Marcus Alert Local Plan Guide

Version: March 2026

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

Background

Marcus-David Peters Act

The Marcus-David Peters Act was enacted in 2020, in response to a 2018 incident where 24-year-old, Marcus-David Peters was tragically killed during a mental health crisis. The act mandates a behavioral health focused response to behavioral health emergencies, across the Commonwealth, by July 1, 2028.

The legislation required DBHDS to develop a state plan that outlines three protocols which are the structure of the Marcus Alert system:

1. Diverting behavioral health calls from PSAPs to the Regional Crisis Contact Centers,
2. Including written requests for law enforcement to provide backup during a mobile crisis response in formalized agreements between all partnered agencies, and,
3. A "specialized response" from law enforcement when responding to behavioral health calls.

As of July 1, 2022, an amendment made to the Marcus-David Peters Act that allows for exemptions, depending on population sizes in each locality. The exemptions allow for Protocols 2 and 3 to be optional for law enforcement agencies serving populations less than 40,000.

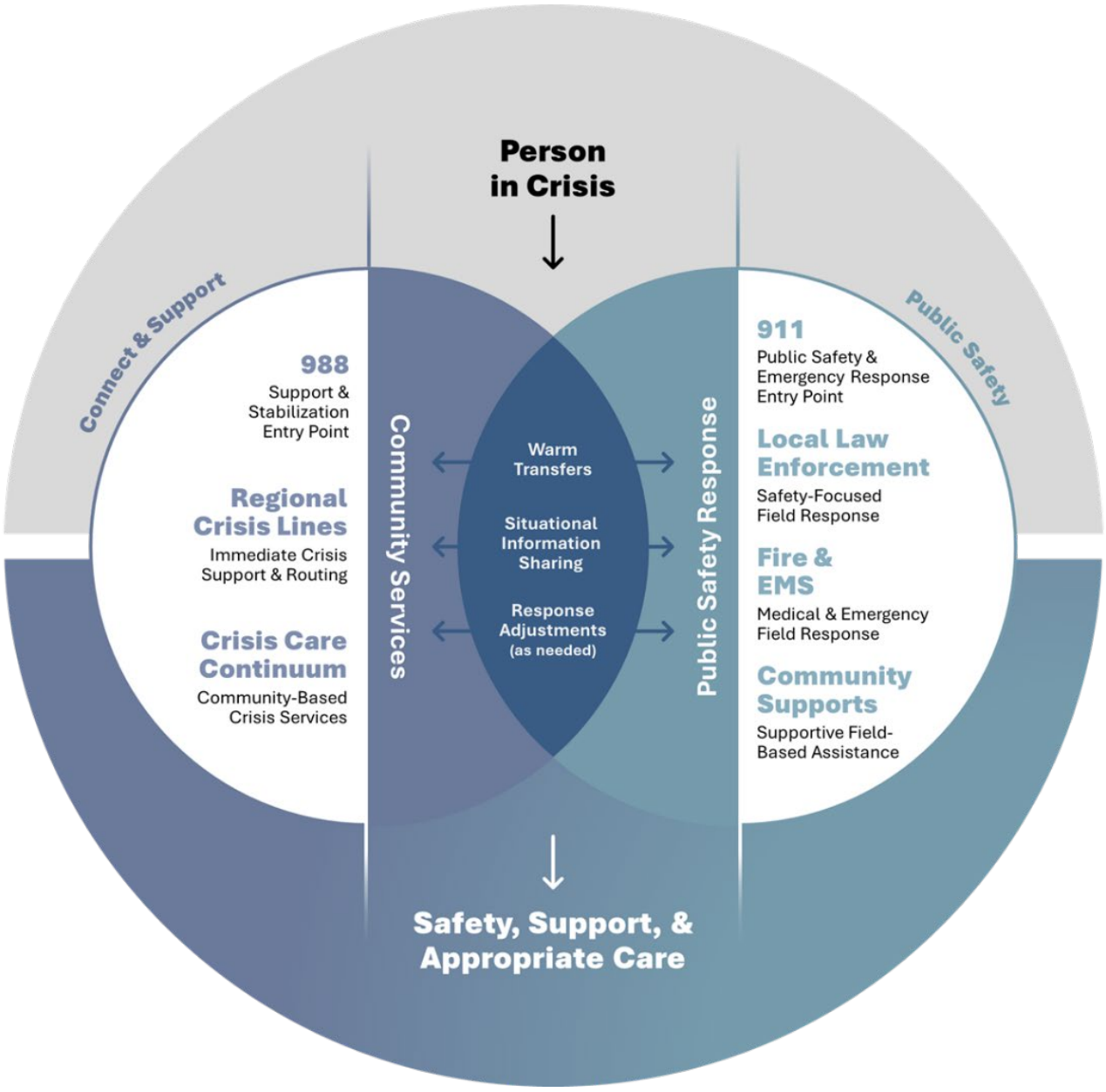
An amendment from July 1, 2023, dictates that every locality must establish a voluntary database to be made available to PSAPs to provide relevant mental health information and emergency contact information for appropriate response to an emergency or behavioral health crisis. The list of localities by population can be found on Page 28.

The latest amendment to the Marcus-David Peters Act, was passed on July 1, 2026, which allows DBHDS, in collaboration with DCJS, to rewrite the Marcus Alert State Plan as the operational framework for relevant components of the comprehensive crisis system and the Marcus alert system. State agencies and local implementing partners shall align their policies, procedures, and operations on an ongoing basis with the requirements and guidance set forth in the written plan, as amended.

Marcus Alert System & The Crisis Continuum

Virginia's behavioral health crisis system is designed to connect people in crisis with the right support at the right time. It brings together behavioral health providers, including mobile crisis response teams and community supports, public safety professionals, and crisis contact centers, to provide coordinated responses based on an individual's needs. While each part of the system serves a different purpose, all components work together within a shared crisis continuum.

The Marcus Alert system strengthens coordination across Virginia's crisis continuum by supporting collaboration between Public Safety Answering Points (PSAPs), crisis (988) contact centers, behavioral health, law enforcement, fire/EMS, and mobile crisis response teams. Through coordinated communication, partnerships, and shared response practices, the system aims to improve safety, increase access to care, and support recovery for individuals in crisis. Virginia's crisis system is also informed by national best practices, including the Crisis Now model, which emphasizes coordinated crisis services and community-based care.


Person in Crisis
Connect & Support
988
Support & Stabilization Entry Point
Regional Crisis Lines
Immediate Crisis Support & Routing
Crisis Care Continuum
Community-Based Crisis Services
Community Services
Warm Transfers
Situational Information Sharing
Response Adjustments (as needed)
Public Safety Response
Public Safety
911
Public Safety & Emergency Response Entry Point
Local Law Enforcement
Safety-Focused Field Response
Fire & EMS
Medical & Emergency Field Response
Community Supports
Supportive Field-Based Assistance
Safety, Support, & Appropriate Care

What are 9-8-8 and the Regional Crisis Contact Centers?

In July of 2022, the United States transitioned the National Suicide and Crisis Lifeline from a ten-digit phone number (800-273-TALK) to a three-digit number (9-8-8) to make receiving help easier and faster. The National Suicide and Crisis Lifeline is made up of an expansive network of over 200 local – and state – funded crisis centers located across the United States. The counselors at these local crisis centers answer calls, chats, and texts from people in distress, 24/7.

Calls that enter through 9-8-8 are Geo-Routed based on the closest cell phone tower and will go to the closest contact center. Three existing contact centers have been awarded contracts to provide full coverage of all Virginia's Lifeline calls and Public Safety Answering Point (PSAP) transfers, allowing integration into Virginia's Crisis Continuum of Care, by dispatching mobile crisis response teams and providing connections to local community resources.

Virginia Crisis Contact Centers by Region

Region	Contact Center Vendor
Region 1 Northwest	Hopelink
Region 2 Northern	Hopelink
Region 3 Southwest	Frontier Health
Region 4 Central	Hopelink
Region 5 Eastern	ProtoCall

The Marcus Alert Resource Toolkit

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

How to Use the Local Plan Guide and Local Plan Template

This guide is designed to assist local areas with navigating how and what to submit for Local Marcus Alert plans. There are nine (9) sections that are required for local plan submissions, they are:

- Local Agency Inventory
- Stakeholder Member List
- Community Roadmap – Decide and Document Sections
- Marcus Alert Responses
- Protocol 1
- Protocol 2 (written requests for law-enforcement back-up during a mobile crisis response in formalized agreements)
- Protocol 3
- Budget
- Master Contact List

For areas that have partnered law enforcement agencies that qualify for and choose exemption, there are seven (7) sections required for local plan submission, they are:

- Local Agency Inventory
- Stakeholder Member List
- Community Roadmap – Decide and Document Sections
- Marcus Alert Responses
- Protocol 1
- Budget
- Master Contact List

Local Plan Guide and Local Plan Template are companion documents intended to support the development and submission of comprehensive Marcus Alert local plans.

