

Implementation of the 988 Hotline:

A Framework for State and Local Systems Planning

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Introduction

What is 988?

The [National Suicide Hotline Designation Act of 2020](#) established 988 as a new three-digit telephone number to function as a national suicide prevention and mental health crisis hotline system that will connect people in crisis with life-saving resources. With this easy-to-remember number, Congress hopes to increase public access to mental health and suicide prevention crisis resources, encourage help-seeking for individuals in need, and provide a crucial entry point to a continuum of crisis care.

988 presents a unique opportunity for the behavioral health system, law enforcement, 911 systems, and other stakeholders to strengthen crisis response capacity throughout the U.S. and to provide people experiencing a mental health crisis with appropriate support.

The Federal Communications Commission designated 988 as the new three-digit number for the [National Suicide Prevention Lifeline \(1-800-273-TALK\)](#) in July 2020; telecommunications companies will be required to route all 988 calls to the National Suicide Prevention Lifeline by July 16, 2022.¹ The Lifeline was launched in 2005 by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and Vibrant Emotional Health,² and comprises a national network of more than 180 local crisis centers.³

988 presents a unique opportunity for the behavioral health system, law enforcement, 911 systems, and other stakeholders to strengthen crisis response capacity throughout the U.S. and to provide people experiencing a mental health crisis with appropriate support. Now is when leaders should rethink how the crisis system currently operates and performs, and articulate a clear vision. It is probable that call volume will increase with 988 implementation,⁴ both because of the easily remembered three-digit number and because calls that would otherwise have been made to 911, or to local crisis and information lines, will begin to shift to 988. People in crisis and their family members may also find 988 to be a more welcoming alternative to 911.

Framework for 988 Planning and Implementation

With this paper, we offer a framework for key stakeholders to use in organizing, planning, implementing, and sustaining an effective 988 crisis call system. We identify eight overarching activities and provide examples of the types of tasks that should be part of each activity. The framework calls for stakeholders to:

- ✓ Establish and Commit to a Systems-Level Planning Process
- ✓ Identify and Address Key Considerations in 988 Design
- ✓ Identify and Address Coordination between 988 and 911
- ✓ Develop Sustainable Financing Mechanisms to pay for 988
- ✓ Develop Marketing and Communications Strategies for 988 Implementation
- ✓ Identify and Address Potential Implementation and Transition Issues
- ✓ Develop Strategies to Monitor Performance and Troubleshoot Problems
- ✓ Ensure Connections and Access to Upstream Services

1. U.S. Federal Communications Commission (n.d.) [Fact sheet: 988 and suicide prevention hotline](#) [PDF]. Retrieved September 27, 2021 from <https://www.fcc.gov/sites/default/files/988-fact-sheet.pdf>

2. U.S. Federal Communications Commission, Wireline Competition Bureau and Office of Economics and Analytics (2019). [Report on the National Suicide Hotline Improvement Act of 2018](#) [PDF]. <https://bit.ly/3mdWeVy>

3. National Suicide Prevention Lifeline (n.d.). [Our network](#). <https://suicidepreventionlifeline.org/our-network/>

4. Vibrant Emotional Health (2020). [988 serviceable populations and contact volume projections](#) [PDF]. <https://bit.ly/3j06sXy>

Crisis Call Centers and Crisis Services: An Overview

The National Suicide Prevention Lifeline provides free and confidential emotional support 24 hours a day, 7 days a week to people in suicidal crisis or emotional distress, anywhere in the United States. The Lifeline fielded 2.2 million calls, texts, and online chats in 2020.⁵ The Lifeline routes calls to local crisis centers, but redirects those calls to other crisis centers if there is insufficient local capacity to field a call in real time. Lifeline crisis centers are encouraged to operate 24 hours a day, 7 days a week, but not all centers operate 24/7.

When someone calls the Lifeline and is connected with a crisis center, a staff person engages the caller and assesses for suicide risk by gathering information about the caller's risk factors, desires, plans, needs, and capacity. Call center staff attempt to provide the least restrictive clinically appropriate care, which could involve voluntary rescue, in which the caller agrees to seek care. However, Lifeline center staff do not initiate active rescue services for imminent concern, for suicide attempts in progress, or when an individual remains at immediate risk but is unwilling or unable to take actions to prevent suicide or mediate their suicidal ideation. Depending on acuity of concern, life-saving measures could also encompass other emergency response providers including mobile crisis and psychiatric outreach teams. In instances of suicide attempts, the goal is to connect the individual with emergency medical care as soon as possible, often, through 911 or emergency medical services (EMS), ambulance, and transport to a hospital. Lifeline crisis centers are expected to have formal relationships with emergency service providers and to engage in coordination and follow-up to ensure that people who receive life-saving measures are successfully connected to appropriate services.⁶ Crisis centers may also coordinate with community mental health professionals or crisis receiving and stabilization facilities when responding to calls.

