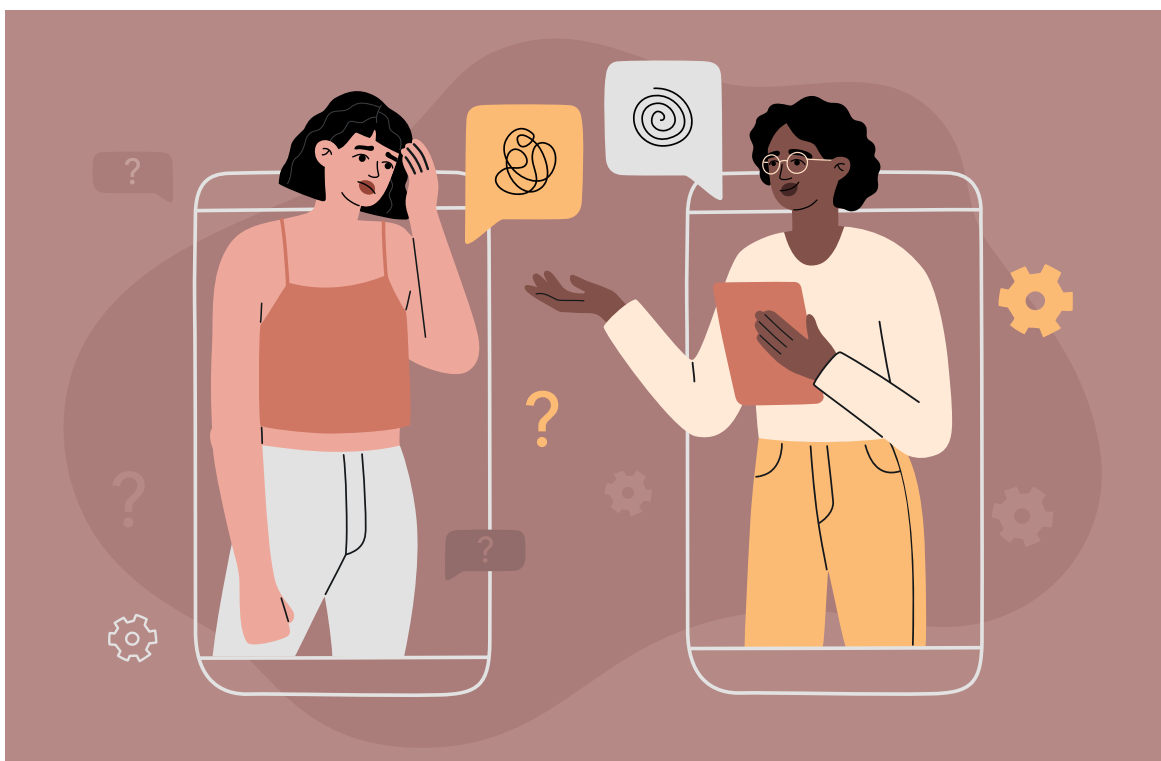


STEPHANIE BROOKS HOLLIDAY, SAMANTHA MATTHEWS, WENDY HAWKINS,
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The Road to 988/911 Interoperability

Three Case Studies on Call Transfer, Colocation, and
Community Response



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About This Report

911 is often the default option for individuals experiencing mental health emergencies, despite the fact that 911 call centers have limited resources to address behavioral health crises. When the 988 Suicide and Crisis Lifeline—the national mental health emergency hotline—launched in 2022, renewed attention was paid to the ways in which jurisdictions approach *988/911 interoperability*, which refers to the existence of formal protocols, procedures, or agreements that allow for the transfer of calls from 988 to 911 and vice versa. This report presents case studies from three jurisdictions that have established models of 988/911 interoperability. It provides details related to interoperability in each model, including the role of each agency (i.e., 988, 911, and organizations involved in in-person response), points of interagency communication, and decision points that can affect the way a call flows through the local system. It also identifies relevant facilitators, barriers, and equity-related considerations that shaped each jurisdiction’s approach to 988/911 interoperability, as well as lessons learned from implementation, to serve as a resource for other jurisdictions. This report should be of interest to jurisdictions that are looking to implement 988/911 interoperability, including jurisdictions that are spearheading local initiatives and those that are responding to state-level legislation. Its findings are relevant to 988 call centers, public safety answering points, mobile crisis units, law enforcement, and local and state decisionmakers. Funding for this research was provided by The Pew Charitable Trusts.

Justice Policy Program

RAND Social and Economic Well-Being is a division of the RAND Corporation that seeks to actively improve the health and social and economic well-being of populations and communities throughout the world. This research was conducted in the Justice Policy Program within RAND Social and Economic Well-Being. The program focuses on such topics as access to justice, policing, corrections, drug policy, and court system reform, as well as other policy concerns pertaining to public safety and criminal and civil justice. For more information, email justicepolicy@rand.org.