The Local Plan Guide provides recommendations, minimum standards, best practices, definitions, sample responses, and implementation considerations for each section of the local plan. The Local Plan Guide is to be used as a tool to assist localities. It is fillable and may be used as a reference when completing the Local Plan Template but may not be submitted. The guide is intended to promote consistency across local plans while allowing flexibility for local operational models and community needs. The Local Plan Guide is available on the Department of Behavioral Health and Developmental Services (DBHDS) website as part of the Marcus Alert toolkit and may be accessed at the following link: [Insert hyperlink].

The Local Plan Template is the required document for plan submission and must be completed in its entirety. The template will be provided to localities as part of their Marcus Alert exhibit during their designated planning year. Localities should provide as much detail as possible within each section to reduce the need for follow-up communication and requests for additional information.

The Local Plan Template is formatted as a fillable PDF and must be submitted without alterations to its format, structure, content, or sequencing. Localities must not modify, delete, rearrange, or otherwise alter any fields, instructions, or formatting contained within the template. If the information for a section exceeds the allotted space within the fillable PDF, enter the following statement in the applicable field: "Additional space was needed. Separate document is attached". The remaining content for that subsection should be provided as a separate attachment and clearly labeled to correspond with the applicable section and subsection of the Local Plan Template. All required attachments must be submitted concurrently with the completed Local Plan Template.

How to Submit a Local Plan

Each Regional Marcus Alert Coordinator will collect the primary email address for the CSB to provide access to its designated Microsoft Teams link, where the local plan can be submitted directly.

Best Practices Checklist

This checklist is a tool for planning purposes and is not required to be submitted. Does your Local Marcus Alert Plan include any of the following? Select Yes or No from the drop-down menu.

Protocol #1	
Choose an item.	Level 1 and 2 calls are fully diverted to 9-8-8.
Choose an item.	Level 3 calls involving youth are coordinated with 9-8-8 and specialized children's mobile crisis teams.
Choose an item.	Level 3 calls involving individuals with ID/DD are coordinated with 9-8-8 and specialized developmental disability mobile crisis teams/REACH program training.
Protocol #2	
Choose an item.	Memorandums of agreement are developed between the contact center, community services board, PSAPs, institutions of higher education, and any responding law enforcement agency.
Choose an item.	Procedures are detailed about law enforcement providing backup.
Protocol #3	
Choose an item.	Community Policing policies and initiatives are agency wide.
Choose an item.	De-escalation is required prior to use of force (as a separate policy or built into use of force policy).
Choose an item.	The use of force policy addresses individuals in behavioral health crisis.
Choose an item.	Implicit bias training and policies are agency wide.
Choose an item.	Bias-based policing policy addresses individuals in behavioral health crisis and individuals with substance use disorders, mental health disorders, or developmental disabilities.
Choose an item.	There is officer wellness supports and policies for behavioral health crisis responses.
Training	
Choose an item.	Officer wellness or peer support programs are available to all officers.
Choose an item.	All officers completed eight-hour mental health first aid or equivalent.
Choose an item.	There is ongoing de-escalation training for all officers, including basic and intermediate training.
Choose an item.	Officers receive interactive, scenario-based de-escalation training, including mental health scenarios, at least yearly.
Choose an item.	PSAP telecommunicators, Officers involved with Co-Response, Fire/EMS and Clinicians attend the Advanced Marcus Alert training to receive education on cultural humility, anti-racism, and cultural competence are available.
Choose an item.	Agencies have coverage on each shift by an appropriate number of officers who have completed 40-hour CIT training in the context of voluntary participation, aptitude/interest in working with individuals in behavioral health crisis, and supervisor approval. These supports can be provided in an "on call" format based on agency staff and size but should be available for response. CIT recommends that 20% of officers are trained to achieve adequate coverage; percentage of appropriate coverage will vary based on side of agency.

Quality Improvement	
Choose an item.	CIT programs adopt other CIT best practices.
Choose an item.	There is a plan for a high-level engagement by each area (mental health, law enforcement, PSAPs, and other entities) in cross-sector quarterly meetings and a commitment to data-driven quality improvement processes at the local level.

Future Elements

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

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

Crisis Team Composition Models

Regional Mobile Crisis Response (MCR)

- Description: Regional Mobile Crisis Response (MCR) Teams are state-mandated behavioral health crisis response teams that operate 24 hours a day, 7 days a week and provide coverage throughout the Commonwealth of Virginia. Coordinated through designated Regional Crisis Hubs, MCR Teams deliver rapid assessment, early intervention, and crisis support to individuals experiencing an emergent behavioral health crisis with the goal of maintaining individuals safely in the community whenever possible.
- Team Composition: MCR Teams are typically comprised of Licensed Mental Health Professionals (LMHPs), LMHP-Eligible providers, Qualified Mental Health Professionals (QMHPs) and Peer Recovery Specialists who are trained in crisis intervention, de-escalation, engagement, and community-based stabilization. Comprehensive crisis assessments are conducted by a LMHP-type provider, as required by state regulations.
- Operational Structure: MCR Teams are dispatched through Regional Crisis Hubs and provide both in-person and telehealth services in the least restrictive and most appropriate setting, including an individual's home, workplace, school, or other community location. Teams respond when a behavioral health-focused intervention can be delivered safely and effectively. Services may be provided for up to 72 hours following the initial contact to support stabilization, care coordination, and transition to ongoing services. Some regions may offer specialized expertise or teams to address the unique needs of populations such as youth and individuals with intellectual and developmental disabilities.
- Primary Functions: MCR Teams provide person-centered crisis intervention, comprehensive assessment, de-escalation, stabilization, safety planning, care coordination, and follow-up support. Teams work to prevent symptom escalation, reduce the risk of harm, divert individuals from unnecessary emergency department visits and hospitalization when clinically appropriate, and facilitate linkage to community-based behavioral health, recovery, and support services.

CSB Local Mobile Crisis Teams

- Description: CSB Local Mobile Crisis Teams are community-based behavioral health crisis response teams operated by Community Services Boards (CSBs) or their contracted providers. These teams primarily serve the localities within a CSB's designated service area and may operate independently or in coordination with a Regional Crisis Hub.
- Team composition: CSB Local Mobile Crisis Teams are typically comprised of Licensed Mental Health Professionals (LMHPs), LMHP-Eligible providers, Qualified Mental Health Professionals (QMHPs) and Peer Recovery Specialists who provide crisis intervention and stabilization services within the community.
- Operational structure: CSB Local Mobile Crisis Teams generally utilize locally established referral, dispatch, or self-dispatch protocols based on community needs and available resources. In some regions, CSB Local Mobile Crisis Teams may be integrated with or support Regional Mobile Crisis Response Team operations to expand coverage and response capacity.
- Primary functions: CSB Local Mobile Crisis Teams provide in-person and telehealth crisis intervention, assessment, stabilization, de-escalation, safety planning, service coordination, and follow-up support. Teams assist with diversion and deflection from emergency departments, law enforcement involvement, and other higher levels of care when appropriate, while facilitating connections to community-based treatment, recovery, and support services.

Community Care Teams

- Description: Community Care Teams are multidisciplinary crisis response teams designed to address behavioral health crises involving complex clinical, medical, social, or environmental needs. These teams provide a behavioral health-led response that incorporates additional professional expertise when circumstances require coordinated intervention.
- Team composition: Community Care Teams commonly include Licensed Mental Health Professionals (LMHPs), LMHP-Eligible providers, Qualified Mental Health Professionals (QMHPs), Peer Recovery

Specialists, and Fire/EMS personnel. Additional disciplines may be included based on local operational models and community needs.

- Operational structure: Community Care Teams are deployed when a crisis presentation may benefit from both behavioral health intervention and the ability to address concurrent medical, wellness, or public safety concerns. Team structures and deployment protocols may vary across localities.
- Primary functions: Community Care Teams provide crisis assessment, stabilization, de-escalation, medical screening or support, safety planning, service coordination, and linkage to ongoing care. These teams seek to resolve crises in the least restrictive setting possible while coordinating access to behavioral health, medical, and community-based resources.

