. Such proactive guidance will be crucial in empowering the remaining localities to meet the 2028 deadline, regardless of the financial or operational barriers they face.

RECOMMENDATION 4

The General Assembly may wish to consider including funding in the 2026 Appropriation Act for the remaining thirteen CSBs that have not yet begun their Marcus Alert planning process.

Chapter 2: Implementation status of the Marcus Alert system

3 Effectiveness of the Marcus Alert System

The Marcus Alert system was envisioned as a framework to provide appropriate behavioral health supports and services to individuals experiencing a crisis, while limiting the role of law enforcement to situations that involve a public safety risk. Specifically, statute sets forth three goals for the system to achieve: (1) a behavioral health response to behavioral health crises, (2) diversion to the behavioral health or developmental services system, and (3) specialized training for law enforcement.

To date, there has been no comprehensive evaluation of the Marcus Alert system that could reveal to what extent the system has moved toward achieving these goals. Implementation remains early for the 17 communities that formally adopted Marcus Alert, and some Community Services Boards (CSBs) are still hiring staff for Marcus Alert-related roles. An adjustment period is also expected as stakeholders become more comfortable with Marcus Alert protocols and community members learn about 988. Over half of Virginia CSB areas have yet to implement Marcus Alert and are not required to do so until 2028. It is not known what implementation barriers these communities will face or how effective their systems will be, especially because they tend to be smaller and more rural than the 17 CSB areas that have already implemented. This chapter describes early results from these 17 communities, identifies the barriers that have negatively impacted performance, and offers policy solutions to realize the goals of the Marcus Alert system and help remaining localities bypass avoidable barriers.

Law enforcement responds to the majority of behavioral health calls, but there have been positive developments

Law enforcement remains the default response in many localities, despite a substantial increase in the prevalence of behavioral health responses to 911 calls. The rate of CIT-trained officers dispatched has increased among law enforcement dispatches, but Marcus Alert goals prioritize behavioral health response over dispatch of specially trained law enforcement**.** Still, the rate of behavioral health responses has doubled since the beginning of Marcus Alert implementation, signaling progress toward the system's statutory goals.

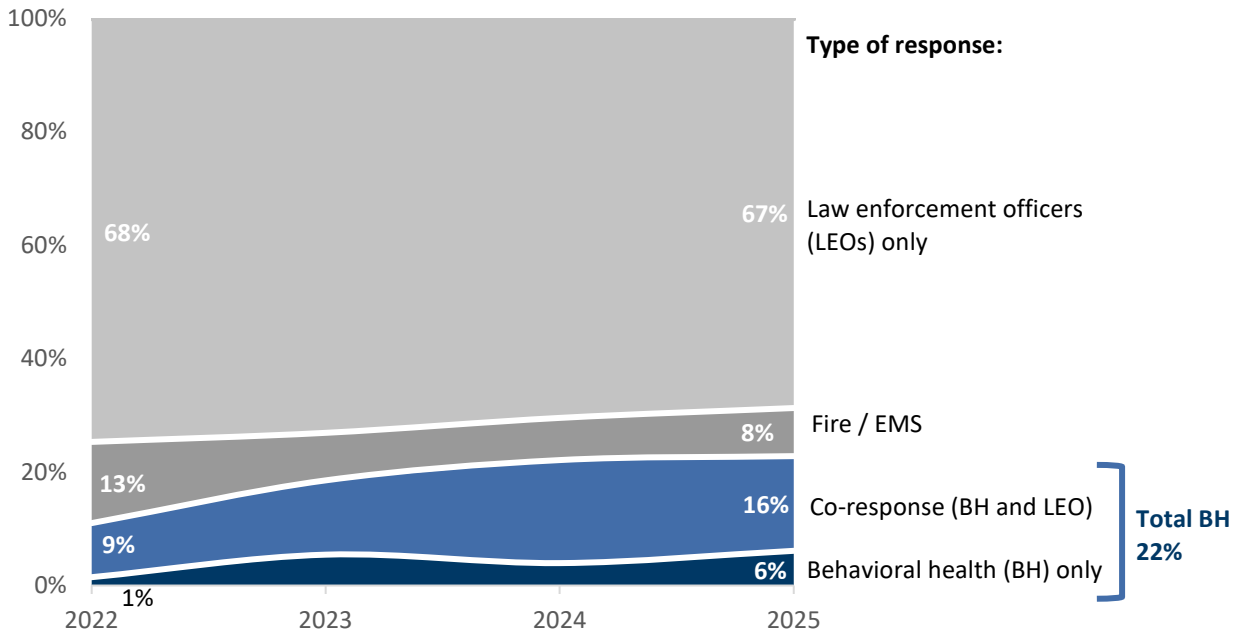
Data about responses to 911 behavioral health calls was not collected prior to 2022, making it impossible to know precisely how often behavioral health responses occurred prior to Marcus Alert, and to what extent the Marcus Alert system contributed to trends that occurred after implementation.

Majority of behavioral health calls to 911 are not receiving a behavioral health response, but trend is improving

Over two-thirds of 911 calls from individuals in crisis in 2024 received a law enforcement response without a behavioral health practitioner in localities that had implemented Marcus Alert (Figure 3-1). However, the frequency of behavioral health responses has more than doubled since 2022. In 2024, about 22 percent of behavioral health calls to 911 received a behavioral health response, compared to 10 percent in 2022. This increase reflects a growth in responses from both co-response teams and from behavioral-health only teams during that period. Behavioral health-only responses occurred almost exclusively for lower-urgency calls (Levels 1 and 2), whereas co-response dispatches were made more frequently for Levels 2 and 3 calls in 2024 (Table 3-1).

Behavioral health responses to 911 calls were inconsistent across localities before Marcus Alert. Some Public Safety Access Points (PSAPs) directed telecommunicators to transfer low-level mental health calls to their CSB, but this was not a universal practice. Some co-response teams existed, especially in large urban areas, but Marcus Alert funding has led to a significant expansion in co-response. New teams have been created in at least fourteen localities and 59 co-response positions have been added.

Figure 3-1
Most calls to 911 still receive a law enforcement-only response



Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert.
Note: “Behavioral health only” also includes non-LE community care teams; figure does not include "other" types of responses (2022: 9 percent; 2025: 3 percent).

Table 3-1
Level 2 and Level 3 calls received the highest proportion of behavioral health responses in 2024

911 disposition	Level 1	Level 2	Level 3	Level 4	All levels
Law enforcement (LE) only	70%	64%	66%	78%	**69%**
Co-response	11%	27%	21%	13%	**18%**
Behavioral health only	12%	2%	1%	0%	**4%**
Other	8%	7%	12%	8%	**9%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert.
Note: "Behavioral health only" also includes non-LE community care teams.

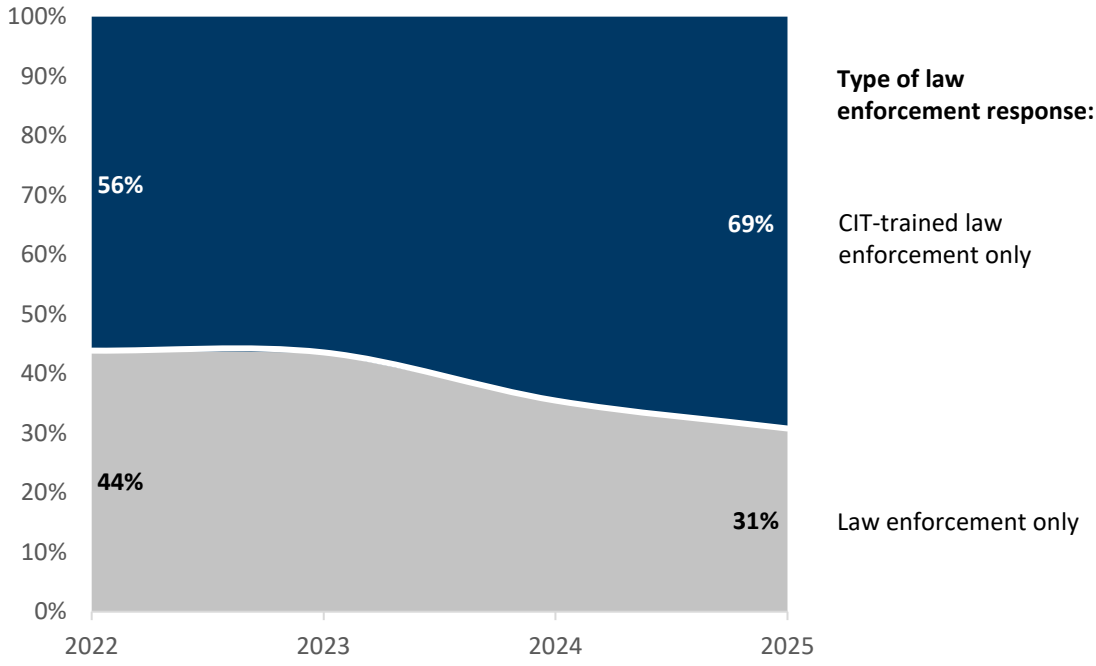
Law enforcement responses have involved CIT-trained officers more frequently since 2022