Acknowledgments

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Summary

Issue

The 988 Suicide and Crisis Lifeline—known more simply as 988—holds promise for significantly improving the mental health of Americans and has the potential to accelerate the decriminalization of mental illness. However, our previous research suggests that the rapid transition to 988 has left many gaps as communities scramble to prepare—not the least of which includes determining how 988 will interface with local 911 response systems and law enforcement (Cantor et al., 2022). Efforts to understand how jurisdictions are planning for the interface between 988 and 911, aligning program procedures, and creating staff buy-in are essential, as they could highlight effective solutions for jurisdictions that do not yet have a plan and reveal common challenges. In the project described in this report, we used a case study approach to understand the different ways in which jurisdictions have approached *988/911 interoperability*—that is, the existence of formal protocols, procedures, or agreements that allow for the transfer of calls from 988 to 911 and vice versa. We also aimed to identify relevant facilitators, barriers, and equity-related considerations that shaped each jurisdiction’s approach.

Methods

The three sites we worked with were the city of Sioux Falls and Minnehaha County, South Dakota; Orange County, New York; and Fairfax County, Virginia. These sites were selected to maximize variation with respect to a number of criteria, including population density and urbanicity, model of 988/911 interoperability, and recency of establishing 988/911 interoperability. For each site, we drew on three primary data sources: (1) a review of documents relevant to 988/911 interoperability (e.g., policy and procedure documents, interagency agreements), (2) qualitative interviews with staff of relevant agencies, and (3) two- to three-day site visits.

Our analysis had two stages. The first stage focused on the individual sites. A key goal of this work was to understand the nuances of the interface between 911 and 988 in each jurisdiction. Therefore, for each jurisdiction, we developed a detailed process map based on our document review, qualitative interviews, and site visits to demonstrate how behavioral health emergency calls were handled in that jurisdiction. We also used rapid qualitative analysis to formally code and analyze the qualitative interviews to understand barriers to and facilitators of 988/911 interoperability, lessons learned from implementation, efforts to serve diverse populations, and benefits of interoperability.

Key Findings

- In two of the three sites, the 988 call center was located separately from the 911 call center or public safety answering point. The third site had 988 and 911 call centers colocated in the same facility.
- Each site described the key decision points that governed the transfer of calls from 988 to 911 and vice versa. These decisions centered around the likelihood of risk of harm to the caller or other people, as defined by such factors as overdose, suicidal intent with access to means and opportunity, and presence of a physical injury.
- When behavioral health calls are handled by 988, the majority are able to be resolved on the phone; for example, one site reported that 97 percent of calls were resolved on the phone. However, some cases require an in-person response, and jurisdictions had a variety of in-person options, including mobile

crisis units, traditional law enforcement officers, Crisis Intervention Team-trained law enforcement officers, co-response teams, and peer support teams.

- Although sites varied with respect to their specific resources and models of 988/911 interoperability, there were some cross-site findings related to effective planning and implementation. For example, planning and implementation should be collaborative, engaging a variety of contributors. Entities involved in planning should focus on developing shared language and mutual respect, even when their cultures differ.
- Having a local champion for 988/911 interoperability is an important facilitator for planning and implementation, though the specific background of the champion may vary across jurisdictions.
- 988/911 interoperability requires more than protocols for transferring calls between 988 and 911. It also must be considered within the larger continuum of crisis services available in the community.

Contents

About This Report	iii
Summary	v
Figures and Tables	ix
CHAPTER 1	
Introduction	1
Site Selection and Methods.....	3
Organization of This Report.....	4
CHAPTER 2	
City of Sioux Falls and Minnehaha County, South Dakota	5
Planning for 988/911 Interoperability.....	6
Interoperability Processes.....	7
Training and Quality Assurance.....	13
Efforts to Serve Diverse Populations.....	14
Facilitators of Planning and Implementation.....	14
Lessons Learned from Planning and Implementation.....	17
Opportunities for the Future.....	19
Benefits of 988/911 Interoperability.....	20
CHAPTER 3	
Orange County, New York	21
Planning for 988/911 Interoperability.....	22
Interoperability Processes.....	23
Training and Quality Assurance.....	29
Efforts to Serve Diverse Populations.....	30
Facilitators of Planning and Implementation.....	31
Lessons Learned from Planning and Implementation.....	33
Opportunities for the Future.....	34
Benefits of 988/911 Interoperability.....	36
CHAPTER 4	
Fairfax County, Virginia	37
Planning for 988/911 Interoperability.....	38
Interoperability Processes.....	40
Training and Quality Assurance.....	46
Efforts to Serve Diverse Populations.....	48
Facilitators of Planning and Implementation.....	49
Lessons Learned from Planning and Implementation.....	52
Opportunities for the Future.....	53
Benefits of 988/911 Interoperability.....	55

CHAPTER 5

Conclusion 57

 Cross-Site Findings Related to Effective Planning and Implementation 57

 Limitations 59

 Takeaways for the Future of Interoperability 59

APPENDIX

Methods 63

Abbreviations 67

References 69

Figures and Tables

Figures

- 2.1. City of Sioux Falls and Minnehaha County, South Dakota, 988/911 Interoperability Summary 8
- 3.1. Orange County, New York, 988/911 Interoperability Summary 24
- 4.1. Fairfax County, Virginia, 988/911 Interoperability Summary 41