Co-Response Teams

- Description: Co-Response Teams are multidisciplinary crisis response teams that combine public safety and behavioral health expertise to respond to behavioral health crises involving elevated safety concerns, public safety risks, or circumstances where law enforcement involvement is necessary.
- Team composition: Co-Response Teams are typically comprised of law enforcement officers, Licensed Mental Health Professionals (LMHPs), LMHP-Eligible providers, Qualified Mental Health Professionals (QMHPs), and Peer Recovery Specialists. Team configurations may vary based on local resources and operational needs.
- Operational structure: Co-Response Teams provide a public safety-led response that integrates behavioral health assessment, crisis intervention, and resource coordination. These teams are commonly deployed when behavioral health needs coexist with safety concerns that require law enforcement presence or authority. Clinical services may be available via telehealth.
- Primary functions: Co-Response Teams support scene stabilization, risk assessment, crisis intervention, de-escalation, diversion from the criminal justice system when appropriate, coordination of behavioral health services, and linkage to community-based supports. The goal of co-response is to address both immediate safety concerns and underlying behavioral health needs while promoting the least restrictive and most clinically appropriate outcome possible.

Four Level Triage Framework – Urgency Determination

Level 1 – Routine: Telephone Community-Based Intervention

The individual is experiencing emotional distress, behavioral health concerns, or situational stressors but remains able to maintain personal safety, communicate needs, and engage in available supports. Specific behaviors that meet criteria for Level 1 calls are:

- Mild anxiety, depression, or emotional distress
- Requests for information, referrals, or support services
- Situational crises without safety concerns
- Conflict with family, peers, or caregivers
- Behavioral changes that do not significantly impair functioning
- Stable symptoms managed through existing supports
- Minimal impairment in daily functioning
- No immediate risk of harm to self or others
- Able to participate in problem-solving and safety planning
- Suicidal thoughts acceptable, if no plan or means

Level 2 – Moderate: Behavioral Health Only Intervention

The individual demonstrates increased distress or functional impairment that may worsen without intervention but does not currently present an imminent safety concern. Specific behaviors that meet criteria for Level 2 calls are:

- Third party callers
- Callers refusing to be transferred to 988
- Escalating emotional distress
- Significant anxiety, panic, or depressive symptoms
- Behavioral dysregulation affecting daily functioning
- Increased caregiver concern
- Emerging suicidal thoughts without plan, intent, or preparatory behaviors
- Difficulty utilizing typical coping strategies
- Increasing social withdrawal or isolation
- No homicidal thoughts, intent, or behavior
- Suicidal thoughts with no plan or direct access to lethal weapons
- Minor self-injurious behavior
- Moderate impairment in functioning
- Reduced ability to independently manage current circumstances
- Safety concerns may emerge if support is delayed

Level 3 – Urgent: Behavioral Health Lead Intervention

The individual is experiencing significant behavioral health symptoms, impaired judgment, or substantial functional impairment requiring immediate intervention to prevent further deterioration or harm. Specific behaviors that meet criteria for Level 3 calls are:

- Third party callers
- Callers refusing to be transferred to 988
- Significant impairment in reality testing
- Severe emotional dysregulation
- Serious behavioral disturbances
- Inability to maintain personal safety without intervention
- Increasing aggression, agitation, or impulsivity that may place the individual or others at risk
- Significant deterioration from baseline functioning
- Florid psychosis
- Substance use and/or substance induced psychosis

- Homicidal thoughts with no active behaviors or intent
- Active self-injurious behavior with concern for medical risk
- Suicidal thoughts with plan and access to lethal weapons
- Major impairment in decision-making, emotional regulation, or daily functioning
- Elevated risk of harm if intervention is delayed
- Requires immediate crisis assessment and stabilization
- Magistrate-issued emergency custody order, if available and requested by law enforcement

Level 4 – Emergent: Public Safety Lead Intervention

The individual presents an immediate threat to their own safety, the safety of others, or is experiencing a behavioral health crisis requiring an emergency response. Specific behaviors that meet criteria for Level 4 calls are:

- Suicide attempt in progress or immediately following an attempt
- Credible threats of serious harm to others
- Violent behavior creating immediate danger
- Severe impairment preventing basic self-protection
- Extreme agitation or behavioral escalation resulting in immediate safety risks
- Serious self-injurious behavior requiring emergency intervention
- Behavioral health symptoms resulting in an immediate inability to maintain safety
- Any gun or weapon present and accessible
- Immediate danger to self or others
- Emergency intervention necessary to address acute safety concerns
- Requires the highest level of coordinated response available within the community
- Magistrate-issued emergency custody order issued with immediate security threat

Special Populations Considerations

Behaviors associated with developmental disabilities, autism spectrum disorder, dementia, traumatic brain injury, substance use, or communication differences should not automatically be interpreted as indicators of behavioral health crisis severity. Communities are encouraged to consider the individual's baseline functioning, communication style, sensory needs, cognitive abilities, and available collateral information when determining urgency. Examples localities may consider are:

Population	Behaviors That May Require Additional Context
Autism Spectrum Disorder	Limited eye contact, repetitive movements, sensory overload responses, difficulty with verbal communication
I/DD	Communication challenges, difficulty following directions, heightened emotional responses
Dementia	Confusion, wandering, memory impairment, disorientation
Traumatic Brain Injury	Cognitive slowing, impulsivity, difficulty processing information
Substance Use	Intoxication, withdrawal symptoms, impaired judgment
Youth	Developmentally appropriate emotional expression, oppositional behavior, emotional dysregulation
Older Adults	Cognitive changes, grief responses, medication interactions

Four Level Triage Framework – Response Options for Community Coverage

Achieving community coverage is possible through a variety of team compositions, demonstrated in samples below.

Coverage with No New Teams

Level 1 Response

- Involve behavioral health as soon as possible
- 911 PSAPs will provide a warm transfer to 988 contact centers, with caller's consent
- All PSAPs have procedures and specifications for warm transfers to 988 contact centers and document the transfer as the call disposition
- 988 will provide telephone intervention which also includes linkage to community-based mental health treatment, follow-up, and other social supports

Level 2 Response

- Involve behavioral health as soon as possible
- 911 PSAPs will provide a warm transfer to 988 contact centers, with caller's consent
- 988 contact centers will conduct a clinical assessment until 988 makes a response determination, specifically, whether MCR is recommended for dispatch
- 988 dispatches MCR utilizing local or regional teams (all under MOU or contract with a regional hub)
- Behavioral health provider should engage with individual during transit, if possible
- Telehealth support from MCR may also be available depending on resources and needs

Level 3 Response

- Involve behavioral health as soon as possible
- Behavioral health remote engagement during transit if possible
- Assess need for medical response
- 911 PSAPs dispatch CIT trained officer, if possible
- Shift coverage with CIT officers and EMS who have received advanced Marcus Alert training are dispatched preferentially
- Law enforcement is dispatched to the scene, without any sirens or lights. Depending on capabilities, mobile crisis response may also be requested simultaneously
- Law enforcement assesses the scene, remains engaged while the provider intervenes with the individual, and the team collaborates on next steps.
- Telehealth-based behavioral health options between CIT officers, CIT trained EMS, and CSB emergency services, mobile crisis hub, or another crisis provide

Level 4 Response

- Involve behavioral health as soon as possible
- Behavioral health remote engagement during transit if possible
- Assess need for medical response
- 911 PSAPs dispatch law enforcement, EMS, and/or fire, without delay
- Shift coverage with CIT officers and EMS who have received advanced Marcus Alert training are dispatched preferentially
- Local specialized response includes linking to the least-restrictive level of behavioral health treatment when the scene is safe for intervention

Coverage with CSB Local Crisis Teams

Level 1 Response

- Involve behavioral health as soon as possible
- 911 PSAPs will provide a warm transfer to 988 contact centers, with caller's consent
- All PSAPs have procedures and specifications for warm transfers to 988 contact centers and document the transfer as the call disposition
- 988 will provide telephone intervention which also includes linkage to community-based mental health treatment, follow-up, and other social supports

Level 2 Response

- Involve behavioral health as soon as possible
- 911 PSAPs will provide a warm transfer to 988 contact centers, with caller's consent
- 988 contact centers will conduct a clinical assessment until 988 makes a response determination, specifically, whether MCR is recommended for dispatch
- 988 dispatches MCR utilizing local or regional teams (all under MOU or contract with a regional hub)
- Behavioral health provider should engage with individual during transit, if possible
- Depending on local resources, 911 PSAPs may dispatch CSB local crisis teams and/or teams may be self-dispatched/referred

- CSB local crisis teams should also be utilized for low-risk crises but involve third party callers or individuals who do not wish to be transferred to 988