Responses provided by CIT-trained officers have increased alongside Marcus Alert implementation. The percentage of calls receiving a response from a CIT-trained officer rather than regular law enforcement has risen from 56 percent in 2022 to 69 percent in 2024 (Figure 3-2). Marcus Alert may have contributed to this trend in two ways: (1) encouraging the dispatch of CIT-trained officers when behavioral health responses are unavailable, and (2) requiring law enforcement agencies to maintain a minimum number of CIT-trained officers in participating localities. Most law enforcement agencies had surpassed that minimum training requirement even prior to Marcus Alert implementation and others were aiming to have 100 percent of their officers CIT trained, according to a 2024 BHC survey of Virginia law enforcement agencies. It is not clear to what extent the Marcus Alert-related training requirements have impacted this trend but the increase in CIT-trained officer responses aligns with the Marcus Alert statutory goal regardless of the cause.

Low call transfer rates and insufficient community care teams limit Marcus Alert's effectiveness

The Marcus Alert system is still in the early implementation stages in many of the 17 communities that have adopted it, but initial results suggest that additional actions will be needed to achieve the system's goals in localities that have implemented the system as well as those expected to roll it out by 2028. The Marcus Alert system has two primary pathways to achieving its main goal of providing a behavioral health response to behavioral health crises: (1) transferring 911 calls to 988 for behavioral health support, facilitated through Protocol 1; and (2) dispatching community care teams that include mental health professionals through 911. Both pathways are being used far more frequently today than in 2021, when Marcus Alert was first implemented in five communities. However, call transfers

Figure 3-2
More law enforcement responses to crises are coming from CIT-trained officers



Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert

from 911 to 988 have fallen far short of the target, even for less urgent calls for which a public safety response is often not required. In addition, there are not enough teams with a mental health professional to provide a behavioral health response to all 911 calls that warrant it. Interviews with PSAPs, CSB, and law enforcement personnel confirmed that localities are now more likely to provide behavioral health responses through the two primary pathways: transfers to 988 and 911-dispatched community care teams.

Only six percent of eligible behavioral health calls have been transferred from 911 to 988

Transfer rates from 911 to 988 remain extremely low despite state plan requirements. The transfer rate for Level 1 calls has remained between six and seven percent since Marcus Alert implementation began, far below the state plan requirement that 100 percent of Level 1 calls be transferred to 988. The transfer rate for Level 2 calls is even lower, between one and two percent (Table 3-2). The low Level 2 transfer rate is particularly problematic because these calls often could benefit from mobile crisis response, and call transfers are the only way to connect someone to regional mobile crisis teams.

In practice, transferring 100 percent of Levels 1 and 2 calls may not be realistic, at least in the near term, but Virginia's transfer rates for less urgent calls should be higher than 10 percent, at a minimum. No national benchmarks or experiences from other states could be found to

estimate a more realistic figure for less urgent calls, but one analysis suggests that at least 10 percent of all calls can be transferred by 988. The analysis, performed by Vibrant in 2020, estimated that between 10 percent and 30 percent of all relevant 911 calls, regardless of urgency level, could be transferred to 988. Relevance was defined as calls relating to an "emotionally disturbed person."

Table 3-2
Only 5-6 percent of low-urgency calls are transferred to 988

Level 1 & 2 calls transferred to 988	2022	2023	2024	Average 2022-2024
Level 1	7%	6%	7%	7%
Level 2	2%	1%	1%	1%
Overall	**5%**	**5%**	**6%**	**6%**

Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert

Addressing the causes of low transfer rates would help ensure that low-urgency calls receive a behavioral health response. When calls that should be served by 988 are answered by 911 instead, law enforcement officers are far more likely to be dispatched than community care teams with mental health professionals, as described in the previous section of this report, even though they do not present a public safety risk that requires law enforcement presence. Level 1 calls involve distressed callers with no homicidal thoughts and no suicidal plan or means, while Level 2 calls involve distressed callers who may be engaging in minor self-injurious behavior and require in-person behavioral health support.

Routine dispatch of law enforcement to behavioral health calls with no public safety risk directly contradicts Marcus Alert statutory goals. Community care teams can be dispatched when available, although they most frequently take the shape of co-response teams that also include law enforcement. Co-response capacity is better reserved for Level 3 and Level 4 calls, which may have a public safety risk.

Protocol 1 (triage, transfer, and dispatch) serves as the foundation of Marcus Alert and must be implemented well to ensure that other elements, such as community care teams, are utilized in keeping with Marcus Alert's statutory goals. Protocol 1 and community care teams combined are the main places where Marcus Alert can make a real impact on outcomes for people in a behavioral health crisis. Low utilization and insufficient resources for those two elements of Marcus Alert substantially impact overall effectiveness.

Several factors have contributed to the low transfer rate between 911 and 988

Several factors have contributed to the low transfer rate of less-urgent calls from 911 to 988, but the primary driver appears to be that PSAPs have not received adequate training, support,

and technical assistance to implement Marcus Alert transfers effectively. PSAPs carry the burden of implementation to achieve interoperability, which is the basis for Protocol 1, but they have received few resources to implement this crucial protocol. PSAPs have also been regularly excluded from Marcus Alert planning and decision-making that directly impact their operations. Additional factors also appear to influence how frequently 911 calls are transferred to 988, such as the PSAP culture of accountability, individuals' refusal to be transferred, and the limited resources that 988 provides when individuals are calling on behalf of someone in crisis.

PSAPs face financial and technical challenges to implementing Marcus Alert

PSAPs have not received dedicated and sufficient funding to implement the technology and other improvements needed to effectively implement the Marcus Alert system. PSAPs do not directly receive Marcus Alert funding despite being required to make significant system and other changes. Marcus Alert funding flows through CSBs, and of the 16 CSBs that submitted local plan budgets, only four (25 percent) indicated that they planned to provide money to the PSAPs in their coverage area. This forces some PSAPs to make inadequate technological and system updates that may compromise Marcus Alert effectiveness.

PSAPs have two systems relevant to Marcus Alert: (1) a computer automated dispatch (CAD) system, and (2) a dispatch protocols system. Most PSAPs must modify their CAD system in order to collect required data on Marcus Alert call levels, and rushed or insufficient software updates can substantially reduce Marcus Alert effectiveness. Due in part to a lack of dedicated funding, PSAPs tend to make do with what can be implemented inexpensively or for free. For example, some PSAPs can use in-house information technology personnel or rely on existing contracts with their CAD vendor to make changes more easily and cost-efficiently. Smaller PSAPs with older CAD systems may need to contract out the work, which can be expensive, or forego more extensive changes.

Dispatch protocols serve as decision trees to help telecommunicators determine which responses are appropriate and what personnel should be dispatched. Some PSAPs use software (often called "questioning software") to guide telecommunicators through the triage process, while others use physical cards with flowcharts and questions for determining urgency levels. PSAPs have to update dispatch protocols in order to operationalize their community's plan for achieving community coverage. PSAPs vary in how much discretion they give telecommunicators—some allow significant flexibility with the decision tree as a guide, while others (especially those using questioning software) expect telecommunicators to follow responses exactly.

PSAPs using physical cards generally reported little difficulty updating them to align with the Marcus Alert triage framework. In contrast, aligning dispatch protocols with Marcus Alert becomes much more difficult and potentially expensive when PSAPs use questioning software. That update requires thoroughly reviewing all relevant questions and linked dispatch options to ensure they lead to Marcus Alert-aligned responses, as well as testing them after updates are made, both of which can be very time consuming. Not properly aligning questioning software may reduce the rate of behavioral health calls receiving behavioral health responses in that jurisdiction. Erroneous updates can also lead to other

undesired outcomes: in one rural county, an error in updating their questioning software briefly led to an ambulance being dispatched every time there was a Marcus Alert call.

