BHC Behavioral Health Commission

Commission meeting

September 9, 2025

Briefing

In this presentation

- Implementation and effectiveness of the Marcus Alert System

Implementation and effectiveness of the Marcus Alert system

Claire Mairead, BHC Policy Analyst

In this presentation

Background

Implementation status

System effectiveness

Takeaways

Study request

- BHC members directed staff to study the implementation and effectiveness of the Marcus Alert system
  - Review status of implementation
  - Analyze early impacts on diversion
  - Examine barriers to adoption
  - Provide options and recommendations to maximize effectiveness and utilization

Research activities

- Interviews with officers of 7 law enforcement agencies and staff with 6 CSBs[1], 4 Marcus Alert regional coordinators, DBHDS[1], DCJS[1], 7 PSAPs[1], and VACSB[1]
- Site visits to 4 CSBs
- Surveys of CSB Marcus Alert coordinators[2] and people with lived experience
- Analysis of data on 911 calls, 988 calls, Marcus Alert local budgets, use of force incidents, and arrests
- Review of the Marcus Alert state plan and all local plans (17), the Appropriation Act, and the research literature

[1]CSB: Community Services Board; DBHDS: Department of Behavioral Health and Developmental Services; DCJS: Department of Criminal Justice Services; PSAP: Public Safety Answering Point; VACSB: Virginia Association of Community Services Boards
[2]40 out of 40 CSBs responded to the survey; Survey was completed by Marcus Alert coordinators or the person most knowledgeable about Marcus Alert system

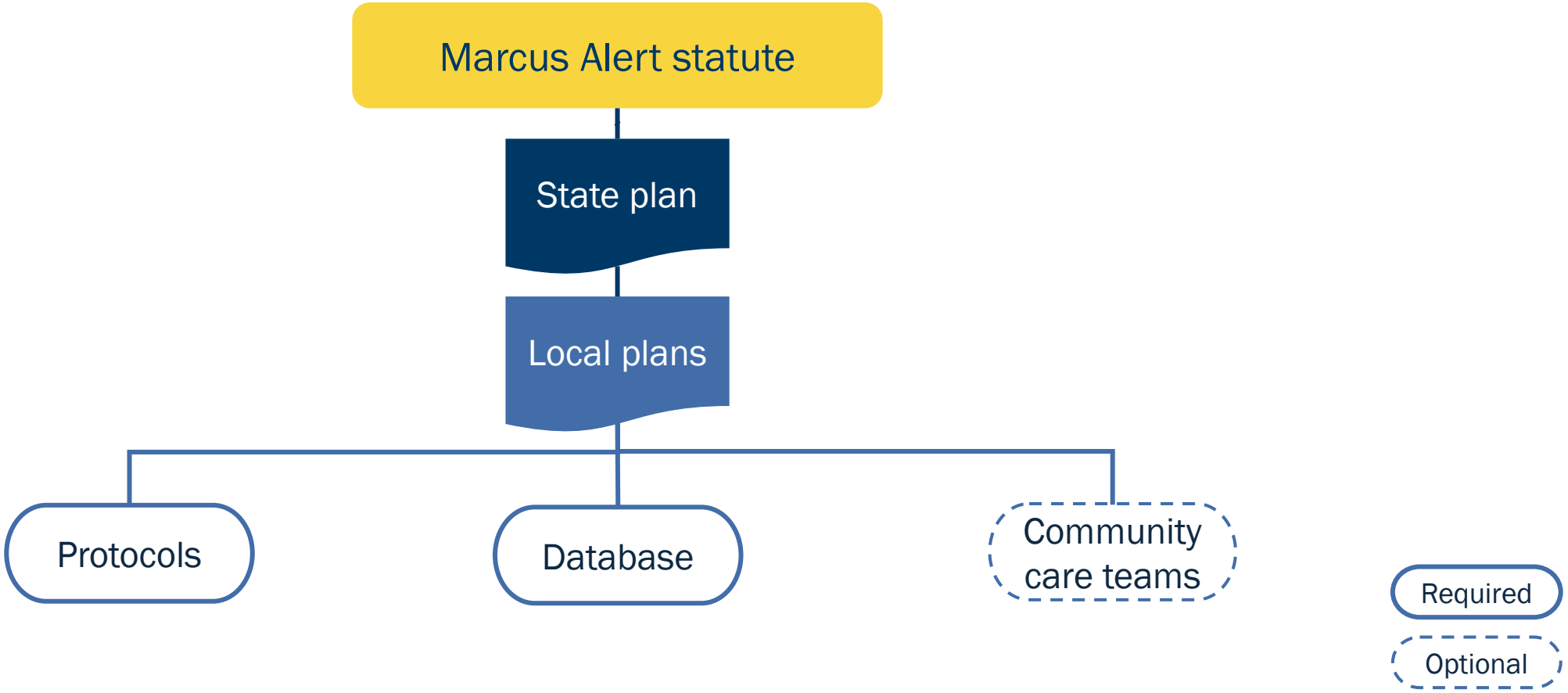
In brief

- One-third of Virginia localities have implemented Marcus Alert, and the rest can likely implement by 2028 with support from the legislature and state agencies
- Funding distribution should reflect the varied needs of CSBs and local agencies
- Majority of behavioral health calls to 911 still receive a law enforcement response, but the rate of behavioral health responses is increasing
- A better process is needed for ongoing evaluation of Marcus Alert's effectiveness

Marcus Alert system aims to provide behavioral health responses to behavioral health crises

- Marcus-David Peters Act passed during the 2020 legislative session
  - Created Marcus Alert system and the comprehensive crisis system
- State plan developed in 2021 to specify requirements and responsibilities of state and local entities
- Operationalized locally through partnership between CSBs, Public Safety Answering Points (PSAPs), and law enforcement agencies