Tables

- 2.1. Strengths of the Continuum of Care in the City of Sioux Falls and Minnehaha County, South Dakota 17
- 3.1. Strengths of the Continuum of Care in Orange County, New York 33
- 4.1. Strengths of the Continuum of Care in Fairfax County, Virginia 51
- A.1. Site Characteristics Considered in the Site Selection Process 64
- A.2. Documents Reviewed Across Sites 65

Introduction

On July 16, 2022, the national mental health emergency hotline—known simply as 988—launched. More formally known as the *988 Suicide and Crisis Lifeline*, 988 is the successor to the hotline formerly known as the *National Suicide Prevention Lifeline*. The shift to 988 followed the enactment of the National Suicide Hotline Designation Act (Pub. L. 116-172, 2020), and the goal was to increase use of the Lifeline by assigning an easier-to-remember three-digit phone number (Cantor et al., 2022). The shift to 988 also expanded the Lifeline’s focus from suicide to mental health crisis more broadly. In the months leading up to the launch of 988, jurisdictions across the United States moved quickly to scale up their available behavioral health services in anticipation of an increase in call volume to the existing Lifeline network, as well as a potential increase in the number of individuals requiring an in-person mental health emergency response after a call to 988. Some prior research had highlighted the number of Lifeline calls that had gone unanswered; one publication, based on 2014 data, highlighted that approximately 30 percent of Lifeline calls went unanswered on some days (Ramchand et al., 2019). In addition to the existing rates of unanswered calls, there was concern as to whether call centers would be able to expand their workforces enough to manage the expected demand—a projected 50-percent increase in calls in the first year (Vibrant Emotional Health, 2020). Moreover, many stakeholders expressed concern that 988 was an “unfunded mandate” (Ohio Department of Mental Health and Addiction Services, 2021; Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, undated), leaving jurisdictions without the necessary resources to implement a continuum of emergency mental health care. States varied substantially with respect to how they approached the financing of 988 and the allocation of earmarked funds for implementation (Purtle, Ortego, et al., 2023). For example, although the federal government authorized states to impose telecommunication surcharges to fund 988, few states opted to do so, and, even as of 2023, only eight states had implemented a 988 fee (National Alliance on Mental Illness, undated).

Recognizing these concerns, in the months leading up to the launch of 988, RAND researchers conducted a survey of 180 state and county behavioral health directors throughout the United States. We asked a series of questions related to preparedness for the launch of 988. We then conducted qualitative interviews with a subset of respondents who had indicated on the survey that they were either more prepared or less prepared for 988 to learn about their processes and plans for implementation (Cantor et al., 2022).

One key theme explored in this study was to understand how 988 would interface with 911, given the need to provide the most appropriate response for each caller regardless of the number called. 911 is often the default option for individuals (or their loved ones) experiencing mental health emergencies, and 77 percent of survey respondents indicated that dialing 911 is a major entry point to care (Cantor et al., 2022). However, a 2021 survey of public safety answering points (PSAPs)—that is, 911 call centers—highlighted the lack of resources that 911 call centers have to address behavioral health crises (The Pew Charitable Trusts, 2021) and the potential for law enforcement responses to mental health crises that could result in adverse outcomes, from injuries to incarceration (Balfour et al., 2022; Saleh et al., 2018). Moreover, a recent nationally representative survey by The Pew Charitable Trusts found that just 13 percent of people have knowledge of both 988’s existence and the reasons someone might contact 988 (Velázquez, 2023). A more recent study found

that when people were prompted with some additional information about 988 (i.e., that it is the three-digit phone number for the Suicide and Crisis Lifeline), there was greater awareness, especially among people who reported higher levels of psychological distress (Purtle, McSorley, et al., 2023). However, more than 50 percent of those respondents still indicated that they were unfamiliar with 988. Without knowledge of 988, it is likely that many of those individuals will call 911 when faced with a mental health emergency. In addition, although the majority of calls to 988—95 percent or more in multiple states that report data (Furfaro, 2023; Helpline Center, undated; Seidman, 2022)—are resolved over the phone, there are situations that may require a public safety response. Together, these factors underscore the importance of understanding not only how 988 and 911 can work together but also how they can interoperate. For the purposes of this effort, we define *interoperability* as the existence of formal protocols, procedures, or agreements that allow for the transfer of calls from 988 to 911 and vice versa.

Despite the value of developing processes through which 988 and 911 can interoperate (referred to as *988/911 interoperability* for the purposes of this report), our 2022 survey demonstrated that, of the 41 percent of state and county behavioral health directors who reported that they had a strategic plan for the launch of 988, only two-thirds of those strategic plans included a plan for service coordination between 988 and 911 emergency response. And in our qualitative interviews, we learned that many jurisdictions were still determining the appropriate responders for 988 callers who required in-person responses, including the role of law enforcement versus that of behavioral health professionals, such as clinicians, social workers, or peer support specialists. Some interviewees observed that there were some situations in which behavioral health teams could respond without law enforcement and other situations in which co-response models would be ideal, but jurisdictions did not have well-developed plans detailing these situations (Cantor et al., 2022).