Many PSAPs strongly desire additional guidance and support. Marcus Alert implementation was especially challenging for the 2021 cohort of PSAPs, which were the very first to roll out the system. Subsequent cohorts have sometimes been able to reach out to those that previously implemented for advice, but the value of information sharing is limited because every PSAP has a unique CAD system, even those that use the same vendor

Direct or guaranteed funding for PSAPs would allow them to make necessary updates, which would in turn improve interoperability and the effectiveness of Protocol 1. Two PSAP leaders interviewed for this study also said they would have used funds to provide their staff with mental health training, including sending some staff to a Dispatcher CIT course. Another PSAP leader said he would have used funds to hire a clinician in his call center.

Option 1 in Chapter 2, which suggests a change to the funding structure of Marcus Alert, also includes language that would ensure that PSAPs receive necessary funds.

PSAP culture, mistrust of 988, and liability concerns limit call transfers

Transferring calls to an outside entity may feel counterintuitive to PSAP telecommunicators, whose culture and training emphasize dispatcher responsibility for calls and liability for outcomes. Telecommunicators often care deeply about their communities and feel personally responsible for ensuring a correct response to a call. PSAP culture is also influenced by leadership and location within local government. Some PSAPs, especially those in rural areas, are a part of the sheriff's office, so the sheriff ultimately has authority over how they operate, even if that sheriff is not participating in Marcus Alert.

Many telecommunicators do not trust 988 to appropriately handle calls, which relates to the responsibility they feel for call outcomes. PSAP personnel attributed their reluctance to transfer calls to wait times, 988 not picking up for transfers, and uncertainty about how calls would be handled once they reach a crisis counselor. One telecommunicator described a warm handoff to 988 where the crisis counselor seemed to be working from home, and she could hear children and pets in the background, which she said did not feel professional.

PSAP staff also expressed concerns about transferring calls to 988 due to potential exposure to lawsuits. There are no known instances of lawsuits against a Virginia PSAP or a telecommunicator related to 988 transfers, but lawsuits in other states may fuel that concern. For example, one PSAP leader referenced a recent lawsuit in Texas when describing her concerns about Marcus Alert liability. 911 telecommunicators in Virginia have broad protection from liability as long as they act in good faith, according to state attorneys, but some PSAP staff remain unsure or unaware of those protections.

Additional state guidance could help address trust and liability concerns. DBHDS and DCJS are developing a 988-911 interoperability training for both 911 telecommunicators and 988 call takers that will cover concepts such as liability and calls from third parties. The training should be ready in early 2026.

PSAPs hesitate to transfer calls made by a third party because 988 often does not provide the type of help requested

PSAP personnel interviewed for this study shared that a significant number of their Marcus Alert calls are made by friends, family members, or bystanders rather than coming directly from the individual in crisis. Telecommunicators hesitate to transfer these types of third-party calls to 988 for two main reasons: (1) callers are often reluctant to accept a transfer because they want to ensure that an in-person response will be dispatched, and (2) telecommunicators perceive 988 as a crisis line designed primarily to assist callers who are personally in crisis, rather than third-party intermediaries.

These perceptions align with how 988 operates in practice. PSAP staff said that third-party callers who contact 911 generally want an in-person response, and 988 usually will not dispatch mobile crisis unless they can speak to the person in crisis to gain their consent. 988 call centers use Vibrant's policies on engaging third-party callers, but those policies focus more on emotional support for the caller and guidance on helping the person in crisis rather than on dispatching an in-person response that could provide direct assistance.

Some callers do not wish to be transferred to 988

Some 911 callers refuse transfers to 988, and telecommunicators will not transfer someone against their will. Residents in rural localities often personally know their local law enforcement and 911 telecommunicators and prefer talking to trusted local public safety staff with whom they have relationships rather than an unknown crisis counselor who may live outside Virginia. Previous outreach campaigns may also influence caller preferences. CSB staff in one large city said residents in their jurisdiction tend to reject transfers because CSB staff previously ran a successful campaign encouraging people to call 911 and ask for a CIT officer. Residents still want to call 911 and ask for a CIT officer, even though 988 is now an option.

This knowledge gap may reduce people's comfort level with being transferred to 988 or initiating a call to 988 instead of 911. Current 988 advertisements are ubiquitous in some areas but non-existent in others. Some interviewees acknowledged that 988 is still a new service and will take time to develop public comfort, even with publicity efforts by state and local agencies.

More urgent behavioral health crises seldom receive a behavioral health response

Only 22 percent of Level 3 calls received a behavioral health response in 2024, while two-thirds received a law enforcement-only response (Table 3-3). PSAPs are required to transfer Level 1 calls to 988 and transferring Level 2 calls is recommended, while Level 4 calls require a fast emergency response with behavioral health as a secondary consideration. Level 3 calls present the most complex challenge because they involve potentially risky situations that still need the input of behavioral health professionals. These calls may pertain to individuals exhibiting florid psychosis, active aggression, or self-harm behaviors that could result in injury, but they do not necessarily present a public safety risk.

The state plan requires localities to provide an option for a behavioral health response at every level, including Level 3; the plan outlines several potential models, including co-response as well as behavioral health-only responses. However, there is limited capacity available among the behavioral health response teams that can be dispatched by PSAPs, even though the vast majority of Level 3 calls came through 911 in 2024.

Table 3-3
Most Level 3 calls did not receive a behavioral health response in 2024

Disposition	Level 1	Level 2	Level 3	Level 4	All levels
Co-response with LE	11%	27%	21%	13%	16%
Community care teams with no LE	5%	1%	1%	0%	3%
CIT law enforcement	42%	27%	45%	62%	44%
Non-CIT law enforcement	28%	37%	21%	17%	25%
Transfer to 988	7%	1%	0%	0%	4%
Other	7%	7%	12%	8%	9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert
Note: Percentages may not total 100 percent due to rounding.

State plan recommends Level 3 calls to be handled by 911, but capacity of community care teams is insufficient

Behavioral health response teams that can be dispatched by 911 lack sufficient capacity to respond to most Level 3 behavioral health calls, which are therefore answered primarily by law enforcement. The vast majority of Level 3 crisis calls come through the 911 system (12,952 calls between January 2024 and May 2025 in implemented localities), and the few that go to 988 (602 statewide during the same period) must be jointly handled with 911, according to the state plan. Standard practice at PSAPs and 988 regional call centers reinforces this arrangement: 911 telecommunicators are unlikely to transfer calls involving active self-harm or psychosis, while 988 call takers are trained to route these calls to 911 for an emergency response. PSAPs are able to dispatch law enforcement, fire and rescue, and community care teams, but they currently do not have the ability to dispatch regional mobile crisis teams that have been built as part of Virginia's crisis system.

All communities that have implemented Marcus Alert have at least one community care team in their CSB coverage area—usually co-response teams—but their operational reach is limited. These teams may not serve every locality within a CSB coverage area, and they

generally operate on restricted schedules, such as weekday business hours. No locality in Virginia currently offers 24/7 co-response availability. Even when a team is on duty, it has limited capacity; if a co-response team is already engaged with another call, law enforcement is often dispatched to the scene instead. CSBs with co-response teams average 2.8 teams in their coverage area, with one team consisting of 1 clinician FTE and 1 law enforcement FTE, according to a BHC survey. Most CSBs indicated that they would need additional teams to meet the needs of their area, with CSBs requesting a median of 3 additional teams per CSB coverage area.

Smaller and more rural jurisdictions have significantly less access to community care teams, limiting behavioral health responses to crises. All but one of the 24 larger implemented localities (over 40,000 residents) have a community care team operating within their jurisdiction. In contrast, half of the smaller implemented localities (40,000 or fewer residents) have this type of team. In localities where no community care team exists, individuals in a Level 3 crisis will almost invariably receive a law enforcement response if they call 911. Twelve localities did not report having a community care team in their local plan, and nine designated law enforcement as their first choice for Level 3 dispatch, specifying CIT-trained officers in two-thirds of cases. There were 11 additional local plans that did not include information about the intended response to Level 3 calls.

Localities that are smaller or less-densely populated may not have enough mental health-related 911 calls to justify a full-time community care team. In communities where the CSB spans multiple localities, planning teams may choose to allocate their finite Marcus Alert funding to behavioral health response teams in higher-density or more populated localities.