Marcus Alert state plan operationalizes statute and guides local implementation



Protocols shape key components of Marcus Alert

	Key components	Required for
Protocol 1	▪ 911-988 interoperability ▪ Triage framework ▪ Community coverage (response options)	All localities
Protocol 2	▪ MOUs between law enforcement and mobile crisis	Localities > 40K residents
Protocol 3	▪ Training requirements for law enforcement (some CIT[1] trained, all MHFA trained[1]) ▪ Departmental policies on use of force, officer wellness, etc.	Localities > 40K residents

[1]CIT=Crisis Intervention Team; MHFA=Mental Health First Aid

Some exempt localities have voluntarily implemented protocols 2 or 3

	% of localities implementing		
	Non-exempt localities (>40K residents)	Exempt localities (≤ 40K residents)	All localities
Protocol 1	100%	96%	98%
Protocol 2	92%	50%	71%
Protocol 3	100%	38%	67%

Required

Source: BHC staff analysis of local Marcus Alert plans submitted to DBHDS and survey data from CSBs (response rate: 100 percent)

Interoperability is crucial for transfers between 911 and 988

- Requires procedures and agreements for transferring calls between 911 & 988
  - 911 is the designated number to access emergency services through PSAP[1]
  - 988 is the designated number to access mental health crisis services through a regional call center
- May include a formal agreement between a PSAP and the regional 988 call center
- Requires changes to PSAP dispatch systems and protocols, and training for dispatchers

[1]PSAP= Public Safety Answering Point

Triage framework helps assign urgency levels to calls to 911 and 988

Level 1
Routine

Mobile crisis

- Behavioral health intervention by phone/referral
- No homicidal thoughts, intent, behavior
- Suicidal, no plans or means

911 must transfer to 988

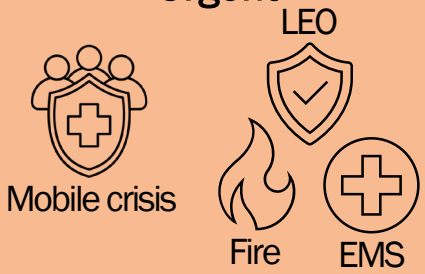
Level 2
Moderate

Mobile crisis

- Imminent need for in-person behavioral health
- No homicidal thoughts, intent, behavior
- Suicidal, no plans or access to weapon
- Minor self injury

911 should transfer to 988

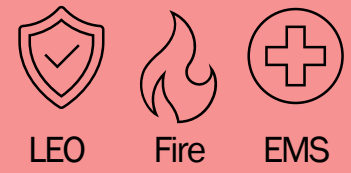
Level 3
Urgent



- Florid psychosis
- Homicidal thoughts, no active intent/behavior
- Active cutting
- Active aggression
- Suicidal thoughts, with plans & access to weapon
- ECO, if available & requested by LEA

No guidance on transfers

Level 4
Emergent



- Direct & immediate threat to life
- Active suicide attempt
- Active assault on others w/ potential harm
- Any gun accessible
- ECO with immediate security threat

988 must transfer to 911

Optional community care teams provide behavioral health responses for calls made to 911

Types of community care teams	Description
▪ Co-response with law enforcement	Law enforcement + behavioral health provider
▪ CAHOOTS-style	EMS or fire + behavioral health provider
▪ CSB behavioral health-only teams	Behavioral health provider + behavioral health provider/peer
▪ *Pre-crisis and post-crisis outreach teams*	*Provide outreach and connection to services, but do not respond to crisis calls*

Database required for localities by statute, but voluntary for individuals

- § 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
- All localities had to have a database by July 1, 2023