In addition to the Lifeline, numerous other call lines throughout the country function as crisis hotlines or provide support to people facing behavioral health challenges. These call lines may be focused on mental health emergencies, but may also serve other purposes, such as “warm lines” that provide emotional support and connect people to resources. Furthermore, other hotlines exist that provide information and referral for a range of mental health resources and other social services and supports. The capacity, configuration, and availability of these lines vary by state, region, and locality. In any given area, people experiencing a behavioral health crisis may be encouraged to call:

- 211
- 311
- A local line that serves a city or county
- A regional call center
- A hotline operated by their managed care provider

Unfortunately, because of the haphazard way in which crisis call lines are organized, people in need do not always know how or when to reach out to them. They may not be aware that the Lifeline will connect them to local resources when

Diverting mental health emergencies from law enforcement to behavioral health clinicians will reduce law enforcement encounters in behavioral health crisis; increase access to services; and establish a clear pathway for reaching out for help during a mental health emergency, regardless of location.

available, so they may instead call 911, or they may not reach out for help at all. For an individual in emotional distress or their family member, the situation can feel overwhelming and it is easy to revert to a known and well-remembered number, 911, instead of the Lifeline or a local crisis call center. People call 911 for a variety of other reasons, too, including public safety concerns, or because a mental health provider instructed them to do so. In some areas, 911 dispatchers do link callers to the Lifeline or to local call centers; however, more often than not, law enforcement is dispatched to manage the emergency even if a mental health response would be more effective. 988 has the potential to establish a national approach to divert mental health emergencies from law enforcement to behavioral health clinicians. This shift will reduce law enforcement encounters in behavioral health crisis; increase access to services; establish a clear pathway for reaching out for help during a mental health emergency, regardless of location; and potentially reduce confusion about what number to call for a mental health emergency.

5. Vibrant Emotional Health (2020). *Annual report 2020: Building resilience and adapting to change*. <https://annualreport2020.webflow.io/>

6. National Suicide Prevention Lifeline (2010). *National Suicide Prevention Lifeline policy for helping callers at imminent risk of suicide* [PDF]. <https://bit.ly/2XHmp88>

For 988 to be fully successful, local systems will need to build capacity by coordinating and integrating their community emergency response and mental health systems. 988 has the potential to streamline access to local crisis centers and mental health resources. However, implementation will require additional crisis line capacity; action to support coordination and capacity across systems involved in behavioral health crisis response; and efforts to increase public awareness. A significant portion of 988 calls will be resolved over the phone, but many will require a more intensive, in-person response. Depending on the local infrastructure, this could mean a mobile crisis team, connection with a crisis response and stabilization facility, or connection with other community behavioral health supports.

Without these types of resources in place, crisis call centers will need to connect with other emergency response resources. In most cases, this would result in a law enforcement response and/or transportation to a hospital emergency department (ED). Unfortunately, EDs do not always have the capacity to effectively help people experiencing a behavioral health crisis, and often lack capacity to admit

people for inpatient mental health care.⁷ This puts individuals at risk for ED boarding, a situation in which patients must wait in the ED for an extended period to access needed supports. Frequently, individuals in distress are unable to endure the wait times and leave before even being seen. Hospitalization, when it is eventually available, may not be the optimal intervention to help individuals address their immediate crisis and connect them with ongoing community behavioral health supports. Worse, many individuals experiencing a behavioral health crisis end up in jail after contact with law enforcement, and in rare circumstances, failure to deescalate crisis situations can lead to injury or death. With 988 implementation, systems have the opportunity to build integrated community behavioral health crisis capacity. If people call 988 and are connected with effective, community-based behavioral health resources, their experience will reinforce the value of 988, and build community confidence. If, on the other hand, individuals in crisis continue to be connected to ineffective or even detrimental responses through 988, confidence in the system may be undermined. For these reasons, diligent planning and thoughtful implementation are imperative for the success of 988.

Establish and Commit to a Systems-Level Planning Process

988 design and implementation cannot be driven or owned by a single system; both planning in a vacuum and collaborative planning that begins too late are likely to result in a fragmented call system that can place individuals experiencing a crisis at risk.

One of the basic questions that systems within states should ask is “Who is responsible for implementing 988?” While there may be an assumed point of responsibility — for example, a state mental health authority — several potential actors and groups share responsibility in the planning phase. System planning efforts will need to dive deep into each of the eight activities described in this paper. It will be helpful to organize a structure or framework to guide planning with a core group of key stakeholders, including some that are not part of state government, such as local law enforcement and 911 call centers, but which are nevertheless instrumental to successful planning. Representation from counties with less dense populations and fewer resources will be crucial to ensuring a smooth process between 988 call centers and community support services. The planning will need to be consultative and designed to engage and meet the needs of these critical partners. Recruitment efforts should ensure that the key stakeholder group represents diverse populations in order to address the multifaceted and robust needs of a

heterogeneous population. Many states have already begun intentional actions to ensure inclusion of appropriate representation. Washington State, for example, passed legislation to create a Tribal Behavioral Health and Suicide Prevention Line, including a subcommittee to examine the needs of individual tribes in the implementation of 988.⁸

Planning efforts should ensure that the key stakeholder group represents diverse populations in order to address the multifaceted and robust needs of a heterogeneous population.