Multi-jurisdictional models could help ensure that behavioral health response teams are available in sparsely populated areas. Funding a separate team in every one of Virginia's 133 localities is not financially viable or efficient, but multiple jurisdictions could pull together resources to create one team to serve them all. A few multi-jurisdictional teams operate in Virginia currently: Washington County Sheriff's Office utilizes a co-response team that has jurisdiction both in Washington County and the city of Bristol, and Blue Ridge Behavioral Healthcare clinicians travel in their own vehicle and respond to calls with law enforcement in any locality in their coverage area. Law enforcement identified challenges to this approach including lack of knowledge about co-response, local politics, and relationships between agency heads; DCJS staff also indicated that law enforcement may be uncertain about the legality of multi-jurisdictional teams. More rural localities will implement Marcus Alert over the next three years, and interest in multi-jurisdictional teams is likely increase.

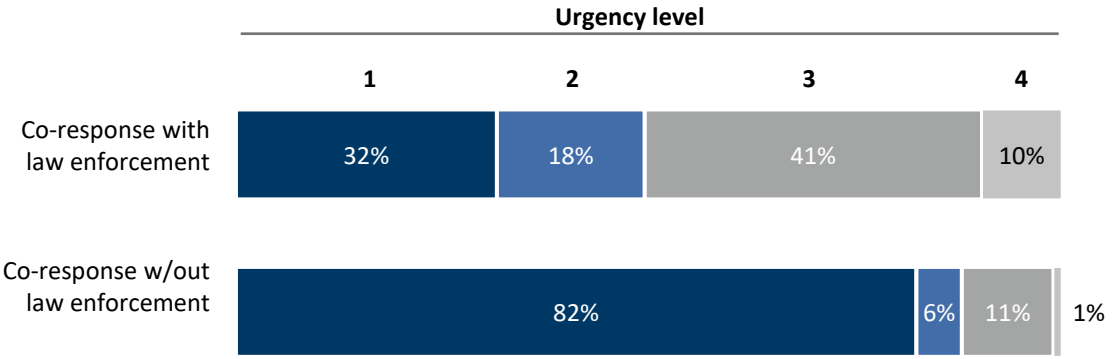
OPTION 2

The General Assembly may wish to amend § 15.2-1726 to include co-response teams with jurisdiction in multiple localities as an acceptable reciprocal agreement between law enforcement agencies.

Behavioral health resources are spread thin over all levels of urgency rather than the most urgent

Many lower-urgency calls are not transferred to 988 and stay with 911, and community care teams are the only option available to PSAPs for providing a behavioral health response to calls regardless of their level of urgency. Community care teams are therefore frequently dispatched to lower-urgency Level 1 and Level 2 calls, which reduces the teams' capacity to handle higher-urgency crises where their specialized skills are required. Half of all co-response team dispatches were to Level 1 or Level 2 calls in 2024, based on PSAP call and dispatch data in localities that have implemented Marcus Alert (Figure 3-3).

Figure 3-3
Half of all co-response team responses were to lower-urgency calls in 2024



Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert

To best align resources with the urgency and needs of 911 calls, regional mobile crisis teams could be leveraged and the capacity of behavioral health-only teams could be expanded, in addition to working to increase transfer rates. This approach would help reserve the limited capacity of co-response teams and CAHOOTS teams for Level 3 and Level 4 calls, where they are most needed.

If given the resources, PSAPs could dispatch a behavioral health response either by (1) expanding the number and capacity of local behavioral health-only teams, which can already be dispatched by 911 and are generally led by CSBs, or (2) enabling PSAPs to leverage regional mobile crisis response teams designed to address Level 1 and Level 2 calls. These options would be aligned with the Marcus Alert plan, which envisioned not involving law enforcement in Levels 1 and 2 calls. The state plan also contemplated using mobile crisis teams to provide community coverage, particularly in smaller communities.

Virginia could expand the capacity of behavioral health-only teams by funding positions at CSBs to staff these teams, which would primarily respond to 911 calls. CSB-led behavioral health-only teams could be dispatched directly by 911, providing immediate behavioral health response without requiring call transfers or assessments before dispatch. This model

would allow PSAPs to maintain control over emergency coordination while ensuring that individuals in crisis receive appropriate and timely clinical intervention. These teams would have to be funded primarily by state and local governments, because they do not bill for services: behavioral health-only teams dispatched directly by 911 generally do not bill the people they serve, and they do not qualify for Medicaid reimbursement in Virginia because they are not dispatched through the Virginia Crisis Connect (VCC) platform.

Behavioral health-only dispatch from 911 is rare in Virginia but is utilized more often in other states. As of 2024, mobile crisis teams can be dispatched from 911 centers in 12 states, according to behavioral health analytics firm NRI. Additionally, about two-thirds of mobile crisis team respondents said that their team can be accessed by calling 911, according to the 2023 National Survey of Mobile Crisis Teams conducted by Vibrant for SAMHSA. In some PSAPs in other states, an embedded clinician can speak to people in crisis and advise 911 telecommunicators on situations when dispatching a behavioral health-only team might be an appropriate option.

The state could also allow 911 telecommunicators to work with VCC dispatchers to leverage the existing network of regional mobile crisis teams. Regional mobile crisis response teams include both CSBs and private providers but can only be dispatched using the VCC system. To efficiently operationalize this model, VCC dispatchers could be embedded within PSAPs, which would allow VCC to remain the single platform from which mobile crisis teams are dispatched (and achieving the "air traffic control" best practice). Embedding VCC dispatchers in the PSAP would reduce the need for transferring calls to 988, which some callers do not want. Long wait times to reach a 988 call taker may also prompt callers to hang up and potentially not receive help. Embedding VCC dispatchers could also help PSAP telecommunicators better understand how to use the Marcus Alert triage framework, and foster a stronger sense of each other's role and culture. This pilot could also include a clinician embedded in the PSAP alongside the VCC dispatcher to help with clinical decisions related to mental health, and to educate 911 telecommunicators on clinically appropriate dispatch options for different situations.

A pilot program with limited funding for each model could be launched at a few PSAPs. A pilot approach would be a more prudent and efficient way to test effectiveness and identify unintended consequences before committing to a statewide approach.

OPTION 3

The General Assembly may wish to consider funding and directing DBHDS to establish two pilot programs available to localities that have implemented the Marcus Alert system. The purpose of these respective pilots would be: (1) developing or expanding the capacity of CSB behavioral health-only teams that can be dispatched by PSAPs; and (2) embedding regional mobile crisis dispatchers and optionally, clinicians, in PSAPs. Priority could be given to localities that do not currently have access to a community care team. DBHDS should develop performance measures (including the percentage of Level 3 calls receiving a behavioral health response) for both pilot models and include a performance evaluation for each model in the yearly report on Marcus Alert and the Comprehensive Crisis System.

Focus and resources have been placed primarily on co-response teams rather than on other teams dispatched through 911

Co-response teams have been a positive and popular addition to dispatch options in many localities, but their dominance may be inconsistent with the overarching goal of Marcus Alert and the vision laid out in the state plan, which is to provide behavioral health-only responses when there is no public safety risk. The co-response model has been essential for securing law enforcement buy-in to Marcus Alert, but it has consumed much of the limited resources provided to implement Marcus Alert. This has left little state funding to support behavioral health-only teams that could be dispatched for Level 1 and Level 2 calls when a 988 transfer is not possible, and for Level 3 calls without a public safety risk (such as active self-injury).

Most communities lack these behavioral health-only options, leaving co-response with law enforcement as the best available choice for telecommunicators. Sixty percent of Marcus Alert localities have a co-response team with law enforcement, while only twenty five percent have a community care team without law enforcement (generally an EMS and clinician or a clinician-only team). Many of these non-law enforcement community care teams are not dispatched as first responders to a 911 call but rather provide preventative care or post-crisis support.

At least three localities in Virginia have developed "CAHOOTS-style" teams as an alternative model. These teams are composed of a behavioral health provider and EMS personnel. Developed in Eugene, Oregon in 1989, CAHOOTS (an acronym for "Crisis Assistance Helping out on the Streets") provides crisis intervention, counseling, first aid, basic emergency care, referrals, and other services in response to 911 and non-emergency calls. CAHOOTS is widely cited as a model for non-law-enforcement crisis response, including by SAMHSA. Increasing CAHOOTS-style teams could help expand the capacity of the Marcus Alert system to provide a behavioral health response to behavioral health crises. DBHDS should work with local fire and rescue entities and PSAPs to develop a strategy for increasing the availability and utilization of CAHOOTS-style teams in localities that have implemented Marcus Alert.