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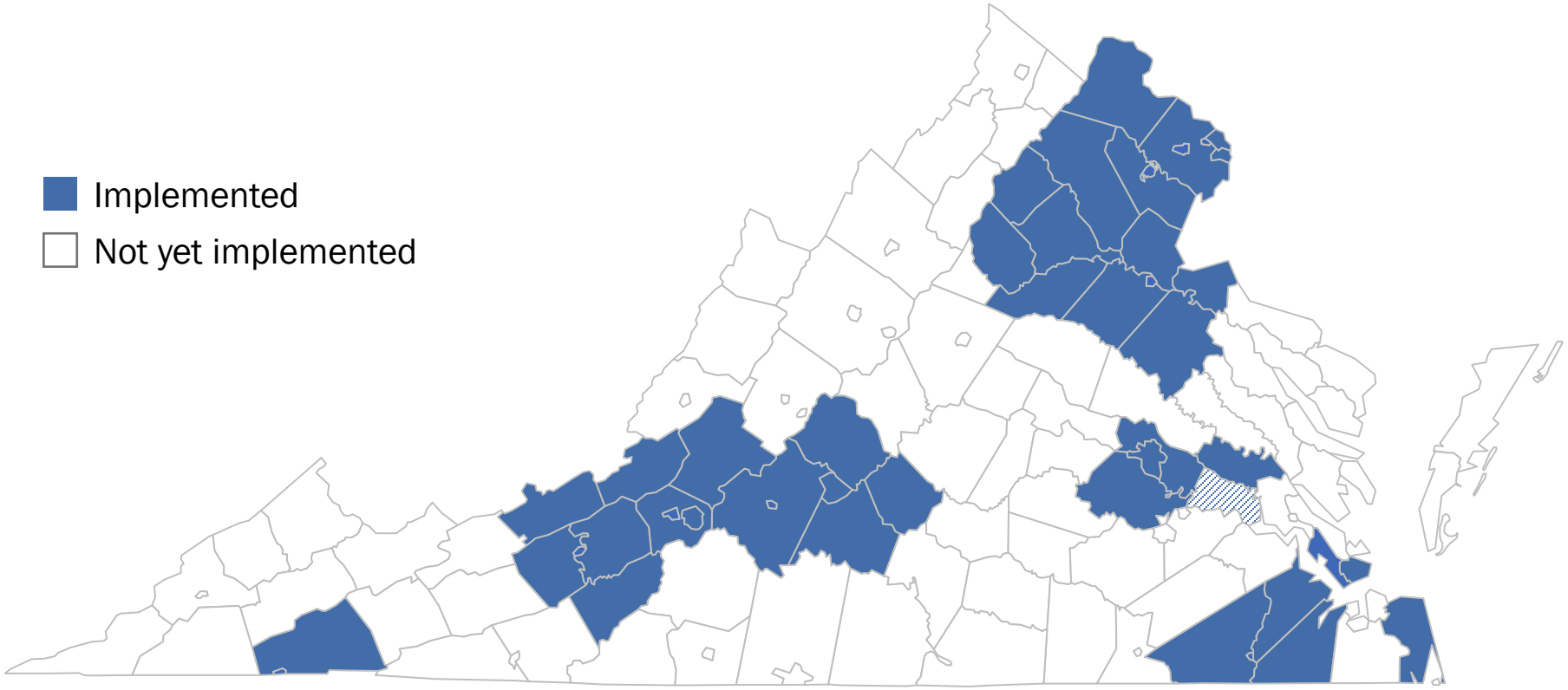
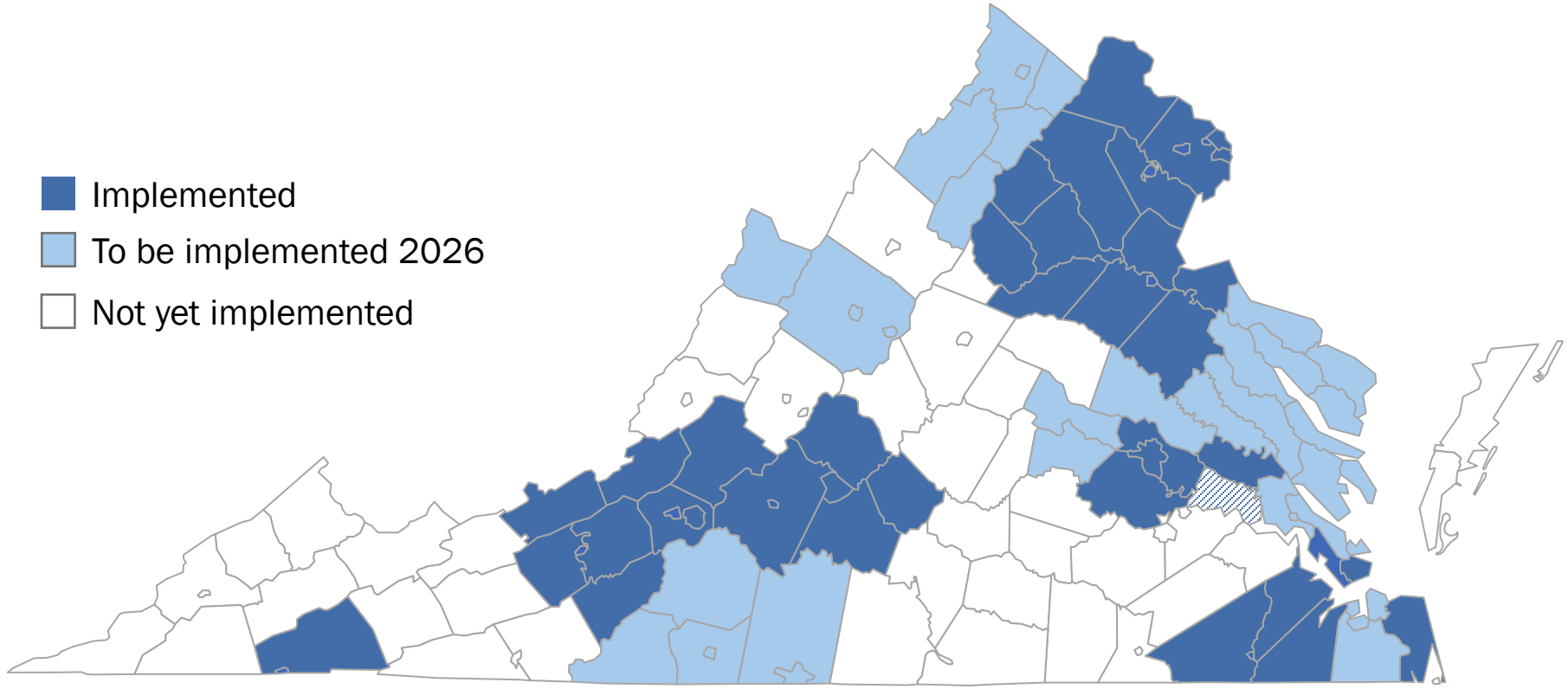
One third of Virginia localities (48) have officially implemented Marcus Alert, covering two thirds of the state's population



Note: Charles City County is in a CSB coverage area that has implemented Marcus Alert, but there is insufficient information to determine whether implementation has occurred in this locality.

36 additional localities are planning to implement Marcus Alert in 2026



Note: Charles City County is in a CSB coverage area that has implemented Marcus Alert, but there is insufficient information to determine whether implementation has occurred in this locality.

General Assembly has appropriated $42M for Marcus Alert, mostly distributed to CSBs

- The General Assembly has appropriated $42M since 2021
  - Mostly funding for local Marcus Alert systems, distributed to CSBs
  - Also funds positions at DBHDS and DCJS
- Each CSB area receives $600,000 per year, starting the year before implementation to support
- CSBs distribute funding based on stakeholder group recommendations

Finding

- Current funding structure of $600,000 annually per CSB is not aligned with need

Cost of Marcus Alert implementation varies based on creation of community care teams and need

- Community care teams are the most costly aspect of Marcus Alert implementation, but they are optional
- CSBs that do not create a community care team may not require $600,000, and those that do may need more
- Cost of PSAP modifications, equipment, and personnel also varies based on local plans

Majority of localities have yet to implement Marcus Alert, and most are small localities that may not create community care teams

- All Virginia localities are required to complete their Marcus Alert implementation by July 1, 2028
- 85 (65% of) VA localities remain to be implemented
  - 21 (25%) must implement all protocols and the database
  - 64 (75%) are exempt because they are small (≤ 40,000 residents); required to implement only Protocol 1 and a database

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

Finding

- Statewide implementation of Marcus Alert can be achieved by 2028 but will require funding, agency flexibility, and communication between state and local entities