Some stakeholders may be involved throughout the entire multi-year planning, design, and implementation process, while others may be brought in on specific issues, such as identifying data metrics and establishing a monitoring and performance process. Individual and group stakeholders that must be involved in planning should be identified and engaged, including:

7. Murphy, G., Draper, J., & McKeon, R. (2010). *Following up with individuals at high risk for suicide: Developing a model for crisis hotline and emergency department collaboration* [PDF]. National Suicide Prevention Lifeline. <https://bit.ly/2UxsDuJ>

8. Hepburn, S. (2021, August 3). *Washington State's 988 legislation includes a 988 tribal crisis line*. Talk.crisisnow.com. <https://bit.ly/3gjc4m4>

Individual & Group Stakeholders

- Individuals with lived experience
- Family members
- State mental health authorities
- State alcohol and drug agencies
- State health or public health departments
- State education departments/universities
- State tribal liaisons or tribal representatives
- Military and Veterans services partners
- State 911 administrators
- County mental health authorities
- Existing crisis call centers, including those participating in the Lifeline
- 911 call centers (also known as Public Safety Answering Points or PSAPs)
- Local police and other law enforcement (e.g. transit police)
- Providers of mental health and substance use disorder services to children, youth, and adults
- Social services and supports, including those related to homelessness and housing

Systems may approach planning in various ways. Several states have developed legislation to support 988 implementation by setting standards for participating crisis centers, mobile crisis response, and crisis receiving/stabilization; establishing a 988 financing structure, including the adoption of user fees; specifying governance structures; and establishing timeframes and milestones for 988 implementation.⁹ States may also build on and incorporate recommended advancements to other systems, such as suicide prevention¹⁰ and best practices in the implementation of 911 systems.¹¹ States may be able to leverage and build on existing planning efforts, such as state suicide prevention strategic plans, which exist in nine out of ten states.¹²

While many planning activities are being instituted by state or local behavioral health authorities, some states are broadening the scope of 988 planning. The New Jersey Office of the Attorney General established a plan to create county planning committees that align with local com-

munities in the state's behavioral health system and will guide and support the work of their statewide steering committee.¹³ Nebraska passed a legislative bill mandating that specific stakeholders — including senators and a law enforcement representative from every county and municipality in each congressional district — participate in the planning task force for 988, to ensure that all necessary entities are involved. The task force is charged with creating legislation to guide 988 implementation throughout the state.¹⁴ Alabama convened a joint commission, which started the planning process with an evaluation of existing suicide prevention programs within the state in order to make recommendations and encourage legislation as 988 rolls out.¹⁵ Colorado has allowed for public stakeholder input via its state website, and has reserved time during certain committee meetings for public comment on the 988 planning process.¹⁶ No matter which approach states adopt, they must consider the specific needs of their populations to determine how to efficiently select contributors.

Identify and Address Key Considerations in 988 Design

The planning process must address an exhaustive list of issues that will inform the design of 988 call centers and systems so that they are as functional as possible. It must

also include behavioral and general health care systems, 911 systems, and local emergency services, including law enforcement. The general public relies on 911 systems be-

9. National Association of State Mental Health Program Directors (2021). *Draft 4-16-21 model bill for core state behavioral health crisis services systems* [PDF]. <https://bit.ly/3xWgYn3>

10. Suicide Prevention Resource Center (2019). *Recommendations for state suicide prevention infrastructure* [PDF]. Waltham, MA: Education Development Center, Inc. <https://bit.ly/3svuBZb>

11. 911.gov (2018). *Guidelines for state NG911 legislative language: Examples and options for legislative language that facilitates the deployment of NG911, Version 2.0* [PDF]. <https://bit.ly/3sJKjQu>

12. Kennedy, K., Carmichael, A., Brown, M. M., Trudeau, A., Martinez, P., & Stone, D. M. (2021). *The state of state, territorial, and tribal suicide prevention: Findings from a web-based survey* [PDF]. Atlanta, GA: Centers for Disease Control and Prevention. <https://bit.ly/3uhecZ4>

13. State of New Jersey Office of the Attorney General, Department of Law & Public Safety *Law Enforcement Directive 2020-14, Establishing Countywide Working Groups to Address Mental Health and Special Needs Populations and Creating a Framework for Coordination with State Partners* [PDF] (2014). <https://bit.ly/3knd6qb>

14. *A Bill for an Act Relating to Mental Health; To Create the Mental Health Crisis Hotline Task Force; To Provide Powers and Duties; And to Declare an Emergency*, L.B. 247, 107th Nebraska State Legislature [PDF] (2021). <https://bit.ly/2XXgDVh>

15. Alabama Commission on the Evaluation of Services (2020). *Program evaluation — suicide prevention programs* [PDF]. <https://bit.ly/3zjDx6D>

16. Colorado Department of Human Services. (n.d.). *988 Implementation Planning Committee*. Retrieved September 28, 2021 from <https://cdhs.colorado.gov/behavioral-health/988-planning>

cause people know that when they dial 911 they will get an emergency response. For 988 systems to achieve a similar level of acceptance, they will have to provide the same reliability. With a centralized number, systems should anticipate an increased call volume and change in the content

of calls, which will directly affect planning considerations around infrastructure, staffing, call triage, and partnership with existing behavioral health resources. Below is a preliminary list of considerations for a comprehensive 988 implementation plan.