There is no state guidance, requirements, tracking, or regulations for co-response teams to help maximize diversion

Co-response teams in Virginia vary widely in terms of their composition, hours, policies, and practices, with limited state guidance or oversight to ensure they maximize their potential for diverting individuals from the criminal justice system. Co-response teams associated with Marcus Alert share some similarities, such as frequently staffing their co-response team's mental health professional position with CSB personnel, and sending co-response officers to the Advanced Marcus Alert training. Other co-response teams in Virginia not associated with Marcus Alert have policies and compositions that remain largely unknown to state agencies. Co-response teams in Virginia have received largely positive feedback, but limited data exists on their effectiveness or what practices make some teams more successful than others. Two-thirds of localities have not yet implemented Marcus Alert, so there will likely be many new co-response teams forming in the next two years. These teams, in addition to existing teams, may benefit from guidance, including information on variations in co-response practices across the state and on best practices.

DCJS staff are aware of the co-response teams that have been developed with Marcus Alert funds, but they do not play an active role in tracking policies or best practices for co-response teams, and they are not always aware of co-response teams that are unaffiliated with Marcus Alert. Community care teams—and mostly co-response teams—are the primary route by which Marcus Alert provides a behavioral health response to people in Level 3 or Level 4 crises. Creating a position to help encourage the formation of co-response teams and facilitate best practices within those teams could ensure that they maximize their potential for diverting individuals in crisis from the criminal justice system.

Directing more attention to best practices for co-response also fulfills the statutory requirements in § 9.1-193 (D), which states that "the specialized response protocols and training shall also set forth best practices, guidelines, and procedures regarding the role of law enforcement during a mobile crisis response" (which includes co-response teams), "including the provisions of backup services when requested, in order to achieve the goals set forth in subsection E and to support the effective diversion of mental health crises to the comprehensive crisis system whenever feasible."

OPTION 4

The General Assembly may wish to consider including in the 2026 Appropriation Act one additional FTE and funding to support hiring one Co-response Coordinator at DCJS.

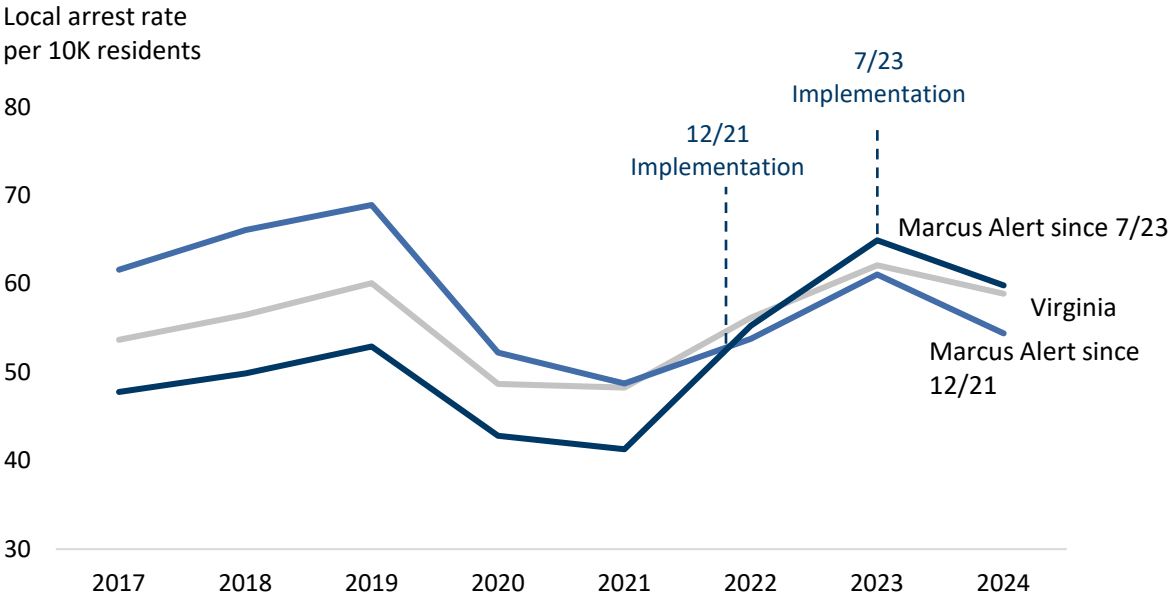
Arrests and use of force appear unchanged since Marcus Alert implementation, but local reports are positive

There is no clear indication that the incidence of arrests and use of force changed after the implementation of Marcus Alert, but local data and stakeholders suggest that co-response teams are achieving better outcomes than statewide data indicates. Implementation is also relatively recent, and it may be too soon to observe changes in downstream outcome measures.

Arrest rates for certain crimes as well as use of force incidents were used as proxies for the impact of Marcus Alert implementation on the outcomes of interactions between law enforcement and individuals in crisis. Arrests rates for localities that implemented Marcus Alert in December 2021 follow a pattern similar to the statewide average, increasing and decreasing in unison. The same applies to the cohort of localities that implemented in July 2023, except for a steeper increase in arrest rates after 2021 compared to the statewide average. This analysis does not yield any clear association between Marcus Alert implementation and a reduction in arrest rates (Figure 3-4). The same conclusions apply to use of force incidents (Figure 3-5).

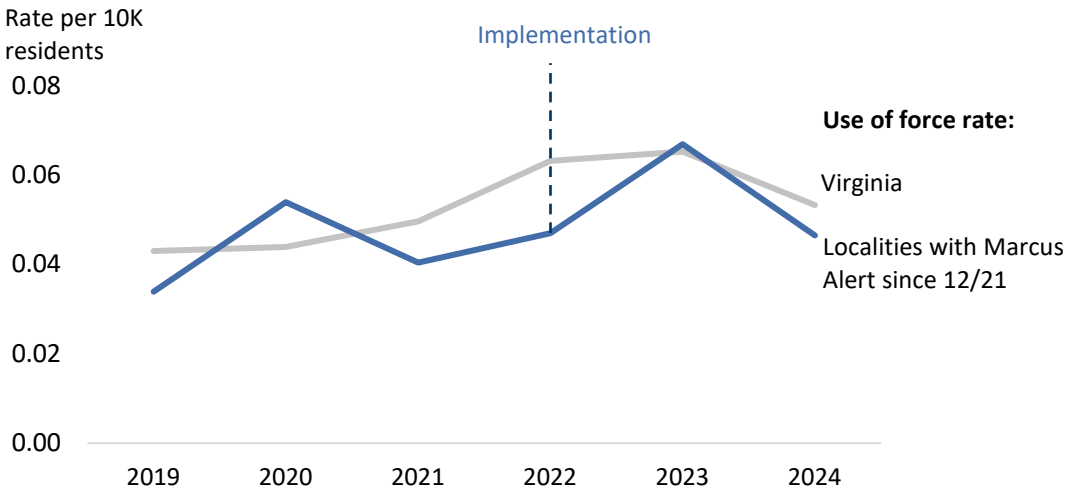
The lack of measurable impact may also reflect the low percentage of behavioral health calls currently receiving a behavioral health response. Interventions may be more effective at preventing arrest or use of force when the Marcus Alert triage protocol is successfully used—either by transferring a call to 988 or dispatching a community care team.

Figure 3-4
Arrests for behavioral health-linked crimes do not appear to be associated with Marcus Alert implementation



Source: BHC staff analysis of arrest data from Virginia State police
Note: Arrest rates include eight charges commonly linked with behavioral health: assault and battery, bomb threats, destruction of property, disorderly conduct, failure to appear, petit larceny, resisting arrest, and trespassing.

Figure 3-5
Use of force incidents do not appear to be associated with Marcus Alert implementation



Source: BHC staff analysis of use of force data from Virginia State Police

CSB and law enforcement personnel interviewed for this study shared experiences and data to convey the impact of their co-response teams. Law enforcement in a Northern Virginia jurisdiction shared that their use of force rate is much lower for their co-response unit than for patrol officers, and law enforcement in one Southwest Virginia jurisdiction shared that they have an "almost non-existent" arrest rate for their co-response team. Some localities also collect their own data on diversion and use of force rates. Another Northern Virginia jurisdiction found that their co-response team had a 71 percent arrest diversion rate, and a co-response team in Southwest Virginia found that they had a 55 percent diversion rate from ECOs and TDOs.