However, there are some jurisdictions that have built or are in the process of building procedures to support 988/911 interoperability. In addition, the National Association of State Mental Health Program Directors (NASMHPD) published its *988 Convening Playbook: Public Safety Answering Points (PSAPs)*, which was designed to be a resource for PSAPs as they prepared for the launch of 988, developing a set of competencies that PSAPs should consider related to 988/911 interoperability and providing case examples (NASMHPD, undated-b). However, there are many factors that could shape the specific model of 988/911 interoperability that a jurisdiction implements. These could include population size and density; availability of local resources, including funding and community-based services; how 988 call centers are organized in the jurisdiction or state; and number of PSAPs in the jurisdiction. Moreover, some jurisdictions may be interested in building 988/911 interoperability from the ground up, whereas others may be responding to top-down mandates; for example, in Virginia, the Marcus-David Peters Act has mandated 988/911 interoperability across the state (Virginia Department of Behavioral Health and Developmental Services [DBHDS], undated-b). Therefore, there is value in having different models of 988/911 interoperability to serve as road maps for jurisdictions that are looking to achieve it.

The study described in this report was intended to address this need. We partnered with three sites across the country and used a case study approach to understand the different ways in which these jurisdictions have approached the interface between 988 and 911. Our goal was to provide details related to interoperability in each model, including the role of each agency (i.e., 988, 911, and organizations involved with in-person responses), points of interagency communication, and decision points that can affect the way a call flows through the local system. We also aimed to identify relevant facilitators, barriers, and equity-related considerations that shaped each jurisdiction's approach to 988/911 interoperability, as well as lessons learned from implementation, to serve as a resource for other jurisdictions.

Site Selection and Methods

The three sites we worked with were the city of Sioux Falls and Minnehaha County, South Dakota; Orange County, New York; and Fairfax County, Virginia. In the appendix, we provide a detailed overview of our site selection method and research methods, though we describe them briefly here.

We collaborated with the National Association of Counties (NACo) to select sites, since it was working on a complementary, Pew-funded project to spotlight the work of counties that have implemented innovations and reforms to improve 911 handling of and response to behavioral health crises. We had preliminary discussions with 13 sites, selected on the basis of geographic spread across the United States and model of interoperability. After those discussions, we evaluated each site on a set of 11 dimensions (summarized in Table A.1, in the appendix). We aimed to maximize variation across these 11 dimensions, but we prioritized three: population density/urbanicity, model of 988/911 interoperability, and recency of establishing 988/911 interoperability. For each site, we then drew on three primary data sources: (1) a review of documents relevant to 988/911 interoperability (e.g., policy and procedure documents, interagency agreements), (2) qualitative interviews with staff of relevant agencies,¹ and (3) two- to three-day site visits. In this report, findings presented in each site-specific chapter of this report are based on data integrated across these three methods. When possible, we cite specific documents that we relied on, but there were times when data were integrated across multiple sources. A complete list of documents in our document review is in Table A.2 (in the appendix).

The purpose of our case study approach was largely illustrative in nature (U.S. General Accounting Office, 1990). Because 988/911 interoperability is fairly nascent, our goal was to describe different models of interoperability, the features that define each model, the factors that shaped the planning and implementation process, and the lessons learned at each site. Although there is some guidance related to planning for 988/911 interoperability, such as the previously described *988 Convening Playbook* for PSAPs (NASMHPD, undated-b), there is currently not enough evidence to suggest potential best practices. Therefore, our aim was to capture how interoperability works in each of the three case study sites. Although we explored strengths and limitations related to each model, these findings were based largely on our analysis of interview data, though we provide some analysis related to our cross-site findings and recommendations in the conclusion chapter.

Each of the next three chapters provides an in-depth look at our three sites. With each site, we explored a number of important questions, including the following:

- Are there specific circumstances in which a 911 call will be triaged to 988 and vice versa?
- In what circumstances is only law enforcement dispatched to a call (as opposed to there being an alternative response, such as a police and behavioral health co-response team or a mobile crisis response team)?
- What types of training and quality assurance (QA) methods are used to ensure the appropriate disposition of calls?
- How do characteristics of these jurisdictions (e.g., rurality, population size) shape the plans for coordinating 911 and 988?
- How are sites addressing the needs of populations that may experience additional obstacles to receiving services?
- What lessons can be learned from implementation in these three sites that may serve as a guide to other jurisdictions?

¹ Throughout this report, we present quotes and information provided by the interviewees. The interviews were not for attribution, so no names are provided. Where appropriate, however, we include information on the interviewee's position or status.