Crisis call center infrastructure, capacity, and operations:

- The extent to which 988 crisis call centers will have text and online chat capabilities
- Geographic coverage of individual call centers, identification of areas with insufficient coverage, and how to support consistency of service when transferring to a remote call center
- Projecting and tracking call volume through 988 implementation
- Policy and regulations for overall design, operations, and staffing
- Workforce development to ensure sufficient staffing with consideration of location and time of year as these affect call volume (e.g., locations with frequent natural disasters/hurricanes) as well as the balance of volunteer staffing versus paid staff
- Workforce training and supervision, taking into account existing processes, current curriculum and expanding training protocols to address additional call content as communities acclimate to using 988
- Developing standards for crisis call centers, taking into account existing standards, accreditation requirements, and other requirements for participating in the Lifeline
- Appropriate responses to a range of potential calls, including crises in areas beyond mental health and suicide that may still warrant a behavioral health crisis response, such as those related to substance use/misuse and overdoses, intellectual and developmental disabilities, and homelessness

- Capacity for crisis call centers to fulfill behavioral health crisis “air traffic control” functions
- Phone operating system considerations, including determining use of automatic calling distribution and geolocation capabilities in order to support triage
- Ensuring access/inclusion for underserved and high-risk populations (e.g., BIPOC, LGBTQ+, rural, youth)

People know that when they dial 911 they will get an emergency response. For 988 systems to achieve a similar level of acceptance, they will have to provide the same reliability.

Collaboration and coordination across systems:

- Triage issues, including 988 to 911 and 911 to 988 and ongoing coordination needs with local PSAPs
- Coordination with hospital EDs and connections to inpatient care when needed, including the capacity to follow up to ensure connection to support
- Procedures governing when and how to connect to community behavioral health crisis resources such

as mobile crisis teams, even when there is no apparent risk of suicide

- Considerations for memorandums of understanding among community partners
- Coordination with local behavioral health crisis systems, including timely access to assessment, care planning, and follow-up care
- Collaboration with social service providers as needed to be knowledgeable of up-to-date resources and referrals for human services support

Behavioral health crisis response infrastructure, capacity, and operations:

- Community mobile crisis response capacity, including tailored response capacity for children, youth, and families; and planned enhancements to the mobile crisis system and timeline projections for increased capacity
- Crisis receiving and stabilization facility capacity, including the ability to track available crisis beds
- Inpatient mental health capacity, including the ability to track available inpatient beds
- Substance use disorder (SUD) withdrawal management and residential capacity, including the ability to track the availability of these resources
- The availability of community behavioral health resources, such as Assertive Community Treatment (ACT), that provide crisis response
- Streamlining/prioritizing intake in community behavioral health services for disconnected individuals who experience crisis

Identify and Address Coordination between 988 and 911

Historically, 911 has been the default number to call for behavioral health crises, but across the country there have been movements to divert behavioral health calls from 911 to crisis call centers to ensure an appropriate response. If 988 is to be promoted as an alternative to 911 for many situations, it must be as functional as 911 on a range of issues. Because Lifeline call centers utilize 911 to ensure that callers are linked to an appropriate response when there is an urgent need, many of them have identified best practices for coordination between their crisis call centers and 911. However, 911 itself is also undergoing reforms and implementing performance-enhancing strategies in order to ensure easy access and prompt response.¹⁷ States and localities will need to take into consideration how such changes may affect communication between 988 and 911. These reforms create an opportune time for state planning considerations of how 911 can interface with 988 in a systematic way. In order to achieve this, intensive technical planning will be required in communications, ensuring that technology for new and existing call centers will include interoperability with 911 systems. For example, PSAPs, or 911 call centers, are equipped to track a person's telephone number (ANI; automatic number identification) and location (ALI; automatic location identification) regardless of whether the individual attempted to block the number.¹⁸ Lifeline call centers are not currently registered as PSAPs, and their telecommunications do not allow for this capability; therefore, transfers to 911 in imminent situations will not transfer ANI or ALI.¹⁹ States need to ensure that planning takes into consideration such critical communication between 988 call centers and 911. In addition, planning should also address the following scenarios:

- A caller dials 988 requiring an in-person crisis response and the 988 center does not have geolocation capacities so they are routed to a service center in a different state, which then has difficulty coordinating the in-person response. Because the crisis center does not have the knowledge of, or connections to, community behavioral health crisis systems, they default to contacting 911.
- A caller dials 988 specifically to avoid a law enforcement response, but is connected to 911 because of a lack of community behavioral health crisis capacity, or lack of coordination between the Lifeline crisis center and community behavioral health crisis resources.

- A caller dials 988 and is connected with a behavioral health crisis system (e.g. a mobile crisis team) with inadequate capacity, leading to response delays or a poor quality response.