Certain aspects of the Marcus Alert system do not appear to meaningfully help the program achieve its goals

Protocol 1 and community care teams represent the primary pathways for achieving the goals of Marcus Alert, while other system components database appear to play a smaller role. Protocol 2 and Protocol 3 have not led to substantial changes in many implementing areas, but they have provided incidental benefits in some communities, such as creating opportunities for education and cultural change in law enforcement agencies. The database is not commonly utilized at this stage but improvements could enhance its utility.

Protocol 2 is most useful in areas without community care teams

Protocol 2 may be more valuable for fostering law enforcement-behavioral health collaboration than for its stated purpose of providing backup to mobile crisis teams. Protocol 2 establishes a signed MOU between the regional mobile crisis hub and law enforcement agencies under which law enforcement provides backup to mobile crisis teams when needed. Several state agency staff and local stakeholders described Protocol 2 as unnecessary, pointing to the fact that law enforcement responds to 911 calls for help regardless of whether an agreement exists with the caller.

The state plan indicates that Protocol 2 is also intended to foster mutual understanding between behavioral health and law enforcement, including understanding each other's professional responsibilities, ethics, and methods. Some stakeholders viewed this aspect of Protocol 2 as valuable. The Protocol 2 MOU becomes particularly important in localities that choose to utilize the state plan's response option to Level 3 calls for areas without community care teams. In these areas, CIT officers must respond in conjunction with mobile crisis or guidance from the regional hub. The MOU would be an important tool for solidifying those relationships and establishing mutual understanding for how officers will engage with regional hubs or mobile crisis teams during a Level 3 response.

Protocol 3 may not have much impact on law enforcement training in most localities

Protocol 3 requires law enforcement agencies to submit policies, maintain CIT training levels, and provide mental health training, but most of them already meet these requirements. Specifically, Protocol 3 requires law enforcement agencies to: 1) have more than 20 percent

of officers CIT trained and commit to preferentially dispatching those officers for behavioral health crises, 2) send co-response officers to Advanced Marcus Alert training, 3) require all officers to complete Mental Health First Aid (MHFA) or an equivalent training, and 4) submit copies of various departmental policies.

Most law enforcement agencies will not need additional training to comply with Protocol 3 requirements. 90 percent of law enforcement agencies in Virginia already have at least 20 percent of their officers CIT trained, according to a 2024 BHC survey of law enforcement agencies.

Under SB 5014 (2020 Special Session I), DCJS has developed proposed minimum training standards for law enforcement that include a crisis intervention training module as part of required pre-employment training for all officers. The proposed regulation is in the final stage and awaits review by the Governor's office. The most recent proposed text for the compulsory minimum training standards also includes some education on Marcus Alert for law enforcement.

Many criminal justice training academies in Virginia already include MHFA or equivalent training in their curricula, and basic mental health training will soon be required of all law enforcement officers.

Some law enforcement agencies have had to revise departmental policies to be fully compliant with Protocol 3, but most agencies that submitted their policies did not require any changes, according to staff from DBHDS and DCJS.

Database component faces compliance challenges and is not broadly utilized

The requirement that each locality have a voluntary database faces compliance challenges and appears to be seldom utilized, despite being required by statute. The database is intended to allow individuals to make their mental health information known to first responders. The *Code of Virginia* requires every locality in Virginia to have a database established by July 1, 2023, regardless of their Marcus Alert timeline or of exemption from Protocols 2 and 3. However, this component of Marcus Alert implementation does not appear to be often discussed as a part of Marcus Alert implementation and is not included in the Local Plan Guide. As of July 2025, at least 6 of the 40 CSB coverage areas had not implemented any database, according to CSB staff.

Some localities have created their own databases housed within the PSAP, but many localities are using platforms such as RapidSOS or Smart911 to fulfill the database requirement. With these platforms, individuals register directly with RapidSOS or Smart911 and provide health or mental health information about themselves or a household member that is then linked to their phone number. When they call 911 from that same phone number, PSAPs utilizing that software are automatically alerted to the information contained in that individual's profile.

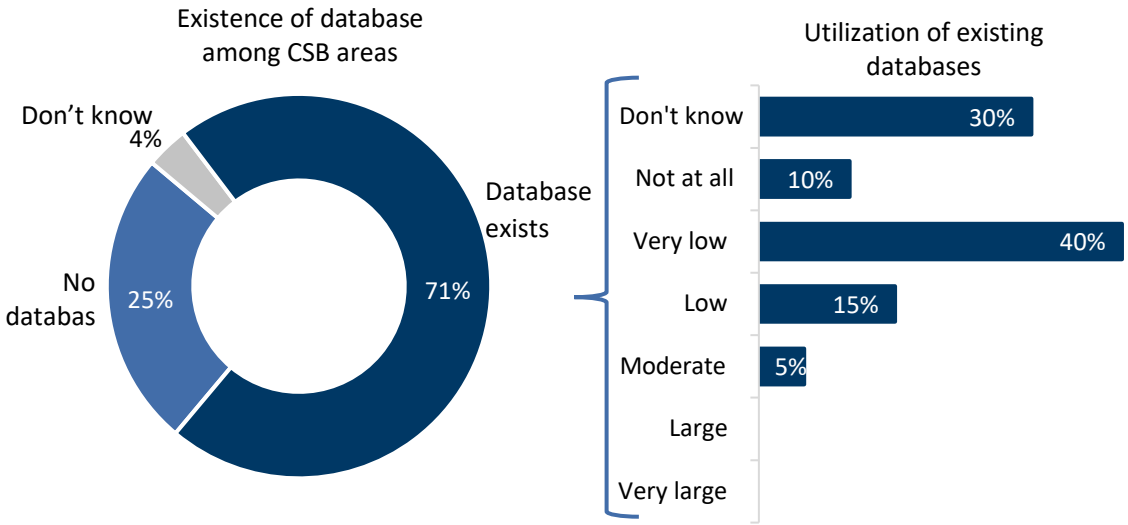
Housing the information outside of PSAPs brings compliance challenges despite offering advantages. These platforms allow agencies to fulfill the statutory database requirement and gather valuable emergency information without designing their own database from scratch. They also benefit individuals because profile information is linked to a phone number rather

than stored at a specific PSAP. If someone moves or travels out of town, RapidSOS and Smart911 will still work in their new location. However, § 9.1-193 specifies that "an individual shall be removed from the database when he reaches the age of 18, unless he or his guardian…requests that the individual remain in the database." Some PSAPs interpret this to mean that they have the responsibility to initiate the deletion of those profiles. PSAPs have no power to delete an individual's profile from RapidSOS or Smart911; the person who made the profile has to delete the information themselves. This creates concerns for some PSAPs that they may be unintentionally out of compliance with the law.

There is no data collection process related to the database component of the Marcus Alert system, limiting understanding of its effectiveness. About 30 percent of CSBs said on a BHC survey that they did not know how broadly the database was utilized in their coverage area (Figure 3-6). Of those who did know about their database's utilization, there was a low-to-very low level of utilization reported.

Currently, localities that implement Marcus Alert do not need to submit information about their database with their local plan submission. CSBs could develop plans for raising awareness about the databases in their coverage area, and this information could be submitted to DBHDS as part of the Marcus Alert planning process.

Figure 3-6
Database has not been implemented in all localities, and does not appear to be heavily utilized where it has been established



Source: BHC staff analysis of survey data from CSBs (response rate: 100 percent)
Note: Figure does not include 12 responses that did not provide sufficient data.

OPTION 5

The General Assembly may wish to amend § 9.1-193 to transfer responsibility for initiating profile deletion within the database from PSAPs to individuals.

RECOMMENDATION 5

DBHDS should update the Marcus Alert Local Plan Guide to include a section on plans for the database and for advertising it in the community.

Stronger processes are needed to assess effectiveness of the Marcus Alert system on an ongoing basis

DBHDS has developed processes to collect local data needed to measure certain aspects of Marcus Alert implementation, but they have been very burdensome for local entities and have not yet resulted in an analysis of the system's implementation or effectiveness in meeting its keys goals. Specific metrics have not been identified, the responsibility for evaluating system performance has not been explicitly placed upon any state agency, and there is little capacity among existing agency staff to take on extensive evaluation responsibilities. In addition, the current processes rely on the work of PSAP staff to manually enter their CAD data into Excel templates, which can be a time-consuming task.