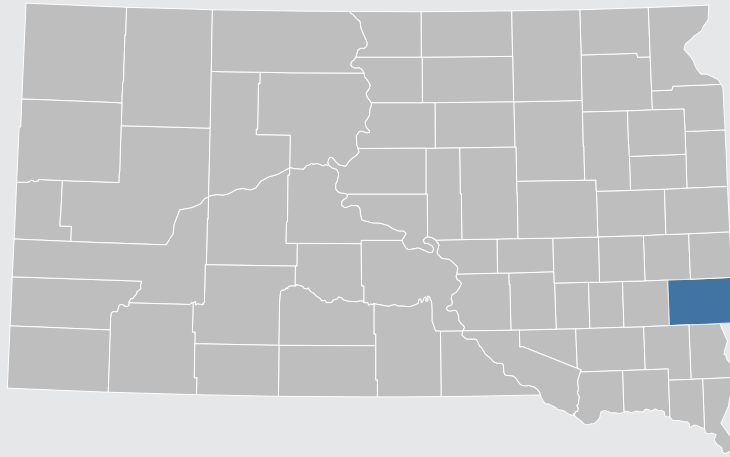
It is important to note that calls to 988 are routed to a specific call center based on the area code of the caller, whereas 911 calls are routed to a PSAP based on the caller's physical location at the time the call is made. In this report, we largely focus on how calls are handled for local callers—that is, people who live in the jurisdictions featured—because these are the individuals who would be interacting not only with the local 988 and 911 call centers but also with the local continuum of crisis care. However, issues related to *georouting* (i.e., routing a call to a specific call center based on the location of the individual) and *geolocation* (i.e., identifying the specific location of the caller) were raised during our site visits and are discussed below. It is also important to note that our case studies focused on individuals who called 988 or 911 rather than using text or chat options and that our studies did not include calls transferred to the Veteran Crisis Line.

Organization of This Report

In each site-specific chapter (Chapters 2–4), we begin by presenting an overview of the characteristics of the jurisdiction: for example, population size and demographic composition, as well as the ways in which 988 and 911 are organized in the jurisdiction. We then provide a detailed description of how 988/911 interoperability occurs—that is, what are the decision points, and how are calls transferred? We also include a detailed process map outlining these points for each site. The description of each site details local procedures. Therefore, any statements within a site-specific description should be seen as applicable to just that specific site. In the final chapter (Chapter 5), we summarize findings across sites and present considerations for other jurisdictions that are interested in achieving 988/911 interoperability, whether by adopting models presented in this report or by adapting elements to their own local needs and resources. The appendix provides a detailed overview of our site selection method and research methods.

City of Sioux Falls and Minnehaha County, South Dakota

Sioux Falls, South Dakota: Quick Facts



Population and area of Sioux Falls: 202,078; 79 mi²

Population and area of Minnehaha County: 203,971; 807 mi² (note that portions of Sioux Falls extend into Lincoln County)

Racial and ethnic demographics of Sioux Falls: 79% White, 7% Black, 6% Hispanic and/or Latinx, 6% two or more races, 2% American Indian/Alaska Native, 2% Asian, <1% Native Hawaiian or Pacific Islander

988 call center structure: Single statewide call center, located in Sioux Falls

911 call center structure: The case study is focused on a PSAP serving Sioux Falls and all of Minnehaha County. The PSAP of focus is an independent agency; South Dakota has 33 PSAPs, three of which are tribal.

SOURCES: State 911 Assessment Program, 2021; U.S. Census Bureau, undated-b; U.S. Census Bureau, undated-d. Map created with MapChart (CC BY-SA 4.0 DEED).

Our first case study site was the city of Sioux Falls and Minnehaha County, South Dakota. (There are portions of Sioux Falls that extend into Lincoln County, South Dakota; our focus was on the geographic areas covered by all of Sioux Falls, plus the remainder of Minnehaha County.) Here, our focus was on learning about the partnership between the local 988 call center (the Helpline Center) and the local PSAP (Metro

Communications Agency, henceforth referred to as *Metro*). However, South Dakota has just a single 988 call center, so, in addition to the strong relationship between the Helpline Center and Metro, we learned about efforts to support 988/911 interoperability between the Helpline Center and other PSAPs across the state. Therefore, in the descriptions that follow, we focus on the procedures and resources in Sioux Falls, but we also provide information about the effort to promote statewide 988/911 interoperability when possible. (We do not cover instances in which a call comes into the Helpline Center because the caller has a South Dakota area code but it turns out that the person is located outside the state.)

Planning for 988/911 Interoperability

Interviewees noted that the groundwork for 988/911 interoperability was laid even before the launch of 988 in 2022. The Helpline Center and Metro had a strong preexisting relationship. For example, even before the launch of 988, the Helpline Center answered calls from the Lifeline, as well as from the center's local 211 number (i.e., the community resource line). When the Helpline Center received a call from someone at imminent risk of harm to themselves or others, it would transfer calls to 911, which allowed the center to build an initial relationship with Metro. There was also an existing relationship between the Helpline Center and the local police department, as the Helpline Center was interested in knowing what happened after police responded to crisis calls for which the Helpline Center had requested dispatch. Therefore, interviewees stated that the launch of 988 provided Sioux Falls with the opportunity to expand on the effort it had been wanting to put in place.

Planning for 988/911 interoperability happened in conjunction with general statewide planning for 988 implementation. Leading up to the launch of 988, South Dakota convened a planning coalition—the Behavioral Health Crisis Services Stakeholder Coalition (South Dakota Department of Social Services, 2022b)—comprising the following organizations and groups:

- the Department of Social Services
- the Helpline Center
- state suicide prevention coordinators
- mobile crisis service providers
- crisis respite and stabilization service providers
- law enforcement
- PSAP leadership
- peer support providers
- mental health and suicide prevention advocacy groups
- tribal organizations
- community mental health centers (CMHCs)
- individuals with lived experience.