CSBs and local agencies need support to plan Marcus Alert system

- 38% of unimplemented CSBs report feeling unprepared, citing concerns with staffing and interagency coordination
- Full state funding in FY27 will support planning process and 2028 rollout
- DBHDS should lead contingency planning and communicate plans to CSBs
- General Assembly could continue to fund Marcus Alert system at current level while adding allocation flexibility until all communities have implemented
  - Re-evaluate in 2028

Recommendation 4

- The General Assembly may wish to consider including funding in the 2026 Appropriation Act for the remaining 13 CSBs that have not yet begun their Marcus Alert planning process

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”

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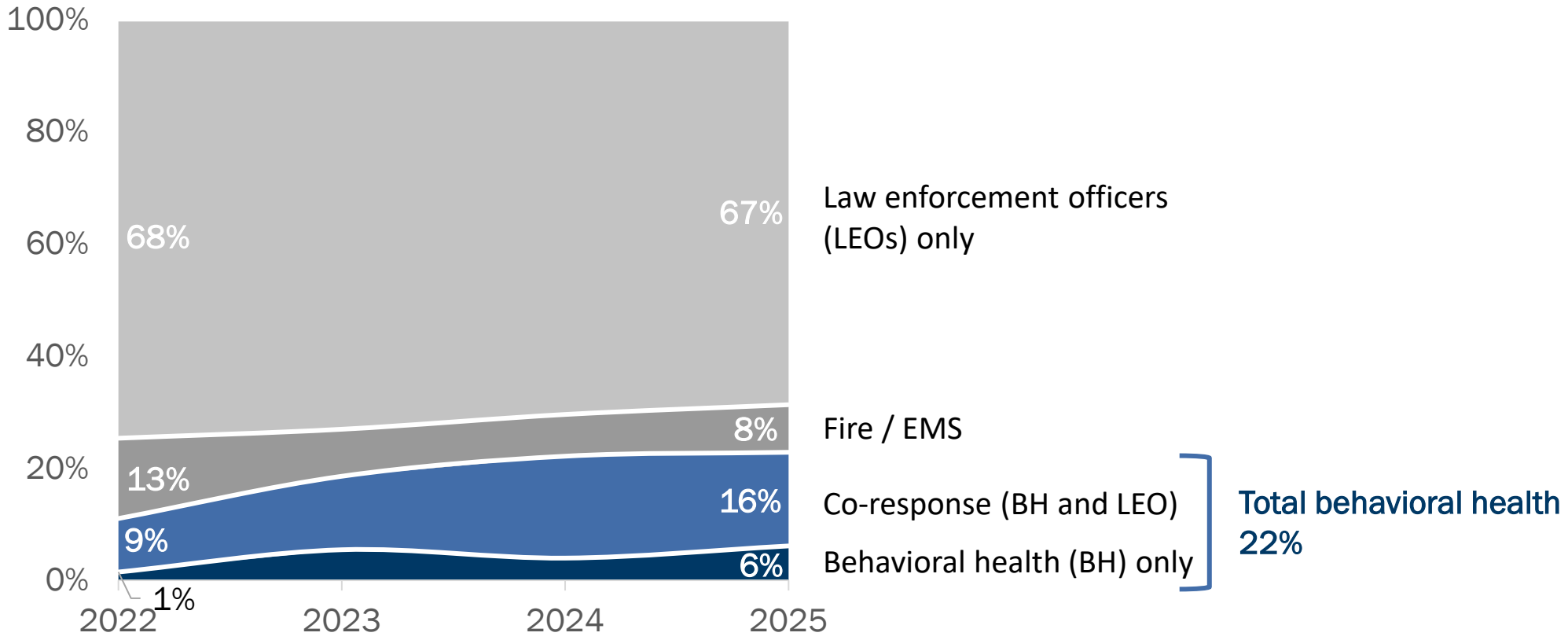
Marcus Alert guides 911 calls toward a behavioral health response

- A large number of mental health calls still come through 911
  - ~43,000 through 911 in implemented localities in 2024 compared to ~165,000 through 988 statewide in 2024
- Behavioral health responses to a 911 call could include:
  - Transfer to 988; or
  - Community care team (including co-response)