No statewide measures exist to evaluate the effectiveness of Marcus Alert, and the body charged with evaluation does not meet

A significant challenge in evaluating the Marcus Alert system is the lack of clear and consistent statewide outcome measures and the absence of an entity assigned to evaluate it. Neither the Code nor the state plan provide clear measures for evaluating the extent to which the Marcus Alert system is meeting its three primary goals: 1) behavioral health response to behavioral health crises, 2) diversion to the behavioral health or developmental services systems, and 3) specialized response by law enforcement. Creating outcome measures would also enable the Black-led Crisis Coalition to review outcomes semiannually and provide feedback for the DBHDS annual report on Marcus Alert, as required in the state plan. To date, this has not occurred.

Many potential measures have already been identified and could serve as a useful starting point. *The Code of Virginia* lists seventeen goals of law enforcement participation, and the state plan lists thirty-three possible outcome measures recommended by stakeholder group participants but notes that the Marcus Alert Evaluation Task Force will need to assess the "feasibility and operationalization" of these measures. The Marcus Alert Evaluation Task Force includes DBHDS and DCJS technical and program leads, Office of Emergency Medical Services (OEMS), Virginia Department of Emergency Management (VDEM), crisis call center platform vendors, 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 state plan designates a Marcus Alert Evaluation Task Force to provide ongoing evaluation and recommendations based on rigorous analysis of data from multiple sectors and state agencies:

"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."

The task force has never met, although the state plan was finalized in 2021. This is partially attributable to the fact that no agency has been tasked with convening or staffing the task force. The lack of input from the task force may contribute to other challenges cited in this report, such as the technical difficulties faced by PSAPs. The state plan notes that, "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." Some of the problems that PSAPs have encountered with updates to CAD systems and dispatch protocols could be mitigated with the attention of an evaluation body tasked with keeping track of those challenges.

The Evaluation Task Force will become increasingly important after the 2028 implementation deadline, when focus will shift from implementation to system improvement. The Evaluation Task Force is charged with making recommendations for the improvement of the Marcus Alert system, and this responsibility will expand once the bulk of the implementation work is completed. State and local entities will need to evaluate the policies and strategies of the fully implemented system and determine what changes are needed to continue improving effectiveness. For example, the Evaluation Task Force may make data-informed recommendations related to Marcus Alert's role in the comprehensive crisis system, potential enforcement or incentive mechanisms for local agency participation, or a proposed funding level per CSB coverage area.

The Marcus Alert Evaluation Task Force could help address outdated components of the state plan, but there is no clear statutory authority as to who can make necessary revisions. Several areas of the crisis system have changed since the state plan was written. For example, 988 has been fully rolled out and follows federal rules related to third-party dispatch, and mobile crisis teams can now only be dispatched through VCC. The state plan may need updates to reflect the evolving nature of the crisis system as well as best practices that have emerged. DBHDS and DCJS could spearhead the updating process, but the lack of explicit authority has led to uncertainty among agency staff. Giving the agencies the ability to make necessary updates would allow Marcus Alert to grow alongside the crisis system and ensure that response options reflect best practices for behavioral health response.

DBHDS currently has one staff member working on Marcus Alert full-time, and the responsibilities already placed upon this position do not allow for additional work to be taken on. Coordination and planning of the task force, along with the collection and analysis of data elements recommended by the state plan, would likely require additional staffing. This position could also work with the current Marcus Alert coordinator to make evidence-based and data-driven recommendations to the General Assembly about future funding for the Marcus Alert system.

RECOMMENDATION 6

The General Assembly may wish to amend §37.2-311.1 to specify that DBHDS is the agency responsible for convening the Marcus Alert Evaluation Task Force and require that the Task Force be convened at least quarterly to design and implement an evaluation process as described in the state plan for Marcus Alert. To provide adequate staffing for this project, the General Assembly may wish to consider including in the Appropriation Act funding and one position for a Marcus Alert Evaluation Analyst at DBHDS.

OPTION 6

The General Assembly may wish to consider amending §37.2-311.1 to specify DBHDS and DCJS have authority to update the "written plan for the development of a Marcus Alert system," provided that stakeholders are afforded an opportunity to provide input before updates are finalized.

Data requirements are unnecessarily burdensome for PSAPs

PSAP personnel face a significant administrative burden to comply with the data reporting requirements of Marcus Alert, particularly after recent template changes that eliminated automated reporting for many systems. Prior to April 2025, most PSAPs used their CAD systems to automatically generate required reports for DBHDS, though some PSAPs were unable to generate those reports and manually reported call data. In April 2025, the reporting template was updated to include new data fields—such as CSB name and DBHDS region—that many existing CAD systems are not configured to track. Consequently, PSAPs with systems that cannot be easily modified to include these new fields must now manually convert their call data to the new template. This has introduced a time-consuming process that was previously automated for many localities. Some PSAPs reported having to use hours of staff time during overnight shifts to complete this manual conversion. This new, static information could be added to the automated data submitted by PSAPs on the back end, after the initial data is submitted. This approach would relieve PSAPs of the manual data entry requirement and place the task with the agency that is conducting the analysis.

RECOMMENDATION 7

DBHDS should revise data collection procedures to allow Public Safety Answering Points to submit Marcus Alert data through CAD system reports, and to minimize the administrative burden on PSAP staff.

Chapter 3: Effectiveness of the Marcus Alert system

Recommendations and options: Implementation and effectiveness of the Marcus Alert system

BHC staff typically offer recommendations or options to address findings identified in its reports. Staff will usually propose options, rather than recommendations, when (i) the action proposed is a policy judgment best made by the General Assembly or other elected officials; (ii) the evidence indicates that addressing a report finding could be beneficial but the impact may not be significant; or (iii) there are multiple ways to address a finding, and there is insufficient evidence to determine the single best way to address the finding.

Recommendations

RECOMMENDATION 1

DBHDS should amend the Marcus Alert Local Plan Guide to strongly encourage CSBs to hire a local Marcus Alert coordinator with implementation funds if they do not already employ staff in this role.

RECOMMENDATION 2

The General Assembly may wish to consider amending § 9.1-193 (H) to change the Code reference from "clause (iv) of subdivision B 2 of § 37.2-311.1", to "clause (vi) of subdivision B 2 of § 37.2-311.1."

RECOMMENDATION 3

DBHDS and DCJS should complete "train the trainer" sessions for the Advanced Marcus Alert training no later than December 31, 2025. DBHDS and DCJS should ensure that Advanced Marcus Alert training is made available to staff at CSBs, PSAPs, and law enforcement agencies no later than April 1, 2026.

RECOMMENDATION 4

The General Assembly may wish to consider including funding in the 2026 Appropriation Act for the remaining thirteen CSBs that have not yet begun their Marcus Alert planning process.

RECOMMENDATION 5

DBHDS should update the Marcus Alert Local Plan Guide to include a section on plans for the database and for advertising it in the community.

RECOMMENDATION 6

The General Assembly may wish to amend §37.2-311.1 to specify that DBHDS is the agency responsible for convening the Marcus Alert Evaluation Task Force and require that the Task Force be convened at least quarterly to design and implement an evaluation process as described in the state plan for Marcus Alert. To provide adequate staffing for this project, the General Assembly may wish to consider including in the Appropriation Act funding and one position for a Marcus Alert Evaluation Analyst at DBHDS.

RECOMMENDATION 7

DBHDS should revise data collection procedures to allow Public Safety Answering Points to submit Marcus Alert data through CAD system reports, and to minimize the administrative burden on PSAP staff.

Options

OPTION 1

The General Assembly may wish to consider amending the budget language related to Marcus Alert implementation to remove the fixed $600,000 allocation per CSB, grant DBHDS discretion to distribute available Marcus Alert funds based on the needs of each community, and stipulate that funding must be provided to PSAPs for necessary system updates, training, and related expenses.

OPTION 2

The General Assembly may wish to amend § 15.2-1726 to include co-response teams with jurisdiction in multiple localities as an acceptable reciprocal agreement between law enforcement agencies.

OPTION 3

The General Assembly may wish to consider funding and directing DBHDS to establish two pilot programs available to localities that have implemented the Marcus Alert system. The purpose of these respective pilots would be: (1) developing or expanding the capacity of CSB behavioral health-only teams that can be dispatched by PSAPs; and (2) embedding regional mobile crisis dispatchers and optionally, clinicians, in PSAPs.