It is imperative that states and localities maintain an ongoing relationship between crisis call centers and 911 dispatch in order to identify and troubleshoot communication concerns, as well as to ensure prompt responses to critical situations. This priority may be supported by the creation of a joint task force within the implementation working group with a specific focus on 911 and 988 communication and behavioral health response capacity. Such a group should include representatives from dispatch, law enforcement, 988 call centers, mobile response teams, and representatives from the broader behavioral health continuum. They should meet regularly during planning and implementation as well as intermittently thereafter. This group should streamline collaboration and address issues such as gaining uniform understanding of which calls warrant a 988 response and which calls warrant a 911 response; taking safety, level of threat, mobile crisis system capacity, and care of the individual into consideration. The task force can also evaluate the need for training protocols for 911 dispatch in order to divert calls to 988 as needed. A pilot of the system may be required in order to identify the mechanism for call transfer that limits the number of dropped calls and the number of errors in coordination to ensure smoother operations prior to July 2022. Interagency processes must also be established that directly address each of the following issues:

- Handling calls triaged from 988 to 911, particularly in areas without crisis service capacity where this may actually increase call volume to 911
- Challenges in transferring from a national line to correct locations
- Successfully managing conferencing calls or call transfers to 911
- Handling increased volume of calls to crisis centers participating in the Lifeline
- Preparing to handle a higher volume of suicide-related and high acuity behavioral health calls
- Conducting staff training to offer enhanced skill development to meet the broader range of anticipated calls

17. Federal Communications Commission. (2020, April 22). *Multi-line telephone systems — Kari's Law and RAY BAUM'S Act 911 direct dialing, notification, and dispatchable location requirements*. Retrieved August 25, 2021 from <https://www.fcc.gov/mlts-911-requirements>

18. Boulder [CO] Emergency Telephone Service Authority (2020). *BRETSAs comments on implementation of the National Suicide Hotline Improvement Act of 2018* [PDF] (submitted to the U.S. Federal Communications Commission). <https://bit.ly/3koj1LL>

19. Vibrant Emotional Health (2020). *988 serviceable populations and contact volume projections* [PDF]. <https://bit.ly/3j06sXy>

Systems have taken several approaches to coordination to ensure care during situations with imminent risk. Austin, TX, for example, embedded clinicians in 911 dispatch centers.²⁰ A memorandum of understanding gives these crisis clinicians access to the city's 911 Computer Automated Dispatch (CAD) system, reducing problems during transfers of 911 calls.²¹ Washington, D.C. piloted its 911 mental health diversion system with test callers in order to identify

errors in transfers, data entry, and screening protocols before public use of the system.²² Denver's STAR program embedded a mental health clinician into the PSAP in order to support communication between the behavioral health system and 911, and created easy-to-follow call guidelines for dispatchers to determine the most appropriate responding entity: mental health, EMS, co-response, or only law enforcement.²³

Develop Sustainable Financing Mechanisms to Pay for 988

In order for 988 call centers to be fully functional and responsive 24/7/365, there must be adequate funding to sustain both operations (especially if there is increased call volume) and access to additional services such as mobile response and crisis stabilization. Currently, the Lifeline and a patchwork of local crisis or information lines are funded, often inadequately, by multiple resources. The National Suicide Hotline Designation Act creates an opportunity for states to establish fees to support implementation and operation of 988 call centers, and several states have passed or introduced legislation to finance 988. Systems should calculate the costs of operating 24/7/365 call centers, as well as the various resources necessary to support upfront and ongoing infrastructure, operations, training, and staffing to ensure quality interventions and access to vital services.

Budgeting plans should include technology, both hardware and software; enhanced telecommunications to support geolocation; and physical location and facilities costs. Systems need to outline the financial implications of staffing a 24/7/365 operation including recruitment, hiring, and training in order to ensure that call takers are equipped with clinical assessment and de-escalation techniques. Staffing financial plans should guarantee that staff have direct access to supervision and support for calls that are outside the scope of their knowledge. Administrative costs related to meetings with community partners, regular audits to ensure quality control and performance monitoring, and data collection and analysis should be accounted for as well. While there is uncertainty about the impact that 988 rollout and implementation will have on call volume, projections suggest that it will increase.^{24, 25} Vibrant Emotional Health, the organization that operates the Lifeline, has developed

cost and volume projections for the states, territories, and Washington D.C. to assist in planning.²⁶

If upstream services like crisis stabilization programs, outpatient services, intensive services, and peer supports are not accessible, the crisis system may be overwhelmed.

The planning phase must identify the types of resources that can support these functions. Ideally, 988 call centers should receive dedicated operations funding that is not vulnerable to annual fluctuations. State legislation may have a role in establishing funding, such as bills introduced recently in several states for telecom fees, to support the 988 system. Virginia successfully passed legislation that increases the 911 fee and establishes an additional 988 fee. The money from the 988 fee will go to a Crisis Call Center Fund which will support a continuum of crisis services. States should work to ensure that such funds are allocated back into their crisis systems, rather than diverted to alternate systems.^{27, 28} Rather than increasing the 911 surcharge, Colorado established a fee that only applies to 988.²⁹

Medicaid, federal block grants, and other state-level resources could be used to support some operations. Medicaid can be an important source of funding, but only pays for

20. Hepburn, S. (2021, June 1). *Austin's 911 call center integrates mental health call crisis diversion*. #CrisisTalk. <https://bit.ly/3B8SrwU>