Findings

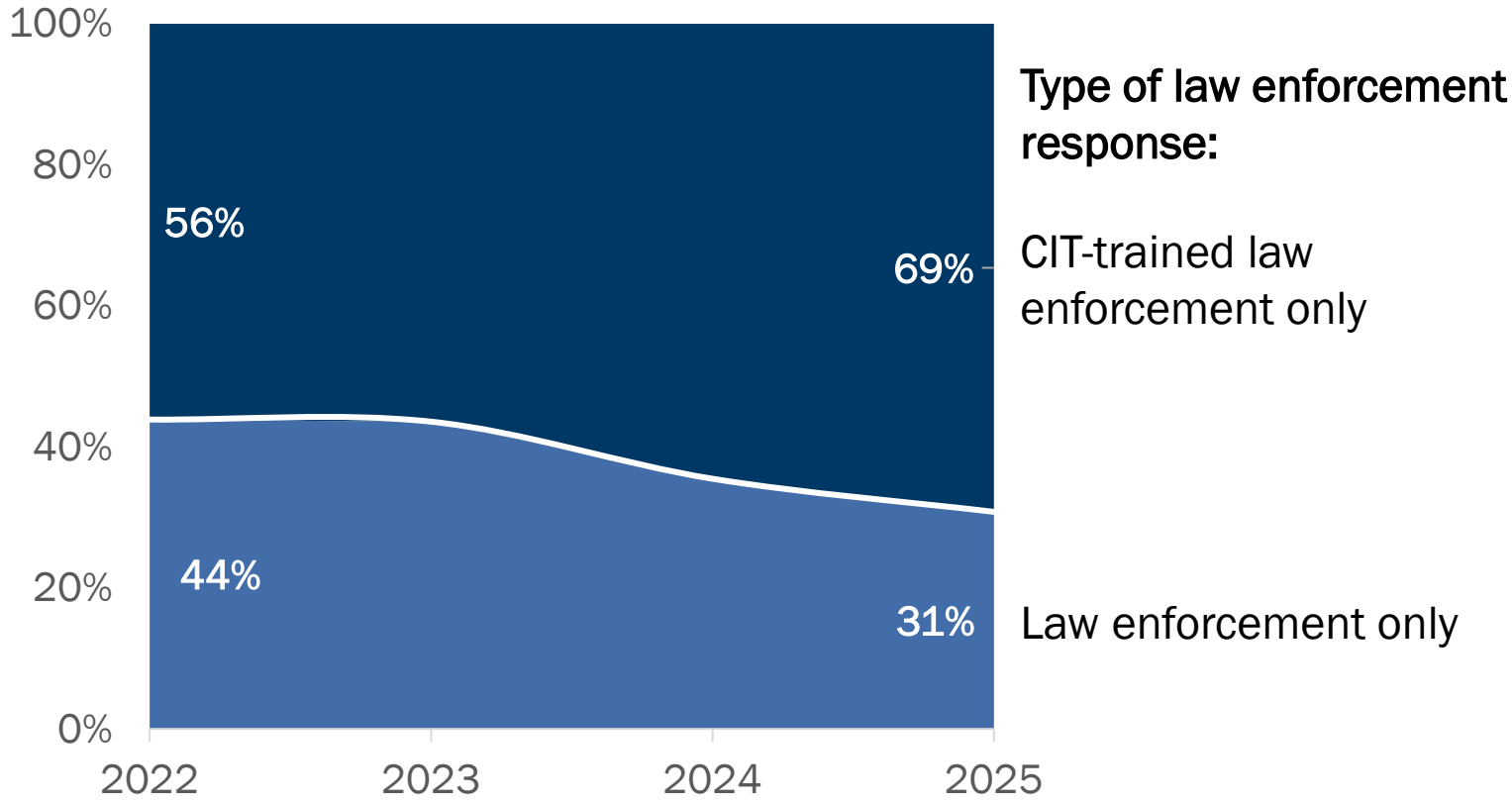
- Majority of calls to 911 do not receive a behavioral health response, but some positive trends have emerged. Since 2022,
  - the rate of behavioral health responses has doubled
  - there has been an increase in the rate of law enforcement responses that include a CIT-trained officer

Only 22% of Marcus Alert calls to 911 receive a behavioral health response, but that rate has doubled since 2022



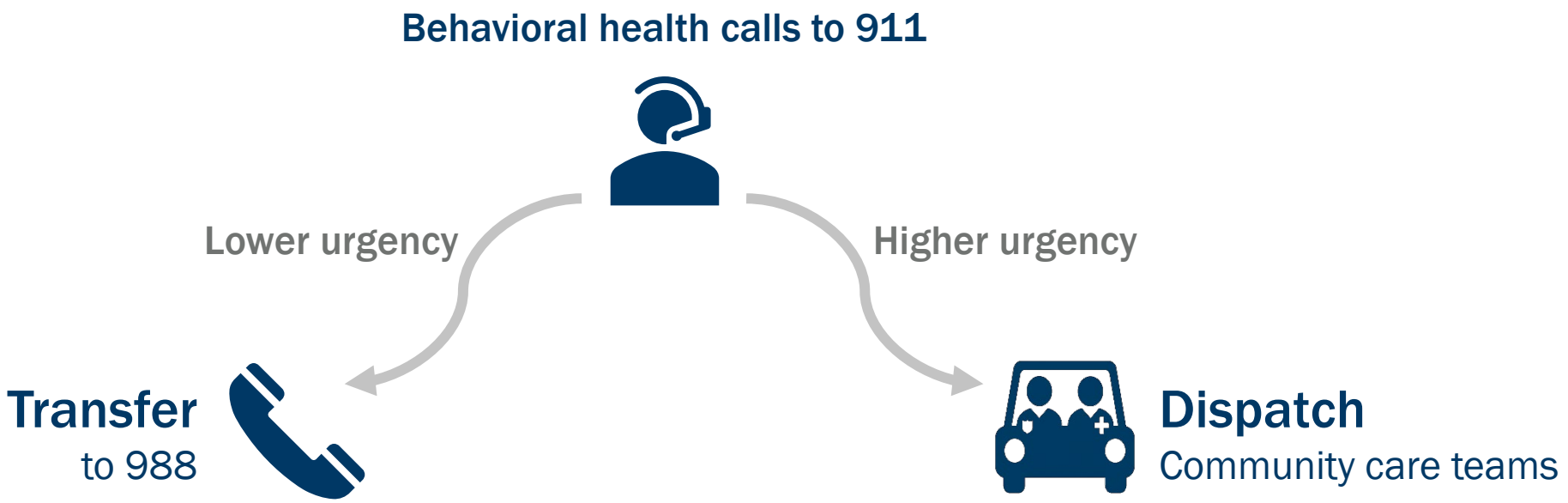
Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert (2022-2025)
Note: Figure does not include "other" types of responses (2022: 9%, 2025: 3% in 2025).

Law enforcement responses are shifting to more CIT officers



Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert (2022-2025)

Marcus Alert system provides two pathways for 911 calls to receive a behavioral health response



Source: BHC staff analysis of the State Plan for the Implementation of the Marcus David Peters Act

Finding

- Lower urgency calls are rarely transferred to 988

Only 6% of Level 1 and Level 2 calls are transferred from 911 to 988

	Transfers to 988		
	2022	2023	2024
Level 1	7%	6%	7%
Level 2	2%	1%	1%
Overall	**5%**	**5%**	**6%**

Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert (2022-2024)