Priority could be given to localities that do not currently have access to a community care team. DBHDS should develop performance measures (including the percentage of Level 3 calls receiving a behavioral health response) for both pilot models and include a performance evaluation for each model in the yearly report on Marcus Alert and the Comprehensive Crisis System.

OPTION 4

The General Assembly may wish to consider including in the 2026 Appropriation Act one additional FTE and funding to support hiring one Co-response Coordinator at DCJS.

OPTION 5

The General Assembly may wish to amend § 9.1-193 to transfer responsibility for initiating profile deletion within the database from PSAPs to individuals.

OPTION 6

The General Assembly may wish to consider amending §37.2-311.1 to specify DBHDS and DCJS have authority to update the "written plan for the development of a Marcus Alert system," provided that stakeholders are afforded an opportunity to provide input before updates are finalized.

Appendix A: Research activities and methods

Key research activities performed by BHC staff for this study included:

- structured interviews with CSB staff, PSAP staff, and law enforcement;
- site visits to CSBs;
- a survey of CSBs;
- a survey of people with lived experience of mental illness;
- review of state and national research literature;
- review of state law and policies relevant to Marcus Alert;
- analysis of all local Marcus Alert plans submitted to DBHDS;
- analysis of data on 988 calls, 911 calls and dispositions, arrests, and use of force incidents.

Structured interviews

Structured interviews were a key research method for this report. Interviewees were asked about topics such as their experience with Marcus Alert implementation, the successes and challenges of implementing various protocols, operations of co-response teams in their area, funding structure and needs related to Marcus Alert, and recommendations for improving system effectiveness. Key interviewees included:

- CSB staff
- PSAP staff
- Law enforcement
- Staff of DBHDS and DCJS
- Regional Marcus Alert coordinators

Site visits to CSBs

BHC staff conducted in-person site visits to four CSBs, which included meetings with CSB staff, law enforcement officers, and on two occasions, PSAP staff. Localities were selected to offer variation in geography and population density with an emphasis on visiting CSBs in the first Marcus Alert implementing cohort (December 2021). The purpose of the visits was to learn about experiences with Marcus Alert implementation and hear staff perspectives on regional crisis response needs. Visits were conducted at the following CSBs:

- Highlands Community Services (Abingdon, VA)
- Mount Rogers CSB (Wytheville, VA)
- Prince William County CSB (Woodbridge, VA)
- Virginia Beach CSB (Virginia Beach, VA)

Surveys

Two surveys were conducted for this study: (1) a survey of CSBs, and (2) a survey of people with lived experience of mental illness.

Survey of CSBs

BHC staff administered an electronic survey sent to all Virginis CSBs in June 2025. The purpose of the survey was to collect information about the experiences of CSBs that had already implemented Marcus Alert, and the readiness of CSBs that had not yet implemented. The survey asked CSBs about Marcus Alert implementation status, barriers to implementation, mobile crisis teams, community care teams, staffing, and database utilization. 40 of 40 CSBs that were invited to participate in the survey submitted a completed response, which equates to a 100 percent response rate.

Survey of people with lived experience of mental illness

BHC staff administered an electronic survey sent to people who had registered to be a resource on the BHC website and had indicated that they had personal experience with topics relevant to this study. To be eligible to complete the survey, respondents had to have lived in Virginia in the past five years. The purpose of the survey was to collect information on individuals' experiences with the crisis system and co-response teams. The survey asked questions about experiences with the crisis system and the civil commitment system, experiences with 988, and experiences with co-response teams. The survey was distributed to 22 people, and seven responses were received, which equates to a 32 percent response rate.

Appendix B: CSBs and localities that implemented the Marcus Alert system

Community Services Board (CSB)	Date implemented	Localities
Encompass Community Services (formerly Rappahannock-Rapidan)	12/1/2021	Culpeper County Fauquier County Madison County Orange County Rappahannock County
Highlands Community Services	12/1/2021	Washington County Bristol
Prince William Community Services	12/1/2021	Prince William County Manassas City Manassas Park
Richmond Behavioral Health Authority	12/1/2021	Richmond
Virginia Beach Community Services	12/1/2021	Virginia Beach
Blue Ridge Behavioral Health	7/1/2023	Botetourt County Craig County Roanoke City Roanoke County Salem
Chesterfield Community Services Board	7/1/2023	Chesterfield County
Fairfax-Falls Church Community Services Board	7/1/2023	Fairfax County Fairfax City Falls Church
Hampton-Newport News Community Services Board	7/1/2023	Hampton Newport News

Community Services Board (CSB)	Date implemented	Localities
Rappahannock Area Community Services Board	7/1/2023	Fredericksburg Spotsylvania County Stafford County Caroline County King George County
Arlington Community Services Board	7/1/2024	Arlington County
Alexandria Community Services Board	7/1/2024	Alexandria
Henrico Area Mental Health & Developmental Services	7/1/2024	Charles City County* Henrico County New Kent County
Horizon Behavioral Health	7/1/2024	Amherst County Appomattox County Bedford Campbell County Lynchburg
Loudoun Community Services Board	7/1/2024	Loudoun County
New River Valley Community Services Board	7/1/2024	Giles County Floyd County Montgomery County Pulaski County Radford
Western Tidewater Community Services Board	7/1/2024	Suffolk Southampton County Franklin Isle of Wight County

*Information on implementation was unavailable

Appendix C: Glossary

988- designated number to access mental health crisis services through a regional call center

CAD- Computer automated dispatch system used by PSAPs to dispatch responses to 911 calls

CAHOOTS-style team- Community care team that has a behavioral health provider and emergency medical services staff or a paramedic. Acronym stands for "Crisis Assistance Helping out on the Streets" and is based on a model from Eugene, Oregon.

CIT- Crisis Intervention Team

Community care teams- locally based teams that include at least one behavioral health service provider and are designed to address gaps in the crisis continuum. They include co-response teams, CAHOOTS-style teams, 911-dispatched behavioral health-only teams, and pre-crisis and post-crisis outreach teams.

Community coverage- the existence of sufficient response options and availability for each of the Marcus Alert levels

Co-response team- a community care team consisting of a behavioral health provider and a law enforcement officer

Database- § 9.1-193 requires that localities create a database for people with mental illness or developmental disability and their families to voluntarily add their health information to be made available to 911 dispatchers

DBHDS- Department of Behavioral Health and Developmental Services

DCJS- Department of Criminal Justice Services

DPB- Department of Planning and Budget

"Exempt" localities- Localities with a population of 40,000 or fewer as of the 2020 census. These localities may opt out of Protocol 2 and Protocol 3, but not Protocol 1 or the database

LE- law enforcement

LEO- law enforcement officer

LEA- law enforcement agency

Level 1- calls featuring distressed callers with no homicidal thoughts or plans for suicide who are suitable for intervention over the phone. The state plan requires 911 to transfer Level 1 calls to 988

Level 2- calls including situations where clinical intervention might be necessary, such as someone engaging in minor self-injurious behavior or dependence on substances

Level 3- calls involving an increased level of risk, such as active aggression, homicidal thoughts, or psychosis, but without direct and immediate threat to life

Level 4- that are emergency situations that require immediate dispatch of first responders, such as a suicide attempt in progress

Local plan- Plan detailing the Marcus Alert system (all protocols, including community coverage) for the localities in a CSB coverage area

Marcus Alert- defined in §37.2-311.1 as "a set of protocols to (i) initiate a behavioral health response to a behavioral health crisis, including for individuals experiencing a behavioral health crisis secondary to mental illness, substance abuse, developmental disabilities, or any combination thereof; (ii) divert such individuals to the behavioral health or developmental services system whenever feasible; and (iii) facilitate a specialized response in accordance with § 9.1-193 when diversion is not feasible."

MHFA- Mental Health First Aid

Protocol 1- 911-988 interoperability, triage framework, and community coverage. Required of all localities in Virginia.

Protocol 2- MOUs between law enforcement and mobile crisis. Required of localities with a population greater than 40,000

Protocol 3- Training requirements and departmental policies for law enforcement. Required of localities with a population greater than 40,000

PSAP- Public Safety Answering Point. A 911 call center/ emergency communications center

REACH team- a mobile response team offering crisis stabilization and prevention for individuals with an intellectual or developmental disability

State Plan- the *State Plan for the Implementation of the Marcus David Peters Act*, written by a group of 45 stakeholders to develop the Marcus Alert protocols defined in statute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