21. Hepburn, S. (2021, June 1). *Austin's 911 call center integrates mental health call crisis diversion*. #CrisisTalk. <https://bit.ly/3B8SrwU>

22. Uliano, D. (2021, May 26). *DC begins final testing in shifting 911 calls to mental health counselors*. WTOP News. <https://bit.ly/38c41ef>

23. Sailon, C., (2021, September 7). Personal communication with Jordan Gulley [videoconference]

24. U.S. Federal Communications Commission, Wireline Competition Bureau and Office of Economics and Analytics (2019). *Report on the National Suicide Hotline Improvement Act of 2018* [PDF]. <https://bit.ly/3mdWeVy>

25. Vibrant Emotional Health (2020). *988 serviceable populations and contact volume projections* [PDF]. <https://bit.ly/3j06sXy>

26. Vibrant Emotional Health (2021). *988 Center-Level Cost Estimates* [PDF]. <https://bit.ly/3mahGcn>

27. Hepburn, S. (2021, May 4). *Virginia is first state to pass 988 service fee legislation*. #CrisisTalk. <https://bit.ly/3yiLho6>

28. Federal Communications Commission (2021, April 1). *911 fee reports and reporting*. Retrieved August 25, 2021 from <https://bit.ly/2Wnq2V8>

29. Colorado Legislative Council Staff (2021). *Final fiscal note for S.B. 21-154: 988 Suicide Prevention Lifeline Network* [PDF]. <https://bit.ly/2UOefyv>

services for Medicaid beneficiaries, not those who are uninsured or are covered by other third party insurance. Many states have included call center services in their Medicaid waivers or State Plans in order to allow for reimbursement for 988 services. Utah proposed to explore partnerships with insurance companies to complement its system and reimburse for services not covered by Medicaid.³⁰ The American Rescue Plan Act allows states

the opportunity to enhance funding for mobile crisis services that can work in tandem with 988 to ensure adequate response to individuals in crisis.³¹ However, it is critical that systems address financing to link to upstream services as part of planning for 988. If upstream services like crisis stabilization programs, outpatient services, intensive services (e.g., ACT), and peer supports are not accessible, the crisis system may be overwhelmed.

Develop Marketing and Communications Strategies for 988 Implementation

In some areas, there are multiple local crisis call lines with varying functions, creating potential confusion. 988 implementation has the potential to mitigate such problems, providing a single recognizable way to get assistance for people experiencing a behavioral health crisis. In order for 988 to be used as readily as 911, however, a significant effort must be made to educate the public. Systems should consider appropriate timelines of marketing plans for specific populations, such as the public, so as not to create confusion regarding when the number becomes functional. Marketing and education on when to call 988 instead of 911 will need to be delivered over a long period in order for it to become ingrained with groups and in order to reach key groups that may need additional outreach. As national marketing and communications strategies are developed over the next year, local systems should align with and build on

these campaigns. Systems should identify how 988 will be described and marketed to specific target audiences (e.g., police and fire departments, EMS, schools, and the general public). Some of this communication, particularly for involved public systems, should come before July 2022, but much of it should be focused on general awareness after 988 becomes available across telecommunications platforms.

Different audiences will require different messaging. For the public, it may be necessary to provide messaging that conveys the essential functions of the 988 system and explains how to use the system, as well as general education on recognizing signs of a behavioral health crisis. More tailored messaging and training should be directed to behavioral and general health care providers; law enforcement; EMS; human and social services; housing; and other public and private systems likely to interact with people experiencing behavioral health crises. Marketing plans should be designed with input from individuals with lived experience and their family members in order to ensure that communication is effectively geared toward those who benefit from the service. Tensions may arise if more developed crisis behavioral health systems connected with 988 want to publicize 988 capacity that is not generally available outside of their region. States should work with community 988 systems to ensure that local messaging does not confuse potential users or create false expectations about 988 capacity more generally.

Marketing plans should be designed with input from individuals with lived experience and their family members in order to ensure that communication is effectively geared toward those who benefit from the service.

30. *988 Mental Health Crisis Assistance*, Utah Senate Bill 155 (2021). <https://le.utah.gov/~2021/bills/static/SB0155.html>

31. Traube, A., Boozang, P., & Guyer, J. (2021, April 30). *American Rescue Plan provides a new opportunity for states to invest in equitable, comprehensive and integrated crisis services*. State Health & Value Strategies. <https://bit.ly/2XUsQtb>

Identify and Address Potential Implementation and Transition Issues

Implementation of 988 provides an opportunity to improve access to emergency mental health services, but also comes with risk if not done well. Systems must identify potential implementation and transition issues in order to minimize confusion for potential callers, 911 call centers, first responders, and others. In many systems, nothing will change, and calls to previously existing Lifeline call centers will function as before. In other systems that create additional 988 capacity, possibly by converting existing non-Lifeline call centers, there may be new volume, capacity, training, interoperability, or other issues that need to be addressed to minimize problems with response.