The coalition began meeting in March 2021 to prepare for the launch of 988 (South Dakota Department of Social Services, 2022b) and met up until the launch (in July 2022). It was led by two consultants from an agency focused on strategic planning, communications, and project management. The topic of 988/911 interoperability was a focus of the work group. According to interviewees, having local PSAP directors and the state 911 coordinator involved was an important part of those work-group discussions.

Interviewees described a soft rollout of 988 and 911 interoperability that took place in November 2021 and involved the Helpline Center and Metro in Sioux Falls. Leading up to this soft rollout, the deputy director of Metro and the CEO of the Helpline Center engaged in local planning and goal setting related to interop-

erability and then expanded their planning discussions, first to the local police department and sheriff's department and then to behavioral health and mobile crisis providers. At each stage of local planning, stakeholders focused on identifying and solving challenges before incorporating the next stakeholder group. An important part of this process was providing education to relevant stakeholders about interoperability and its benefits.

During the planning process, stakeholders also determined what infrastructure was needed to support 988/911 interoperability. For example, interviewees said that they decided to create a back-end phone line (i.e., a direct telephone line specifically for PSAPs) at 988 that PSAPs could use so that they did not have to go through the main phone number. Stakeholders also needed to determine which call scenarios were appropriate for transfer and what information would be shared between the two agencies.

During the soft launch, the Helpline Center and Metro were able to test the protocols that had been developed, discuss opportunities for improvement, and fine-tune their process. At the end of this six-month soft-launch period, the agencies felt ready for the launch of 988 and formal 988/911 interoperability. This pilot also allowed stakeholders to engage in discussion about what 988/911 interoperability could look like on a statewide basis.

Interoperability Processes

The process map presented in Figure 2.1 summarizes the basic process of transferring calls between 911 and 988 in the city of Sioux Falls and Minnehaha County, including the key decision points and actions taken by call-takers and other relevant stakeholders (e.g., law enforcement, mobile crisis). In this section, we provide more detail about each of the steps in this process. The information in this section is synthesized from data obtained in our interviews and a review of local policy and memorandums of understanding (MOUs) (see Table A.2 for all documents reviewed).

Calls Transferred from 988 to 911

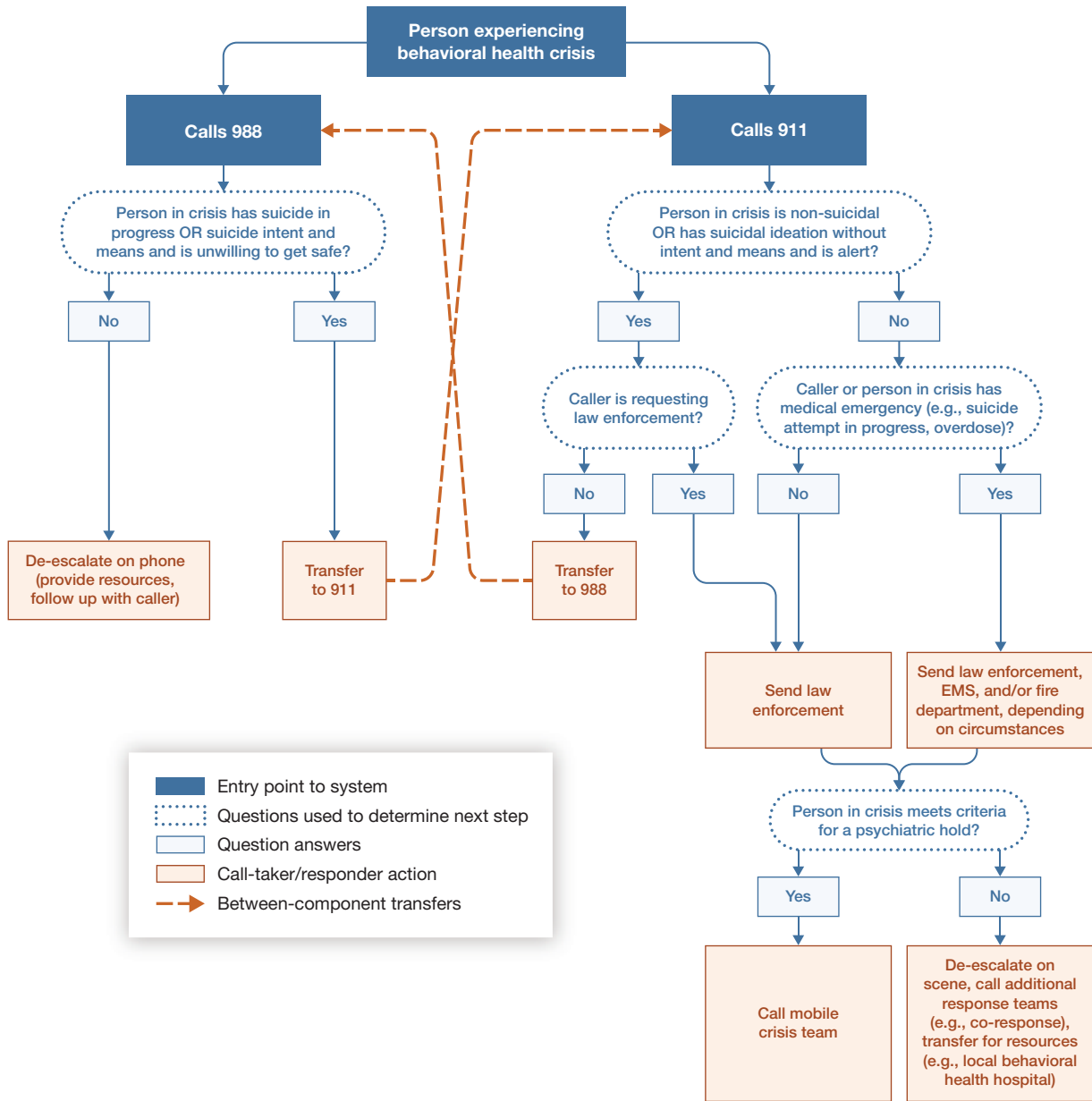
Initial Phone Call and Assessment of Caller Needs