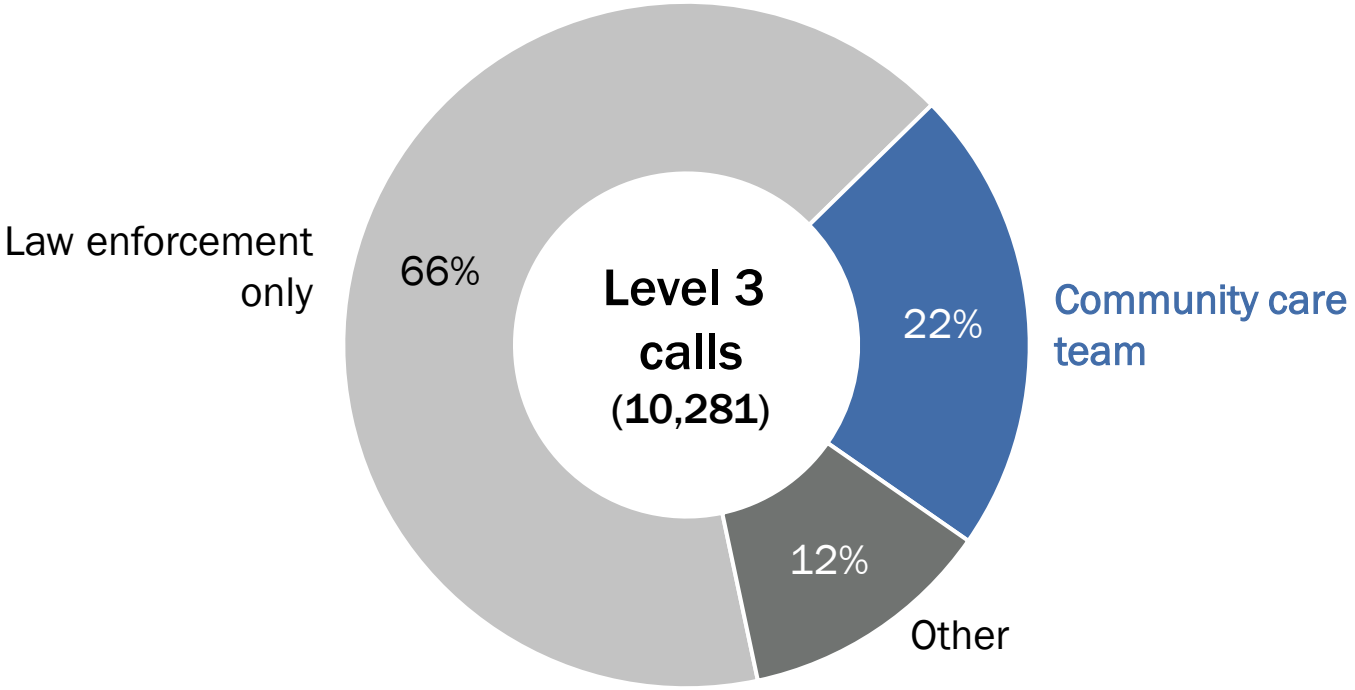
Several factors contribute to low 988 transfer rate

- Many calls are from family members and neighbors rather than the person in crisis
- Some people do not want to be transferred to 988
- 911 dispatchers feel a sense of responsibility and do not always fully trust 988
- Some PSAPs lack appropriate technology and funding

Finding

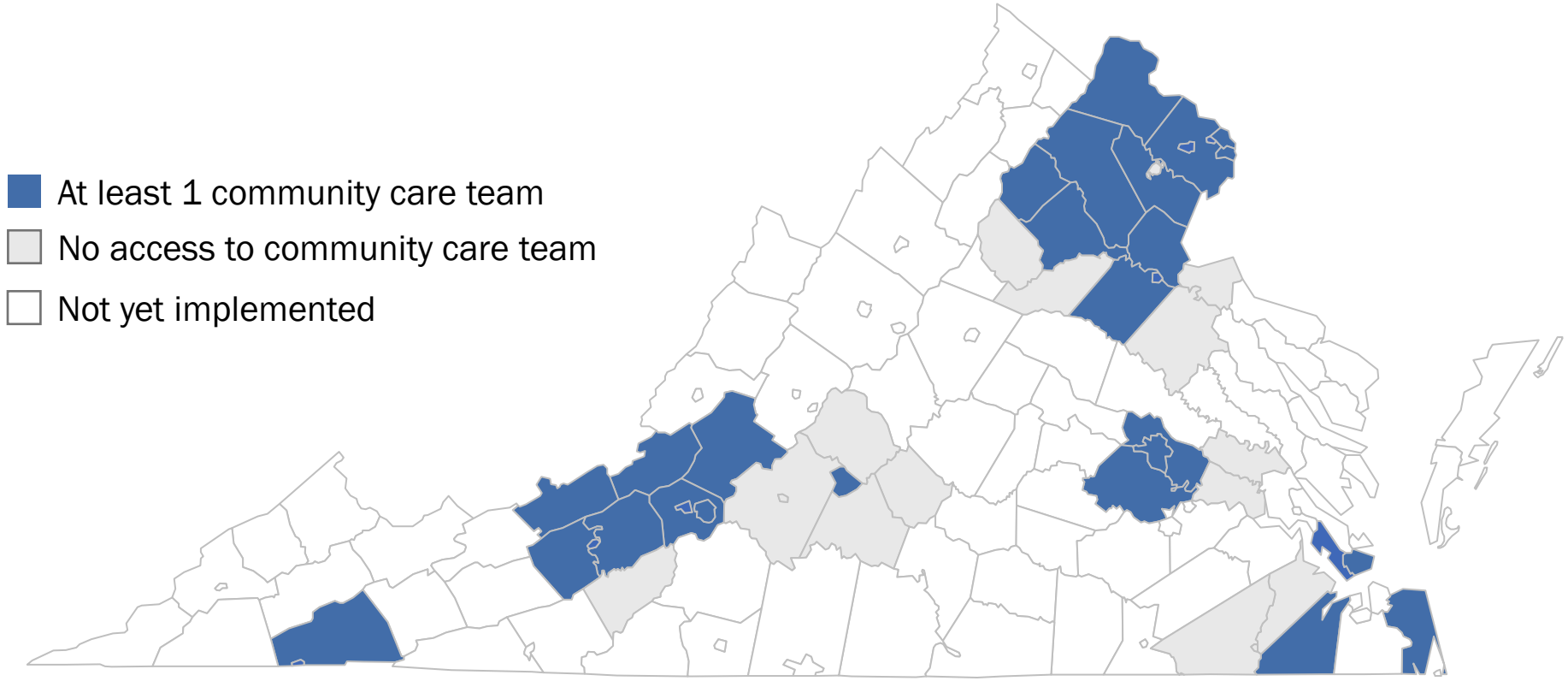
- Higher urgency calls often do not get community care team response

22% of Level 3 calls to 911 received a community care team response in 2024



Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert (2022-2025)
Note: “Other” includes Fire/EMS dispatch, no transfer or dispatch, and “not specified”.