States should consider adopting timelines and projected targets based on a deliberate vision of what 988 capacity should be within the first six months versus two years into implementation. Systems should plan to address potential increases in call volume as more people call 988 instead of 911, and should incorporate timeframes for capacity-building — including staffing and training for call centers and mobile crisis teams — that may, over time, reduce the number of calls redirected to 911. Many communities are experiencing difficulty in locating qualified behavioral health staff and this challenge is exacerbated in rural areas so systems may need to incentivize staffing and strengthen their peer networks.³² Systems will need to manage how capacity-building information is communicated to the public to protect against frustrations that might lead people to revert to 911.

All crisis centers participating in 988 will have to meet Lifeline standards,^{33, 34, 35} so for systems that already utilize Lifeline systems, the target deadlines will be more

aggressive as 988 rollout will have minimal initial impact on operations. Communities planning to convert centers or create new 988 call centers can anticipate more

Systems must identify potential implementation and transition issues in order to minimize confusion for potential callers, 911 call centers, first responders, and others.

issues during the implementation phase. States can consider designating Certified Community Behavioral Health Clinics (CCBHCs) as 988 call centers, as 75 percent of CCBHCs currently operate 24-hour call centers but only 21 percent participate in the National Suicide Prevention Lifeline network.³⁶ Planning will need to include evaluation of current systems in order to create realistic timelines and contingency plans for anticipated challenges. Regular meetings between key stakeholders should be held throughout the transition in order to identify gaps in the system where individuals are not receiving adequate care. Systems should modify implementation based on feedback from callers, providers, mobile crisis, law enforcement, and other community partners.

Develop Strategies to Monitor Performance and Troubleshoot Problems

Planning should include a monitoring and performance framework that begins on day one. This framework should specify the types of data to be collected by 988 and 911 call centers, and whether and how data will be shared between the two networks and with key stakeholders. Data should also be collected from existing call centers that do not convert to 988 in order to fully understand the

volume and types of calls coming in throughout the system, as well as to identify performance improvement strategies and cost efficiencies. Lifeline and SAMSHA have identified core required reporting measures that include both operational and service-oriented metrics such as call volume, average speed of answering calls, call abandonment rate, and number of individuals connected to services, as well

32. Gale, J., Janis, J., Coburn, A., & Rochford, H. (2019). *Behavioral health in Rural America: Challenges and opportunities* [PDF]. Iowa City, IA: Rural Policy Research Institute. <https://bit.ly/2Y1dUtx>

33. National Suicide Prevention Lifeline (n.d.). *Minimum requirements* [PDF]. <https://bit.ly/3kr3nPF>

34. National Suicide Prevention Lifeline (2007). *National Suicide Prevention Lifeline (NSPL) suicide risk assessment standards* [PDF]. <https://bit.ly/3sXayD9>

35. National Suicide Prevention Lifeline (2010). *National Suicide Prevention Lifeline policy for helping callers at imminent risk of suicide* [PDF]. <https://bit.ly/2XHmp88>

36. Jones Chandler, L., Parks, J., Goldfinger, J., & Aguilar, M. (n.d.) *Fulfilling the promise of 9-8-8: Understanding the behavioral health crisis care continuum* [PowerPoint slides]. Vibrant Emotional Health. <https://bit.ly/3gBnGJ3>

as documentation requirements.^{37, 38} States will need to assess the structure, services, and caller outcomes for the 988 call center. There are significant national disparities in access to behavioral health care between white people and black, indigenous and people of color (BIPOC) populations,³⁹ as well as racial disparities in death by suicide.⁴⁰ Whenever it is possible and clinically appropriate to do so, call centers should attempt to obtain as much demographic information as possible from callers in order to support system evaluation. This information can help states evaluate whether outcomes vary based on race, gender identity, and other factors, in order to address any disparities in access to services. The 988 system allows states to collect data across the continuum in a more comprehensive way in order to evaluate overall behavioral health system efficacy and health outcomes of individuals. Some states and localities, such as Arizona and Washington DC, have

positioned the Lifeline call center within the behavioral health system to allow for real time data collection related to the individual. This allows for the behavioral health system to track follow-up, outcomes, and ongoing service connection, and to evaluate system interventions.⁴¹

In order to support data improvement, systems should also collect and analyze data jointly to inform cross-system decision making. Data-sharing and use agreements should be planned now to address privacy concerns related to the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2 regulations for SUDs. States should also identify mechanisms for oversight and quality assurance, both evaluating long-term outcomes and providing shorter-term feedback that facilitates the real-time resolution of problems.

Ensure Connections and Access to Upstream Services

States and localities should identify potential avenues to prevent and divert burgeoning crisis situations through connection to upstream community services. Evidence shows that calls to Lifeline and other mental health crisis lines can be deescalated and diverted at the call level, and that connecting people to urgent treatment and supports is critical.⁴² Existing and new 988 call centers must establish connections with a range of services for people to access in order to continue to deescalate the person's crisis. In most systems, these services should minimally include mobile response teams, crisis stabilization, outpatient treatment, intensive in-home supports, and housing. Expansion of access to these services can help ensure the crisis system is not overwhelmed. In addition to providing mobile crisis supports, CCBHCs are in a unique position to assist with linking individuals to preventive care by providing same-day access to behavioral health services in a non-hospital setting.⁴³ Call centers should also maintain relationships with community-based providers to provide warm-handed referrals to existing supports, such as ACT teams, in order to divert emergency services utilization. States and localities will need to plan holistically for how call increases will impact not only behavioral health system capacity, but other social services as well, such as

housing and benefits. Coordination with homeless services and housing providers as well as connection to public benefits should be considered as call centers assess potential