When a 988 call-taker answers a call, they have specific pieces of information that they are trying to ascertain through their discussion with the caller, including who that person is, where they are, whether they are having thoughts of suicide, and whether they have taken any actions to harm themselves. The call-taker also assesses other potential risk and protective factors, such as overall mental well-being, family and social relationships, community connections, and whether there are people present or nearby to provide support, as well as aspects of the environment (e.g., is the caller in a safe place? Are there current threats?). Although the call-taker needs to obtain specific information to assess the caller's needs and safety, these questions are not asked in the form of a structured protocol; rather, the call-taker approaches the caller in a more conversational manner, building rapport with the caller while obtaining information. Throughout the call, a goal is to de-escalate the caller if they are experiencing heightened mental health symptoms. In every call, when possible, the 988 call-taker works to develop a safety plan in collaboration with the caller.

Throughout the call, the call-taker is working to determine whether the caller needs an in-person response. If the person is determined to be at *imminent risk* (i.e., in immediate danger of physically harming themselves or others), that is grounds for an in-person response. Indicators of imminent risk include having a caller who will not engage in safety planning and cannot guarantee their safety, has a plan for suicide, has means and proximity to means, and/or has a timeline for harming themselves.

If a person does *not* need an in-person response, which is the case for about 97 percent of calls (as of 2023; Helpline Center, undated), the resolution to the call involves (1) developing a suicide safety plan (Helpline

FIGURE 2.1
City of Sioux Falls and Minnehaha County, South Dakota, 988/911 Interoperability Summary



NOTE: EMS = emergency medical services.

Center, 2023), which guides the caller to identify crisis warning signs, coping strategies, and people they can contact for help, among other pieces of information; (2) determining whether the person needs to be linked to services, such as counseling, basic needs, and other community resources; and then (3) obtaining consent to follow up with that individual. Ideally, 988 call-takers make at least three follow-up calls to check on the individual who called.

If the person *does* need an in-person response, then the call will be transferred to 911. Sometimes, even if an in-person response is not required, a caller will specifically request that police come; in this case, the call-taker will try to provide additional education about what law enforcement can (and cannot) provide and

see whether they can offer alternative resources. But if the caller is adamant that police respond, the call-taker will transfer the call to 911.

How the Transfer to 911 Occurs

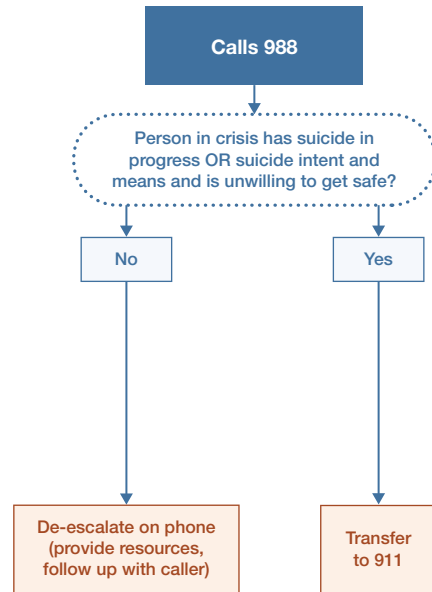
When a 988 call-taker transfers a call to 911, they have a couple of options. If the caller is able to commit to staying on the line safely, the call-taker can put the caller on hold, call the 911 dispatcher, and then join the call together as a three-way call. Alternatively, if the caller is so distressed that they cannot commit to staying on the line safely, or if there is a suicide in progress, then the call-taker will flag down another staff member in the 988 call center, explain the situation briefly, and have that second staff member call 911.

Once they have the 911 call-taker on the phone, the 988 call-taker will provide details of the situation—for example, the person’s name and address if available, the nature of the situation, and what the person wants to have happen or is expecting to happen.

At that point, the 911 call-taker can dispatch the appropriate in-person response. If law enforcement is being sent to the caller, the 988 call-taker will sometimes stay on the line with the caller to continue to provide support until law enforcement arrives.

There are some situations in which the caller will not (or cannot) provide their geographic location. In these cases, the police department does its best to ping cell phone towers to identify the caller’s location so that an in-person response can be sent. Note that not all law enforcement departments in South Dakota have this option, which is dependent on size and resources, though this option is available in the city of Sioux Falls and Minnehaha County.