Level 3 Response

- Involve behavioral health as soon as possible
- Behavioral health remote engagement during transit if possible
- Assess need for medical response
- 911 PSAPs dispatch CIT trained officer, if possible
- Shift coverage with CIT officers and EMS who have received advanced Marcus Alert training are dispatched preferentially
- Law enforcement is dispatched to the scene, without any sirens or lights. Depending on availability and safety, CSB local crisis teams may be requested simultaneously
- Law enforcement assesses the scene, remains engaged while the provider intervenes with the individual, and the team collaborates on next steps.
- Local specialized response includes linking to the least-restrictive level of behavioral health treatment when the scene is safe for intervention
- Telehealth-based behavioral health options between CIT officers, CIT trained EMS, and CSB local crisis teams, CSB emergency services, mobile crisis hub, or another crisis provide

Level 4 Response

- Involve behavioral health as soon as possible
- Behavioral health remote engagement during transit if possible
- Assess need for medical response
- 911 PSAPs dispatch law enforcement, EMS, and/or fire, without delay
- Shift coverage with CIT officers and EMS who have received advanced Marcus Alert training are dispatched preferentially
- CSB local crisis teams may be dispatched simultaneously and kept continually informed in transit and does not arrive or approach the scene until it has been safe and appropriate to do so, by law enforcement and EMS
- Law enforcement assesses the scene, remains engaged while the provider intervenes with the individual, and the team collaborates on next steps
- Local specialized response includes linking to the least-restrictive level of behavioral health treatment when the scene is safe for intervention
- Telehealth-based behavioral health options between CIT officers, CIT trained EMS, and CSB local crisis teams, CSB emergency services, mobile crisis hub, or another crisis provide

Coverage with Community Care Team

Level 1 Response

- Involve behavioral health as soon as possible
- 911 PSAPs will provide a warm transfer to 988 contact centers, with caller's consent
- All PSAPs have procedures and specifications for warm transfers to 988 contact centers and document the transfer as the call disposition
- 988 will provide telephone intervention which also includes linkage to community-based mental health treatment, follow-up, and other social supports

Level 2 Response

- Involve behavioral health as soon as possible
- 911 PSAPs will provide a warm transfer to 988 contact centers, with caller's consent
- 988 contact centers will conduct a clinical assessment until 988 makes a response determination, specifically, whether MCR is recommended for dispatch
- 988 dispatches MCR utilizing local or regional teams (all under MOU or contract with a regional hub)
- Behavioral health provider should engage with individual during transit, if possible
- Depending on local resources, 911 PSAPs may dispatch community care teams and/or teams may be self-dispatched/referred
- Community care teams should also be utilized for low-risk crises but involve third party callers or individuals who do not wish to be transferred to 988

Level 3 Response

- Involve behavioral health as soon as possible
- Behavioral health remote engagement during transit if possible
- Assess need for medical response
- Depending on local resources, 911 PSAPs may dispatch community care teams and/or teams may be self-dispatched/referred
- A community care team respond to the scene to provide a behavioral health lead intervention
- Community care teams may also be utilized for crises that involve third party callers or individuals who do not wish to be transferred to 988
- Law enforcement is aware of location and prepared to serve as a backup, if needed, or released
- CIT officers who have received advanced Marcus Alert training are dispatched preferentially

- Team does brief follow ups after encounters for preventative support and continued linkage to services

Level 4 Response

- Involve behavioral health as soon as possible
- Behavioral health remote engagement during transit if possible
- Assess need for medical response
- 911 PSAPs dispatch law enforcement, EMS, and/or fire, without delay
- Shift coverage with CIT officers and EMS who have received advanced Marcus Alert training are dispatched preferentially
- Community care teams may be dispatched simultaneously and kept continually informed in transit and does not arrive or approach the scene until it has been safe and appropriate to do so, by law enforcement and EMS
- Law enforcement assesses the scene, remains engaged while the provider intervenes with the individual, and the team collaborates on next steps
- Local specialized response includes linking to the least-restrictive level of behavioral health treatment when the scene is safe for intervention
- Telehealth-based behavioral health options between CIT officers, CIT trained EMS, and community care teams, CSB emergency services, mobile crisis hub, or another crisis provide

Coverage with Co-Response Team

Level 1 Response

- Involve behavioral health as soon as possible
- 911 PSAPs will provide a warm transfer to 988 contact centers, with caller's consent
- All PSAPs have procedures and specifications for warm transfers to 988 contact centers and document the transfer as the call disposition
- 988 will provide telephone intervention which also includes linkage to community-based mental health treatment, follow-up, and other social supports

Level 2 Response

- Involve behavioral health as soon as possible
- 911 PSAPs will provide a warm transfer to 988 contact centers, with caller's consent
- 988 contact centers will conduct a clinical assessment until 988 makes a response determination, specifically, whether MCR is recommended for dispatch
- 988 dispatches MCR utilizing local or regional teams (all under MOU or contract with a regional hub)
- Behavioral health provider should engage with individual during transit, if possible
- Depending on local resources, 911 PSAPs may dispatch co-response teams and/or teams may be self-dispatched/referred
- Co-response teams should also be utilized for low-risk crises but involve third party callers or individuals who do not wish to be transferred to 988

Level 3 Response

- Involve behavioral health as soon as possible
- Behavioral health remote engagement during transit if possible
- Assess need for medical response
- Depending on local resources, 911 PSAPs may dispatch co-response teams and/or teams may be self-dispatched/referred
- A co-response team respond to the scene to provide a behavioral health lead intervention
- Co-response teams may also be utilized for crises that involve third party callers or individuals who do not wish to be transferred to 988
- Law enforcement is aware of location and prepared to serve as a backup, if needed, or released
- CIT officers who have received advanced Marcus Alert training are dispatched preferentially
- Team does brief follow ups after encounters for preventative support and continued linkage to services

Level 4 Response

- Involve behavioral health as soon as possible
- Behavioral health remote engagement during transit if possible
- Assess need for medical response
- 911 PSAPs dispatch law enforcement, EMS, and/or fire, without delay
- Shift coverage with CIT officers and EMS who have received advanced Marcus Alert training are dispatched preferentially
- Co-response teams may be dispatched simultaneously and kept continually informed in transit and does not arrive or approach the scene until it has been safe and appropriate to do so, by law enforcement and EMS
- Law enforcement assesses the scene, remains engaged while the provider intervenes with the individual, and the team collaborates on next steps
- Local specialized response includes linking to the least-restrictive level of behavioral health treatment when the scene is safe for intervention
- Telehealth-based behavioral health options between CIT officers, CIT trained EMS, and co-response teams, CSB emergency services, mobile crisis hub, or another crisis provide

Marcus Alert Response Options

Using the information provided in the Four Level Triage Framework, define responses available, for your locality, at each of the Marcus Alert levels.

A. Community Coverage

In detail, describe the Marcus Alert response options, including 988 Contact Centers, Regional Mobile Crisis Response (MCR), Co-Response, Regional Youth Mobile Crisis, REACH, CIT officers, or any other form of Community Care Teams for each level of urgency. *Full community coverage is not required at the time the local plan is due, but instead by the implementation date that will vary based on implementation schedule.

Level 1 Sample Answer:

Level 1 calls involve individual is experiencing mild emotional distress, anxiety, grief, interpersonal conflict, or situational stressors. The individual is cooperative, able to communicate needs, maintain personal safety, and utilize available supports. No immediate risk of harm to self or others is identified. These calls are fully diverted to 988 and no dispatch is made.

Level 2 Sample Answer:

Level 2 calls involve moderate behavioral health symptoms or functional impairment were mobile crisis intervention, in-person assessment, or timely behavioral health response may be beneficial. Response options are MCR (available 24/7), REACH teams (available 24/7), Youth Mobile Crisis (available 10am -8pm daily), community care team (available 11am-11pm daily) – if no behavioral health only team or community care team is available for dispatch, CIT trained officers will be preferentially deployed to the scene with technology in hand for telehealth with a behavioral health clinician.

Level 3 Sample Answer:

Level 3 calls involve elevated behavioral health risk, significant impairment, or complex circumstances requiring an urgent coordinated response between behavioral health and public safety partners. Response options are community care team (available 11am-11pm daily) and CIT trained officers. Once scene is determined to be safe, additional behavioral health responses will be dispatched such as, MCR (24/7), REACH teams (available 24/7), Youth Mobile Crisis (available 10am -8pm daily). Telehealth behavioral health consultation may supplement in-person response.

Level 4 Sample Answer:

Level 4 calls involve immediate threats to life or safety requiring emergency response, with behavioral health engagement occurring as soon as conditions safely permit. The immediate response is EMS, Fire, or law enforcement are dispatched per standard PSAP protocols. If determined appropriate and safe community care team (available 11am-11pm daily), MCR (24/7), REACH teams (available 24/7), Youth Mobile Crisis (available 10am -8pm daily) will be alerted to dispatch and asked to stage the scene. Telehealth behavioral health consultation may supplement in-person response.