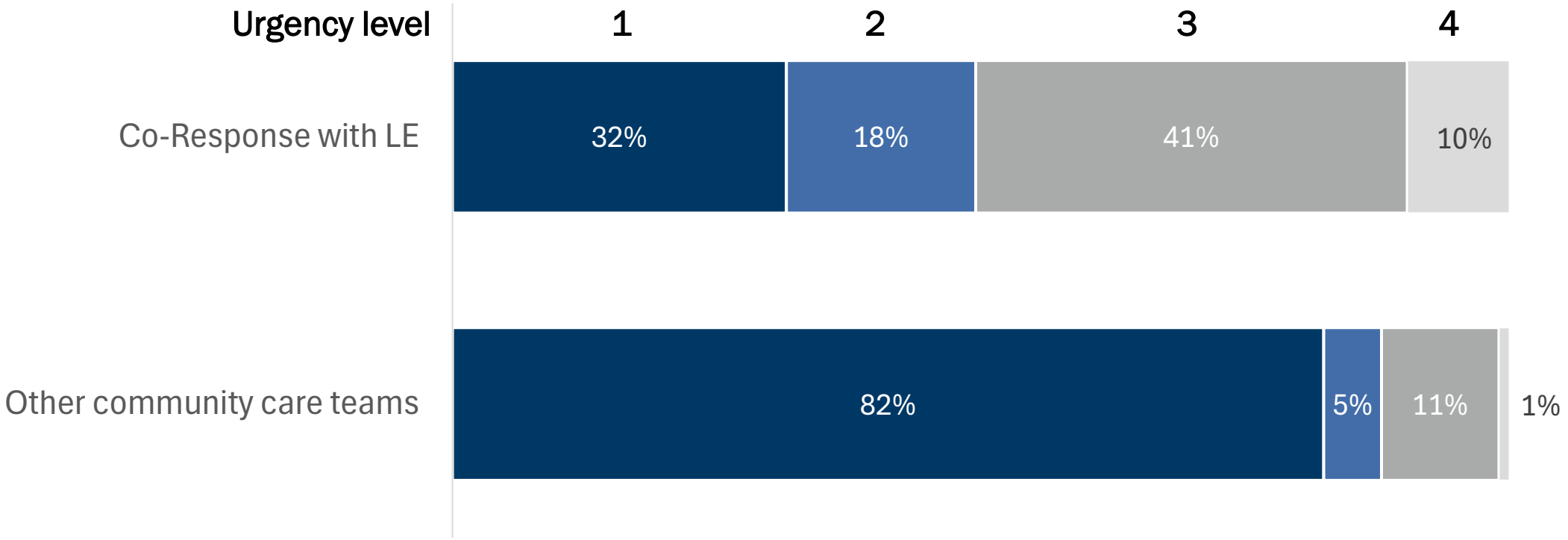
67% of implemented Marcus Alert localities have a community care team that responds to 911 calls



Findings

- Response capacity of community care teams available to 911 is insufficient
  - Existing capacity of co-response teams being used for lower-urgency calls
  - Not scalable with current single-jurisdiction model for co-response
  - Regional mobile crisis teams typically not available for 911 calls

Co-response teams are often used for lower-urgency calls, reducing capacity for Level 3 and Level 4 calls



Source: BHC staff analysis of DBHDS data collected from PSAPs in localities that have implemented Marcus Alert (2024)
Note: Percentages may not total 100% due to rounding.

Few alternatives to co-response teams exist for low-urgency calls to 911

- 911-dispatched behavioral health teams are needed to respond to Level 1 and Level 2 calls that cannot be transferred to 988
- In many Marcus Alert localities, the only option for a 911-dispatched behavioral health response is a co-response team (or there is none at all)
- State plan envisioned using regional mobile crisis teams, but currently reserved for 988 calls
- Increasing the options for behavioral health-only teams dispatched by 911 would free up co-response capacity to respond to more Level 3 and Level 4 calls

Option 3

- The General Assembly may wish to consider funding and directing DBHDS to establish two pilot programs available to localities that have implemented Marcus Alert. 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

Creating co-response teams that cover multiple jurisdictions could help increase coverage, but are uncommon in Virginia

- Not feasible or efficient to create 133 co-response teams for 133 localities
- At least 5 multi-jurisdictional teams exist today
  - Washington County and Bristol
  - Montgomery County, Christiansburg, and Blacksburg
  - Roanoke Valley
  - Fauquier County and Warrenton
  - Harrisonburg and Rockingham County (not Marcus Alert implemented)
- Lack of statutory clarity may contribute to liability concerns over creating multi-jurisdictional teams

Option 2

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

Finding

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

Co-response teams are well regarded but best practices are unknown

- Co-response teams are regarded positively by many stakeholders and have support in both behavioral health and law enforcement communities
- Wide variety among teams and response styles
- No state agency is tracking or actively supporting co-response teams, or compiling and sharing best practices
- As more localities implement Marcus Alert in the next 2 years, there will likely be many new co-response teams that could benefit from guidance