Given that individuals seen in a hospital emergency department often do not follow up with recommended care, call centers should identify strategies for individuals connected to these services, to ensure service connection at the resolution of the crisis through follow-up.

partnerships. Anticipated increased call volume may create additional strain on upstream services. Moreover, if 988 is not able to connect individuals experiencing emerging

37. National Suicide Prevention Lifeline (n.d.) *Crisis call center metrics part 1: Service and efficiency* [PDF]. <https://bit.ly/3DqqX7I>

38. Substance Abuse and Mental Health Services Administration (2020). *National guidelines for behavioral health crisis care best practice toolkit* [PDF]. Rockville, MD: Substance Abuse and Mental Health Services Administration. <https://bit.ly/2XVmxpj>

39. Department of Health and Human Services, Agency for Healthcare Research and Quality (2020). *2019 National Healthcare Quality and Disparities Report* [PDF]. Rockville, MD: Agency for Healthcare Research and Quality. <https://bit.ly/2WDm6zE>

40. Suicide Prevention Resource Center (n.d.). *Racial and ethnic disparities*. Retrieved October 1, 2021, from <https://www.sprc.org/scope/racial-ethnic-disparities>

41. Flannery, D. (September 24, 2021). Personal communication with Jordan Gulley [videoconference]

42. Vibrant Emotional Health (n.d.). *FAQ for understanding 988 and how it can help with behavioral health crises* [PDF]. <https://bit.ly/3iiuMD4>

43. National Council for Mental Wellbeing (2021). *Leading a bold shift in mental health & substance use care: CCBHC impact report, 2021* [PDF]. <https://bit.ly/3ohncfV>

crises to diversionary services, situations may escalate to requiring emergency or 911 response.

Given that individuals seen in a hospital emergency department often do not follow up with recommended care, call centers should identify strategies for individuals connected to these services, to ensure service connection at the resolution of the crisis through follow-up. Research shows that follow-up prior to a behavioral health appointment increases the likelihood that the individual will attend the appointment.⁴⁴ Depending on capacity and system design, there are opportunities for follow-up prior to hospital discharge. Some states and localities embed peer recovery

specialists, individuals with lived behavioral health experience who have been successful in their recovery journey, into hospital emergency departments and other community-based teams. These peers ensure that individuals in crisis are connected to ongoing preventive behavioral health services; call center staff can coordinate with them to increase supports as needed.⁴⁵ In its current iteration, the behavioral health system is disjointed and often difficult for individuals to navigate, but the National Suicide Hotline Designation Act of 2020 allows states to evaluate not only crisis services, but preventive and ongoing community care as well, in order to create a comprehensive continuum of care.

Conclusion

In this paper, we have examined the need for systems to actively plan the design and implementation of the new 988 national crisis hotline, and have identified specific activities to address in this planning. Each of these activities requires a deeper analysis and assessment, with specific strategies to ensure successful implementation of 988. The launch of 988 provides a significant opportunity to make accessing mental health professionals in emergencies easier. While the new 988 number creates a national strategy to improve access to care during mental health emergencies, systems throughout the U.S. must identify and develop strategies that meet local needs.

The capacity of 988 systems and connected behavioral health crisis systems will vary considerably in states and

localities, and the process of improving these systems will extend far beyond July 2022. Planners will need to consider how to publicize and use these evolving systems in a way that leverages and supports their potential without leading to frustration and poor outcomes that could impair success. Systems need to work toward the point where local mental health systems and providers feel legally safe and ethically comfortable with changing their voicemail messages from “if you are experiencing a mental health emergency, dial 911” to “dial 988.” A world in which dialing 988 provides a consistent effective behavioral health crisis response will be one with more efficiently used resources, better outcomes, and an improved experience for individuals and families experiencing a behavioral health crisis.

More Information

- [Report on the National Suicide Hotline Improvement Act of 2018 \[PDF\]](#)
- [Vibrant Emotional Health 988 Behavioral Health Crisis Care Continuum \[PDF\]](#)
- [Mental Health America 988 FAQ \[PDF\]](#)
- [Following Up With Individuals at High Risk for Suicide: Developing a Model for Crisis Hotline and Emergency Department Collaboration \[PDF\]](#)
- [State Suicide Prevention Infrastructure Recommendations \[PDF\]](#)

44. National Suicide Prevention Lifeline & Vibrant Emotional Health (2021). *Crisis center guidance: Follow-up with callers and those discharged from emergency department and inpatient settings* [PDF]. <https://bit.ly/2WtSnsJ>

45. Richardson, J. & Rosenberg, L. (n.d.). *Peer support workers in emergency departments: Engaging individuals surviving opioid overdoses — qualitative assessment* [PDF]. Washington, D.C.: National Council for Behavioral Health. <https://bit.ly/38gckpn>