Protocol 1: 9-1-1 Diversion

This section will clarify the technological changes to the agency's Computer-Aided Dispatch (CAD) systems, workflow processes, and operations of how calls will be triaged, coordinated, and or transferred from PSAPs to the 988 Contact Center.

A. Urgency Determination

In detail, describe what methods PSAPs will use to classify incidents at each Marcus Alert level type call. If all Psychiatric/Behavioral Problem calls are classified as Marcus Alert, please include this information. Indicate what criteria, questions, key words, chief complaints, etc. will indicate each Marcus Alert level type call.

Urgency Determination Guidance Note: Localities should identify the specific call-taking protocols, chief complaint codes, key words, scripted questions, and decision-support tools used by the PSAP to classify Marcus Alert level type calls. The examples provided below are illustrative and are not intended to prescribe a specific call-taking methodology, computer-aided dispatch system, or dispatch protocol.

Level 1 PSAP Workflow Example

- Call is received by the PSAP and screened for immediate threats to life, safety, or medical emergencies.
- The call-taker utilizes the locality's approved call-taking protocols, key words, chief complaints, and decision-support tools to identify behavioral health-related concerns.
- Calls may be classified as Level 1 when the individual is experiencing emotional distress, situational stressors, resource needs, or behavioral health symptoms that do not present an immediate safety concern and can be addressed through telephonic or telehealth intervention.
- Indicators may include requests for behavioral health resources, anxiety, grief, interpersonal conflict, mild emotional distress, or non-urgent behavioral health concerns.
- The call-taker determines that the individual can maintain personal safety, communicate needs, and engage voluntarily in available supports.
- If appropriate and with consent, the caller is offered a warm transfer to 988.
- If accepted, the caller is transferred to 988 for crisis intervention, assessment, resource coordination, and follow-up planning.
- If transfer is declined, the PSAP provides information regarding available behavioral health resources or follows locally established referral procedures.
- Call disposition is documented according to local protocols.

Level 2 PSAP Workflow Example

- Call is received by the PSAP and screened for immediate threats to life, safety, or medical emergencies.
- The call-taker utilizes the locality's approved call-taking protocols, key words, chief complaints, and decision-support tools to identify behavioral health concerns involving moderate distress, functional impairment, or circumstances that may worsen without intervention.
- Calls may be classified as Level 2 when the individual is experiencing increased emotional distress, worsening behavioral health symptoms, emerging safety concerns, or reduced ability to manage the situation independently, but no immediate threat to life or safety is identified.
- Indicators may include escalating anxiety, panic symptoms, worsening depression, passive suicidal ideation without plan or intent, increased caregiver concern, significant behavioral changes from baseline, or diminished ability to utilize coping strategies.
- If the individual in crisis is the caller and agrees, the caller is offered a warm transfer to 988.

- 988 conducts a clinical assessment and determines whether Mobile Crisis Response (MCR) or other behavioral health services are appropriate.
- If the individual declines transfer to 988, disconnects prior to transfer, is unable to participate in the transfer, or if the caller is a third party, the PSAP follows locally established protocols for behavioral health consultation, referral, or crisis activation.
- Depending on local procedures, information may be shared with 988, MCR, Community Care Teams, or other designated behavioral health providers for outreach or response.
- Community Care Teams or MCR may be dispatched when available and appropriate, regardless of whether direct contact with the individual has occurred.
- Behavioral health personnel may attempt telephone, telehealth, or in-person engagement based on available information and local protocols.
- If safety concerns emerge or the situation escalates, MCR or behavioral health personnel notify the PSAP to request an appropriate public safety response.
- CIT-trained law enforcement officers are dispatched whenever available and indicated.
- Responders coordinate assessment, stabilization, safety planning, service linkage, and follow-up support.
- Call disposition and response outcomes are documented according to local procedures.

Level 3 PSAP Workflow Example

- Call is received by the PSAP and screened for behavioral health concerns involving elevated risk, significant functional impairment, escalating behavior, or safety concerns requiring an urgent response.
- The call-taker utilizes the locality's approved call-taking protocols, key words, chief complaints, and decision-support tools to assess the need for law enforcement, EMS, fire-rescue, behavioral health personnel, or a multidisciplinary response.
- Calls may be classified as Level 3 when behavioral health symptoms substantially impair judgment, emotional regulation, or daily functioning and create elevated, but not immediate, safety concerns.
- Indicators may include active suicidal ideation with concerning risk factors, significant agitation, escalating self-harm behaviors, impaired reality testing, inability to maintain personal safety, substantial changes from baseline functioning, or behaviors indicating an increased likelihood of harm without timely intervention.
- Community Care Teams receive preferential dispatch whenever available and appropriate.
- If the caller is a third party, the PSAP continues response coordination using available information and established local protocols.
- If the individual in crisis declines transfer to 988, is unable to participate, or direct contact cannot be established, the PSAP continues response coordination based on available information.
- Behavioral health personnel are notified as early as possible and may provide consultation during dispatch or while responders are en route.
- Community Care Teams may be dispatched simultaneously with public safety responders, depending on scene safety and local protocols.
- CIT-trained law enforcement officers and EMS personnel are dispatched whenever available.
- Responding personnel conduct an on-scene assessment and continuously evaluate safety conditions.
- Law enforcement or EMS may establish scene safety before behavioral health personnel engage directly with the individual when necessary.
- Behavioral health personnel provide crisis intervention, assessment, de-escalation, stabilization, and disposition planning when conditions permit.
- Responders collaborate to identify the least restrictive clinically appropriate outcome while addressing immediate safety concerns.
- Follow-up outreach, referral, and service linkage occur according to local procedures.

Level 4 Workflow Example

- Call is received by the PSAP and identified as involving an immediate threat to life, safety, or serious harm.
- The call-taker utilizes the locality's approved call-taking protocols, key words, chief complaints, and decision-support tools to identify emergency conditions requiring an immediate public safety response.
- Calls may be classified as Level 4 when there is an immediate threat of serious harm to self or others, an active medical emergency, a suicide attempt in progress, active violence, credible threats of serious violence, severe self-injurious behavior, or behaviors that prevent the individual from maintaining personal safety.
- Law enforcement, EMS, and/or fire-rescue are dispatched without delay according to local protocols.
- CIT-trained responders are dispatched whenever available.
- Behavioral health personnel are notified as early as possible and may provide consultation during response operations.
- Community Care Teams may be activated concurrently and staged until scene conditions permit safe engagement.
- Emergency responders establish scene safety, address immediate threats, and provide emergency medical care when necessary.
- Once safe and appropriate, behavioral health personnel assist with crisis intervention, assessment, stabilization, and disposition planning.
- Responders coordinate access to the least restrictive clinically appropriate level of care.
- Follow-up outreach, referral, and service linkage occur according to local procedures.
- Call disposition and response outcomes are documented according to local procedures.

B. Technical Changes to integrate data collection into the CAD

In detail, describe the technical changes that have been, or will be, implemented to integrate data collection into the agency's CAD. CSBs must attempt to utilize funds from their planning year to cover direct costs associated with these changes. If the PSAPs decline additional funding for necessary CAD updates, the CSB must provide proof of written communication that funds were declined. Please include this information here AND in the planning budget.

The Community Services Board (CSB), in collaboration with participating Public Safety Answering Points (PSAPs), assessed existing Computer-Aided Dispatch (CAD) capabilities to identify technical modifications necessary to support Marcus Alert implementation, data collection, and reporting requirements.

Planned CAD enhancements include the creation of Marcus Alert-specific incident identifiers, integration of Marcus Alert level classifications (Levels 1–4), development of behavioral health-related chief complaint codes, and the addition of data fields to document behavioral health involvement, response team composition, warm transfers to 988, Mobile Crisis Response (MCR) activation, Community Care Team deployment, and final call disposition. The participating PSAPs will also implement updates to support the collection and reporting of required Marcus Alert performance measures, including call volume by Marcus Alert level, response type, transfer outcomes, responder utilization, and linkage to behavioral health services.

The CSB has allocated $50,000 in planning year funds to support direct costs associated with necessary CAD modifications, including vendor configuration, software updates, testing, implementation, and staff training.

The PSAPs have accepted the proposed funding and will coordinate with the CSB and their CAD vendors to complete system modifications in accordance with established implementation timelines. Planned updates are anticipated to be completed by July 1, 2026, with user testing and staff training occurring prior to full implementation.

The $50,000 allocation is included in the Marcus Alert planning budget under technology and infrastructure costs.
If additional technical modifications are identified during implementation, the CSB and participating PSAPs will continue to collaborate to assess needs, identify funding sources, and ensure ongoing compliance with Marcus Alert reporting requirements.