Option 4

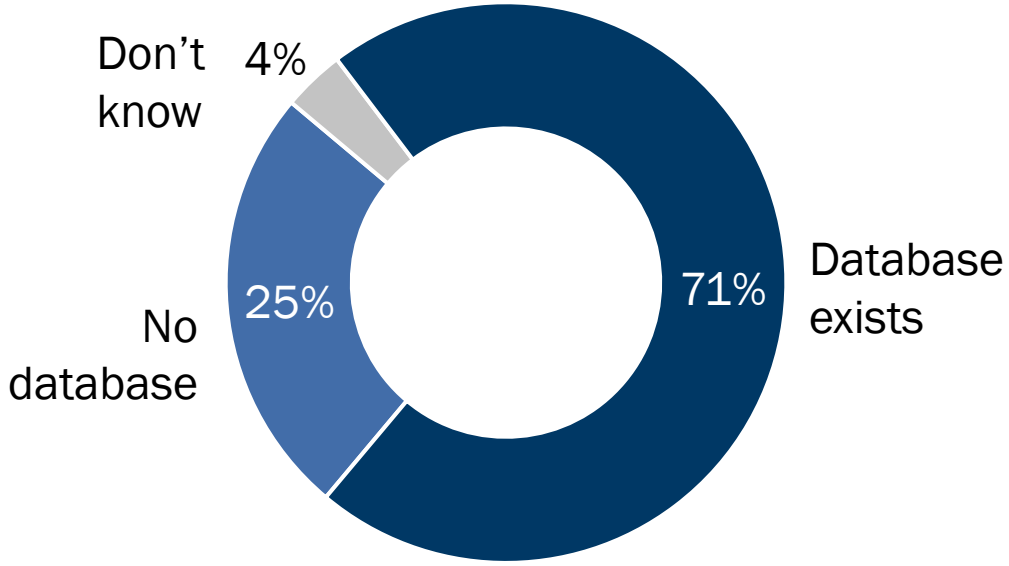
- The General Assembly may wish to consider including in the 2026 Appropriation Act one additional FTE and funding to support hiring one Co-response Coordinator at the Department of Criminal Justice Services (DCJS)

Finding

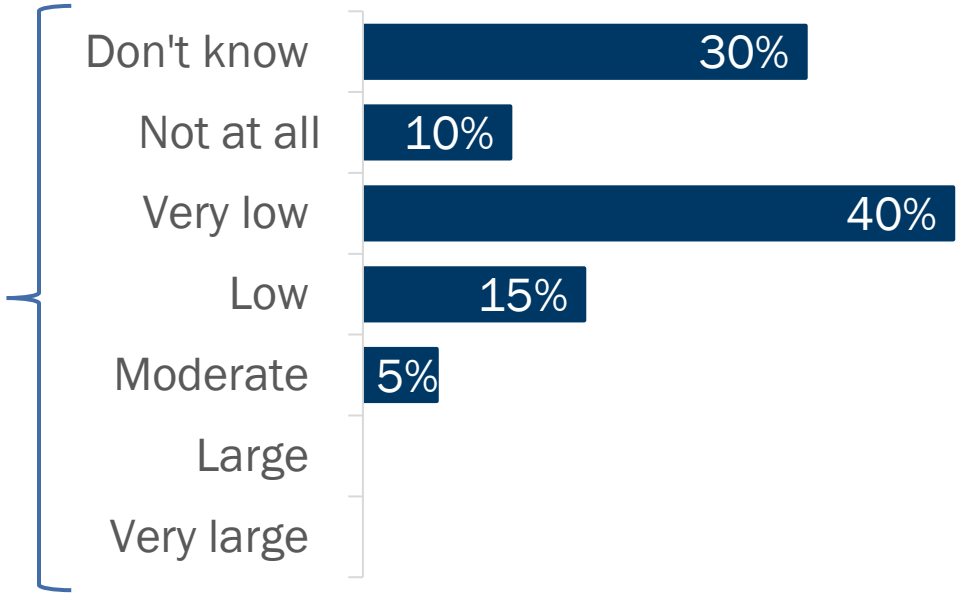
- Database is not widely utilized and may expose PSAPs to liability risk

Database is not implemented statewide, and not widely utilized in areas where it has been established

Existence of database among CSB areas



Utilization of existing databases



Source: BHC staff analysis of survey data from CSBs (response rate: 100 percent)

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

Finding

- Stronger process is needed to assess the effectiveness of Marcus Alert on an ongoing basis

Task force is required to evaluate Marcus Alert, but has never met

- Marcus Alert Evaluation Task Force is required by the state plan and is charged with:
  - Collecting and analyzing performance data
  - Evaluating Marcus Alert's performance toward its goals
  - Making recommendations for the future of the system
- Evaluation Task Force has never met
  - State plan does not place any entity in charge of convening the task force
- Need task force to make future recommendations on:
  - Funding
  - Updates to the state plan

Recommendation 6

- The General Assembly may wish to consider amending §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
- The General Assembly may wish to consider including funding and one FTE in the Appropriation Act for a Marcus Alert Evaluation Analyst at DBHDS

Option 6

- The General Assembly may wish to consider amending §37.2-311.1 to specify that 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

Takeaways

- One-third of Virginia localities have implemented Marcus Alert, and the rest can likely implement by 2028 with support from the legislature and state agencies
- Funding distribution should reflect the varied needs of CSBs and local agencies
- Majority of behavioral health calls to 911 still receive a law enforcement response, but the rate of behavioral health responses is increasing
- A better process is needed for ongoing evaluation of Marcus Alert's effectiveness

Summary of recommendations to DBHDS

Issue	Recommendation	#	Chapter
▪ Local Marcus Alert coordinators improve support to PSAPs	Amend the 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 that role.	1	2
▪ No statewide training	Complete the Advanced Marcus Alert training and make available to CSB, PSAP, and law enforcement staff by April 1, 2026.	3	2
▪ Database is not widely utilized	Update the Marcus Alert Local Plan Guide to include a section on the database in local plans.	5	3
▪ Data requirements are unnecessarily burdensome for PSAPs	Revise data collection procedures to allow Public Safety Answering Points to submit Marcus Alert data through computer-aided dispatch (CAD) system reports, and to minimize the administrative burden on PSAP staff.	7	3

Staff for this report

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BHC Behavioral Health Commission

Next meeting

October 7, 2025

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