C. Training Materials and Tools

In detail, describe the training that has been provided to PSAPs on the handling of calls and/or whether the agency will utilize the Interoperability training developed June 2026. Attach training materials and new policies and procedures that are developed for Marcus Alert implementation. Attach a guide card or other script that has been created.

The participating Public Safety Answering Points (PSAPs), in collaboration with the Community Services Board (CSB) and local Marcus Alert partners, will utilize the Marcus Alert Interoperability Training developed in June 2026 as the foundational training program for call-takers, dispatchers, supervisors, and other applicable personnel.

Training will focus on the identification, classification, and handling of Marcus Alert level type calls, including the use of approved call-taking protocols, behavioral health chief complaint codes, scripted questions, decision-support tools, warm transfer procedures to 988, Mobile Crisis Response (MCR) activation, and coordination with Community Care Teams, Co-Response Teams, EMS, fire-rescue, and law enforcement.

Training content will include, at a minimum:

- Overview of the Marcus Alert framework and statutory requirements
- Roles and responsibilities of 911, 988, Mobile Crisis Response, Community Care Teams, Co-Response Teams, EMS, fire-rescue, law enforcement, and Community Services Boards
- Identification of behavioral health crisis indicators and urgency determination criteria
- Procedures for assigning Marcus Alert Levels 1–4
- Protocols for warm transfers and information sharing between 911 and 988
- Procedures for handling third-party callers, callers who decline transfer to 988, disconnected callers, and individuals unable to participate in a transfer
- Trauma-informed and person-centered communication strategies
- Considerations for special populations, including youth, older adults, individuals with intellectual and developmental disabilities, neurodivergent individuals, and individuals with co-occurring medical or substance use concerns
- Documentation requirements and CAD data collection procedures
- Local policies and procedures for behavioral health response coordination and disposition planning

The PSAP will incorporate Marcus Alert-specific procedures into existing training programs and provide initial and ongoing training to applicable personnel in accordance with local policy.

The following materials are attached to support Marcus Alert implementation:

- Attachment A: Marcus Alert PSAP Policies and Procedures
- Attachment B: Marcus Alert Interoperability Training Materials (June 2026)
- Attachment C: Marcus Alert PSAP Guide Card / Emergency Medical Dispatch (EMD) Card
- Attachment D: Marcus Alert PSAP Workflow and Decision Tree
- Attachment E: Marcus Alert Call-Taking Script and Warm Transfer Procedures

Additional training materials, job aids, and updated policies will be developed and revised as needed to reflect changes in local protocols, response models, and statewide guidance.

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

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

Planning Consideration: Localities should describe any dedicated transfer lines, backup transfer processes, information-sharing agreements, transfer failure protocols, and procedures for handling disconnected callers, non-voice communications, language interpretation services, and callers located outside the PSAP's jurisdiction.

Level 1: Behavioral Health Consultation and Resource Connection

- Calls classified as Marcus Alert Level 1 shall be transferred from the PSAP to the Regional Crisis Contact Center through a dedicated PSAP priority line or other established transfer process.
- Prior to transfer, the PSAP telecommunicator shall inform the caller about the purpose of 988 services and obtain consent for transfer.
- The PSAP telecommunicator should conduct a warm transfer and avoid blind or cold transfers whenever possible.
- During the transfer, the PSAP telecommunicator should provide all relevant information obtained during call processing, including:
    - PSAP name and callback number
    - CAD incident number
    - Individual's name, location, and callback number, if known
    - Determined Marcus Alert level
    - Chief complaint and presenting concerns
    - Any known safety considerations
    - Whether public safety resources have been dispatched
- Once all pertinent information has been communicated, the Regional Crisis Contact Center may dismiss the PSAP telecommunicator. This handoff should typically occur within 30 to 45 seconds.
- The Regional Crisis Contact Center assumes primary responsibility for crisis intervention, assessment, resource coordination, safety planning, and follow-up.
- The interaction concludes when the individual is stabilized through telephonic or telehealth intervention, linked to appropriate community resources, or referred for additional services.

Level 2: Behavioral Health Response and Mobile Crisis Activation

- Calls classified as Marcus Alert Level 2 should be coordinated with the Regional Crisis Contact Center through a dedicated PSAP priority line or other established transfer process.

- Prior to transfer, the PSAP telecommunicator shall inform the caller about 988 services and obtain consent for transfer whenever feasible.
- If the caller is a third party, the individual declines transfer, disconnects, or is unable to participate in the transfer, the PSAP shall follow locally established procedures for information sharing and behavioral health coordination.
- The PSAP telecommunicator should conduct a warm transfer and provide all relevant information obtained during call processing, including:
    - PSAP name and callback number
    - CAD incident number
    - Individual's name, location, and callback number, if known
    - Determined Marcus Alert level
    - Chief complaint and presenting concerns
    - Known safety considerations
    - Information provided by third-party callers
    - Whether public safety resources have been dispatched
- Once all pertinent information has been communicated, the Regional Crisis Contact Center may dismiss the PSAP telecommunicator. This handoff should typically occur within 30 to 45 seconds.
- The Regional Crisis Contact Center conducts a clinical assessment and determines whether telephonic intervention, Mobile Crisis Response (MCR), Community Care Team activation, or other behavioral health services are appropriate.
- When indicated, the Regional Crisis Contact Center dispatches MCR or coordinates with locally designated response teams.
- If safety concerns escalate during behavioral health engagement, the Regional Crisis Contact Center shall notify the PSAP to request an appropriate public safety response.
- The interaction concludes when the individual is stabilized in the community, connected to ongoing services, referred to a higher level of care, or otherwise reaches a clinically appropriate disposition.

Level 3: Coordinated Behavioral Health and Public Safety Response

- Calls classified as Marcus Alert Level 3 should be coordinated with the Regional Crisis Contact Center as early as possible while the PSAP initiates the appropriate public safety response.
- The PSAP telecommunicator shall assess the need for law enforcement, EMS, fire-rescue, behavioral health personnel, or a multidisciplinary response based on local protocols.
- CIT-trained responders should be dispatched whenever available.
- If the caller is willing and able to engage, the PSAP may conduct a warm transfer to the Regional Crisis Contact Center provided the transfer does not delay emergency response.
- If the caller is a third party, declines transfer, disconnects, or is unable to participate, the PSAP shall continue response coordination using available information and established local protocols.
- The PSAP telecommunicator should provide all relevant information to the Regional Crisis Contact Center, including:
    - PSAP name and callback number
    - CAD incident number
    - Individual's name, location, and callback number, if known
    - Determined Marcus Alert level
    - Chief complaint and presenting concerns
    - Known safety concerns and risk factors
    - Information provided by third-party callers

    - Public safety resources dispatched and estimated arrival times
- Community Care Teams, Mobile Crisis Response Teams, or other locally designated behavioral health teams may be dispatched concurrently or staged until scene conditions permit safe engagement.
- Behavioral health personnel may provide consultation during dispatch and while responders are en route.
- Responders collaborate to identify the least restrictive clinically appropriate outcome while addressing immediate safety concerns.
- The interaction concludes when the individual is stabilized, connected to services, transported to an appropriate level of care, or otherwise reaches a clinically appropriate disposition.

Level 4: Emergency Public Safety Response with Behavioral Health Coordination

- Calls classified as Marcus Alert Level 4 require an immediate public safety response.
- The PSAP shall dispatch law enforcement, EMS, and/or fire-rescue without delay according to local protocols.
- CIT-trained responders should be dispatched whenever available.
- If required by local protocols, the PSAP should notify the Regional Crisis Contact Center as early as possible to support coordination and follow-up.
- The PSAP telecommunicator should provide the Regional Crisis Contact Center with all available information, including:
    - PSAP name and callback number
    - CAD incident number
    - Individual's name, location, and callback number, if known
    - Determined Marcus Alert level
    - Chief complaint and presenting concerns
    - Known safety concerns and risk factors
    - Resources dispatched and current scene status
- Community Care Teams, Mobile Crisis Response Teams, or other behavioral health resources may be notified or staged until scene conditions permit safe engagement.
- Emergency responders establish scene safety, address immediate threats, and provide emergency medical intervention as needed.
- Once conditions are safe, behavioral health personnel may assist with crisis intervention, stabilization, disposition planning, and linkage to services.
- The interaction concludes when the immediate threat has been mitigated and the individual has been connected to the least restrictive clinically appropriate level of care.

E. Agreements with Regional Crisis Call Center

Attach any formal agreements established between the PSAP and the Regional Crisis Contact Center that support Marcus Alert implementation and satisfy the requirements of Protocol 1.
At a minimum, these agreements should document the processes, roles, responsibilities, and expectations related to coordination between the PSAP and the Regional Crisis Contact Center, including call transfers, information sharing, communication pathways, response coordination, and data collection, as applicable.

Localities should note that this section applies only to formal agreements between the PSAP and the Regional Crisis Contact Center.

Additional formal agreements required to support Protocol 2 implementation, including agreements between the Community Services Board (CSB) and participating stakeholders such as law enforcement agencies, fire-rescue agencies, EMS agencies, hospitals, mobile crisis providers, alternative response teams, or other relevant partners, should be documented and submitted as an attachment.

There is no sample text for this section.

Protocol 2: Formal Agreements

Community Services Boards (CSBs) are required to establish and maintain formal agreements with all Marcus Alert stakeholders that participate in the locality's behavioral health crisis response system. These agreements are intended to formalize collaboration by defining each participating agency's roles, responsibilities, communication pathways, response expectations, information-sharing procedures, data collection, and operational coordination processes.

Formal agreements are required whenever a locality implements a Community Care Team, Co-Response Team, or other multidisciplinary Marcus Alert response model that requires coordination among participating agencies. This requirement applies regardless of the population served by the locality. Formal agreements should also address procedures for requesting and providing law enforcement back-up during Mobile Crisis Response (MCR) or Community Care Team responses, when applicable.

Law enforcement agencies recognized by the Department of Criminal Justice Services (DCJS) for institutions of higher education are also required to participate and should be included in formal agreements.

Optional: Law enforcement agencies serving populations less than 40,000 are not required to enter into formalized agreements with Mobile Crisis Response providers regarding requests for law enforcement back-up during Mobile Crisis Response or Community Care Team responses. However, localities are encouraged to establish these agreements whenever operationally beneficial.

In addition to completing this section of the Local Plan, the CSB shall attach all formal agreements developed to support Marcus Alert implementation. Draft agreements are acceptable for the initial Local Plan submission; however, all agreements must be finalized and fully executed prior to the locality's implementation date.

Participating stakeholders may include, but are not limited to:

- Regional Crisis Contact Centers
- Public Safety Answering Points (PSAPs)
- Local law enforcement agencies
- Fire-rescue and Emergency Medical Services (EMS) agencies
- Mobile Crisis Response providers
- Community Care Teams
- Hospitals and health systems
- DCJS-recognized institutions of higher education law enforcement agencies
- Other local agencies or organizations participating in Marcus Alert implementation

Refer to the Marcus Alert Toolkit available on the DBHDS website for a sample Memorandum of Understanding (MOU) and additional considerations when developing formal agreements.

Protocol 3: Specialized Law Enforcement Response

Protocol 3 Guidance and Helpful Tips

Protocol 3 is intended to establish a specialized law enforcement response to behavioral health crises that emphasizes behavioral health intervention, crisis de-escalation, and collaboration with community behavioral health partners. The protocol is required for all law enforcement agencies serving populations of 40,000 or more and supports the Marcus Alert goal of providing the most appropriate, least restrictive response to individuals experiencing a behavioral health crisis.

When completing this section of the Local Plan, describe how participating law enforcement agencies meet each Protocol 3 criterion. Where applicable, attach supporting policies, procedures, training records, or other documentation demonstrating implementation.

Criterion 1: Behavioral Health-Focused Response/Marcus Alert Response Policy

Purpose: Ensure that specialized law enforcement responses prioritize behavioral health intervention throughout the Marcus Alert continuum. Ensure that law enforcement agencies have policies directing personnel on how Marcus Alert calls are handled. Demonstrate that participating law enforcement agencies have developed a comprehensive specialized response program.

Include in your Local Plan:

- Explain how officers collaborate with behavioral health providers to support de-escalation, stabilization, and connection to services,
- Describe how the least restrictive intervention is considered throughout the response,
- Describe the agency's Marcus Alert response policy,
- Explain how Marcus Alert procedures are implemented whenever a call is identified as a Marcus Alert Level 1, 2, 3, or 4 event, including situations in which the behavioral health crisis is not identified until responders arrive on scene.
- Attach the applicable policy or procedure

Criterion 2: Crisis Intervention Team (CIT) Coverage

Purpose: Promote the preferential deployment of appropriately trained officers during behavioral health crises.

Include in your Local Plan:

- Describe the agency's participation in the local CIT Program.
- Identify the total number of sworn patrol officers.
- Identify the number and percentage of officers who have completed CIT training.
- Provide written documentation confirming the agency's commitment to maintaining greater than 20% CIT-trained patrol officers.

Criterion 3: Advanced Marcus Alert Training

Purpose: Ensure participating agencies continue developing specialized behavioral health response capabilities.

Include in your Local Plan:

- Provide written documentation to the agency's commitment having officers participate in the Marcus Alert Training as it becomes available.
- If the locality operates a Co-Response Team, indicate that assigned officers and clinicians will attend the in-person portion of the training.

Criterion 4: Community Policing

Purpose: Demonstrate ongoing community engagement that supports trust, collaboration, and behavioral health crisis response.

Include in your Local Plan:

- Describe current community policing initiatives.

- Include outreach activities, behavioral health partnerships, community events, school programs, or other engagement efforts.
- Attach supporting flyers, brochures, photographs, or other examples when available.

Criterion 5: Use of Force Policy

Purpose: Ensure officers are trained and expected to utilize de-escalation techniques whenever appropriate during behavioral health encounters.

Include in your Local Plan:

- Confirm the agency maintains a current Use of Force Policy.
- Describe how verbal de-escalation is incorporated into the policy.
- Attach the agency's Use of Force Policy.

Criterion 6: Implicit Bias Training

Purpose: Promote equitable behavioral health crisis response through ongoing education.

Include in your Local Plan:

- Describe when officers receive Implicit Bias Training.
- Identify whether refresher or continuing education is provided following academy training.
- Attach any policies or procedures related to Implicit Bias Training.

Criterion 7: Officer Wellness

Purpose: Support officer well-being and resiliency to promote effective responses during behavioral health crises.

Include in your Local Plan:

- Describe the agency's Officer Wellness Program or initiatives.
- Attach the agency's Officer Wellness Policy.

Criterion 8: Mental Health First Aid

Purpose: Ensure officers receive foundational education regarding behavioral health conditions and crisis response.

Include in your Local Plan:

- Describe the agency's commitment to providing Mental Health First Aid or an equivalent training to all officers.
- Identify any equivalent training utilized by the agency.

Criterion 9: Crisis Intervention Team (CIT) Training Availability

Purpose: Demonstrate that local law enforcement agencies have access to CIT training opportunities.

Include in your Local Plan:

- Describe the local CIT Program.
- Identify which law enforcement agencies participate in the program.
- Attach a current list of participating agencies or other supporting documentation

Budget

The Budget is an important part of the Local Plan because this information provides a realistic picture of what funds are needed in the various regions and team compositions. This information will be used to instruct the State's annual report on Marcus Alert implementation due to the General Assembly. Be as detailed and upfront about expenses incurred as possible. Additionally, a separate budget template will need to be submitted during the planning year providing details on how those funds will be utilized compared to once implemented. CSBs are required to consult with their PSAPs on costs involved for necessary CAD updates and offset this with planning year funds. CSBs will also be required to provide written communication from PSAPs if they decline additional funding. Funds will support purchasing furniture, technological equipment, uniforms, non-law enforcement vehicles and other one-time disbursements of funds during the planning year. CSBs should also consider hiring a position specific to coordinating Marcus Alert implementation to assist with various policies and procedures.

Marcus Alert – Planning Year Budget Sample

I. Personnel (Planning Roles)

Position Title	Role Type	FTE	Annual Salary	State General Funds	Locality Share	Other Funding Source	Anticipated Hire Date
Marcus Alert Coordinator	Program Administration	1.0	$92,000	$92,000	$0	N/A	July 1, 2027
Program Analyst	Data & Evaluation	0.50	$35,000	$35,000	$0	N/A	September 1, 2027
Administrative Support	Administrative	0.25	$15,000	$15,000	$0	N/A	October 1, 2027

Narrative Justification (Sample):

The Marcus Alert Coordinator will oversee planning activities, facilitate stakeholder engagement, coordinate implementation efforts, manage local planning meetings, develop policies and procedures, and serve as the primary liaison with DBHDS and partner agencies. The Program Analyst will assist with workflow development, data collection planning, and performance measure development. Administrative support will assist with meeting coordination, documentation, scheduling, and planning logistics. These positions support Marcus Alert planning and implementation activities and do not duplicate staffing supported through Mobile Crisis Response (MCR), Crisis Intervention Team (CIT), SCOP, or other DBHDS/DCJS funding sources.

II. Equipment & Operational Start-Up Costs

Item Description	Quantity	Unit Cost	Total Cost	Justification
Clinician Vehicle	1	$32,000	$32,000	Transportation for Community Care Team planning and implementation activities
Laptop Computers	3	$1,500	$4,500	Planning, documentation, and interoperability activities
Mobile Phones	3	$800	$2,400	Secure communication between response partners
CAD/Data Integration	1	$50,000	$50,000	Supports Marcus Alert data collection and CAD enhancements
Office Equipment & Supplies	1	$5,000	$5,000	Start-up operational needs

Narrative Justification (Sample):

Equipment purchases support the initial establishment of Marcus Alert infrastructure, including technology needed for communication, planning, reporting, and field operations. Funding for CAD integration will support required modifications to collect Marcus Alert data elements and improve interoperability between public safety and behavioral health partners.

III. PSAP Contributions (Required)

Jurisdiction	Type of Support	Amount	Expected Outcome
ABC County PSAP	CAD System Enhancements	$50,000	Implementation of Marcus Alert level classifications, behavioral health identifiers, and required reporting fields

Sample Narrative:

The Community Services Board allocated $50,000 in planning-year funds to support CAD modifications necessary for Marcus Alert implementation. Funding will support vendor programming, testing, implementation, and staff training related to Marcus Alert data collection and reporting requirements. This expenditure is also reflected in the Planning Year Budget.

If a PSAP declines funding, attach written documentation confirming the declination.

IV. Planning & Infrastructure Activities

Activity	Purpose	Vendor (if applicable)	Amount	Timeline
Stakeholder Meetings	Develop local Marcus Alert partnerships	N/A	$2,500	July–December
Legal Review	Review MOUs and agreements	County Attorney	$5,000	August
Protocol Development	Develop dispatch and response protocols	N/A	$3,000	July–October
Interoperability Planning	Develop 911/988 workflows	N/A	$4,500	July–November
Community Outreach	Public education and marketing	ABC Printing	$2,000	October–December

Narrative Justification (Sample):

Planning and infrastructure activities support development of the local Marcus Alert system by establishing interagency agreements, developing operational protocols, preparing responders for implementation, improving interoperability between behavioral health and public safety partners, and educating the community regarding available behavioral health crisis response resources.

Marcus Alert – Operational Year Budget Sample

I. Operational Personnel

Position Title	Role Type	FTE	Annual Salary	State General Funds	Locality Share	Vacancy Status	Jurisdiction Coverage
Community Care Team Clinician	Licensed Clinician	1.0	$82,000	$82,000	$0	Filled	Countywide
Peer Recovery Specialist	Peer Support	1.0	$48,000	$48,000	$0	Filled	Countywide
Community Care Team Supervisor	Clinical Supervisor	0.50	$52,000	$52,000	$0	Vacant	Countywide

Narrative Justification (Sample):
Personnel funding supports ongoing Community Care Team operations following implementation. Staffing provides behavioral health crisis assessment, crisis intervention, de-escalation, care coordination, follow-up services, and supervision necessary to maintain community-based crisis response. Staffing levels support coverage during peak operating hours while coordinating with Regional Mobile Crisis Response, PSAPs, and local public safety partners.

II. Overtime (Community Care Team Coverage)

Role	Estimated OT Hours	Total Cost	Directly Related to Community Care Team Response? (Y/N)	Explanation
Community Care Team Clinician	250	$15,000	Yes	Supports evening, weekend, and holiday response coverage.
Peer Recovery Specialist	150	$6,500	Yes	Provides additional coverage during periods of increased call volume.

III. Equipment & Ongoing Operational Support

Item Description	Quantity	Unit Cost	Total Cost	Justification
Vehicle Maintenance	2	$2,500	$5,000	Routine maintenance for Community Care Team vehicles
Laptop Replacement	2	$1,800	$3,600	Replacement of aging field documentation equipment
Mobile Phone Service	4	$900	$3,600	Secure communication for Community Care Team staff
Clinical Safety Supplies	1	$2,500	$2,500	Replacement of essential field safety equipment
Operational Supplies	1	$2,000	$2,000	Ongoing operational support

Narrative Justification (Sample):
Equipment funding supports the continued operation of Community Care Teams through routine maintenance, replacement of essential equipment, secure communication capabilities, and operational supplies necessary to maintain field response capacity. No funding is requested for prohibited expenditures, including police vehicles, police equipment, CIT-only programming, or out-of-state travel.

IV. PSAP Contributions (Optional)

Jurisdiction	Type of Support	Amount	Purpose
ABC County PSAP	Annual CAD Maintenance	$8,000	Supports ongoing Marcus Alert reporting and CAD functionality

Sample Narrative:
Optional funding has been allocated to assist the participating PSAP with ongoing maintenance of Marcus Alert-related CAD functionality implemented during the planning year. This funding supports continued data collection, reporting, and interoperability between public safety and behavioral health partners.

V. Planning & Infrastructure Activities

Activity	Purpose	Vendor (if applicable)	Amount	Timeline
Stakeholder Meetings	Ongoing system coordination	N/A	$1,500	Quarterly
Interoperability Review	Review and improve 911/988 workflows	N/A	$2,000	Semi-Annual
Community Outreach	Increase public awareness of Community Care Team services	ABC Printing	$2,500	Throughout Fiscal Year
Refresher Training	Maintain responder competencies	Local Training Provider	$4,000	Annually

Narrative Justification (Sample):
Planning and infrastructure activities support the continued operation and quality improvement of the Marcus Alert system by maintaining interagency collaboration, evaluating operational workflows, providing ongoing training, and increasing community awareness of available behavioral health crisis response services.

Contact Us

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Regional Marcus Alert Coordinators

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

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Locality Population per 2020 Census Data

Localities With < 40,000

Locality	*2020 Census*
Accomack County	33,413
Alleghany County	15,223
Amelia County	13,265
Amherst County	31,307
Appomattox County	16,119
Bath County	4,209
Bland County	6,270
Botetourt County	33,596
Bristol City	17,219
Brunswick County	15,849
Buchanan County	20,355
Buckingham County	16,824
Buena Vista City	6,641
Caroline County	30,887
Carroll County	29,155
Charles City County	6,773
Charlotte County	11,529
Clarke County	14,783
Colonial Heights City	18,170
Covington City	5,737
Craig County	4,892
Cumberland County	9,675
Dickenson County	14,124
Dinwiddie County	27,947
Emporia City	5,766

Localities With > or equal to 40,000

Locality	*2020 Census*
Albemarle County	112,395
Alexandria City	159,467
Arlington County	238,643
Augusta County	77,487
Bedford County	79,462
Campbell County	55,696
Charlottesville City	46,553
Chesapeake City	249,422
Chesterfield County	364,548
Culpeper County	52,552
Danville City	42,590
Fairfax County	1,150,309
Fauquier County	72,972
Franklin County	54,477
Frederick County	91,419
Hampton City	137,148
Hanover County	109,979
Harrisonburg City	51,814
Henrico County	334,389
Henry County	50,948
James City County	78,254
Loudoun County	420,959
Lynchburg City	79,009
Manassas City	42,772
Montgomery County	99,721

Essex County	10,599
Fairfax City	24,146
Falls Church City	14,658
Floyd County	15,476
Fluvanna County	27,249
Franklin City	8,180
Fredericksburg City	27,982
Galax City	6,720
Giles County	16,787
Gloucester County	38,711
Goochland County	24,727
Grayson County	15,333
Greene County	20,552
Greensville County	11,391
Halifax County	34,022
Highland County	2,232
Hopewell City	23,033
Isle of Wight County	38,606
King and Queen County	6,608
King George County	26,723
King William County	17,810
Lancaster County	10,919
Lee County	22,173
Lexington City	7,320
Louisa County	37,596
Lunenburg County	11,936
Madison County	13,837
Manassas Park City	17,219
Martinsville City	13,485
Mathews County	8,533

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

Mecklenburg County	30,319
Middlesex County	10,625
Nelson County	14,775
New Kent County	22,945
Northampton County	12,282
Northumberland County	11,839
Norton City	3,687
Nottoway County	15,642
Orange County	36,254
Page County	23,709
Patrick County	17,608
Petersburg City	33,458
Poquoson City	12,460
Powhatan County	30,333
Prince Edward County	21,849
Pulaski County	33,800
Radford City	16,070
Rappahannock County	7,348
Richmond County	8,923
Rockbridge County	22,650
Russell County	25,781
Salem City	25,346
Scott County	21,576
Smyth County	29,800
Southampton County	17,996
Staunton City	25,750
Surry County	6,561
Sussex County	10,829
Waynesboro City	22,196
Westmoreland County	18,477
Williamsburg City	15,425
Winchester City	28,120
Wise County	36,130
Wythe County	28,290