After the call has been transferred and an in-person response sent, the 988 call is disconnected. As part of their standard procedures, 988 call-takers ask their callers for permission to make follow-up calls in the subsequent days to weeks. If the transferred caller already provided permission for this step to take place, then someone from the 988 call center will follow up with them to see how they are and provide additional resources as needed. There are also instances in which the 988 call-taker will contact the PSAP to find out what happened to the caller. The 911 call-taker will provide the 988 call-taker with a call-for-service number that is assigned to the case. The 988 call-taker can reference this number to call back and find out about the case disposition that comes from law enforcement responding.



Calls Transferred from 911 to 988

Initial Phone Call and Assessment of Caller Needs

The Sioux Falls PSAP (Metro) is accredited through the International Academies of Emergency Dispatch (IAED, 2023). As part of this accreditation, Metro follows emergency dispatch protocols (called *Emergency Medical Dispatch [EMD] protocols*) developed by IAED. The EMD protocols include structured questions that 911 call-takers ask to determine the appropriate response for a 911 caller.

When a call comes in, the 911 call-taker begins by asking the caller where they are and the address of their location. Then, the call-taker asks the caller what has happened. Using the initial information from the caller, the call-taker identifies whether the call is a behavioral health call, and then they can begin using the

EMD protocol for behavioral health calls.¹ The protocol is read word for word, and responses are recorded in ProQA, a computerized system that contains the EMD protocols and integrates with the computer-aided dispatch (CAD) system. Depending on the caller’s responses to the questions, the system will indicate what type of response the caller should receive. There are three priority levels that involve a response from an ambulance:

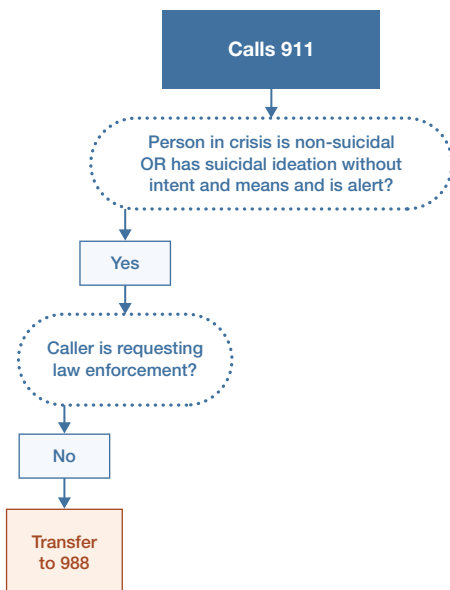
- Priority 1, in which law enforcement, the fire department, and an ambulance are dispatched with lights and sirens on
- Priority 2, in which the fire department and an ambulance are dispatched with lights and sirens on
- Priority 3, in which an ambulance is dispatched but drives in the flow of traffic.

When an ambulance is not needed, there are two other response types: police department only, in which law enforcement is sent to the person in crisis, and 988, in which the call is transferred to 988.

When 988 launched, the PSAP’s EMD protocols were updated to indicate when a behavioral health call could qualify for a transfer to 988. This update meant that a subset of calls that would previously receive a law enforcement response could now be transferred to 988 for de-escalation and follow-up. Initially, the target response was for a somewhat narrow set of circumstances: for instance, if the caller was non-suicidal and still alert or if the caller expressed suicidal ideation but was not actively threatening suicide and was alert. However, in April 2023, IAED launched a new EMD protocol nationally that added questions to collect more information about the situation and tease apart situations in which the person in crisis is experiencing suicidal ideation versus intent. The increased ability to distinguish between suicidal ideation and suicidal intent has led to more scenarios in which a caller can be transferred to 988. Before, according to one of our interviewees, law enforcement responded to situations in which a caller was broadly “threatening suicide.” Now, law enforcement responds when a person is “intending suicide” (i.e., the person is threatening suicide *and* has the means and opportunity). Situations in which someone is threatening suicide without means and opportunity can now be transferred to 988.

How the Transfer to 988 Occurs

The Helpline Center created a direct number that PSAPs with a signed MOU can use to transfer a call. This phone number is preprogrammed into the 911 CAD system, and 988 call-takers can see when a new call is a transfer from 911. In this section, we focus on transfers from Metro to the Helpline Center.



There are multiple ways in which the call can be transferred to 988 in the city of Sioux Falls and Minnehaha County. Sometimes, the 911 call-taker puts the caller on hold, calls 988, provides some basic information about the caller, and then joins the calls together. Other times, the caller is on the line when the transfer is made, so any details shared by the 911 call-taker are heard by the caller as well. The level of detail that the 911 call-taker provides can be influenced by whether the caller is still on the line and how busy the 911 call center is.

There are situations in which the EMD protocol indicates that a caller should be transferred to 988 but the caller indicates

¹ Specifically, this protocol is Psychiatric/Mental Health Conditions/Suicide Attempt/Abnormal Behavior (IAED, 2023). The most recent version of this protocol was released in April 2023.

that they would still prefer an in-person response from a police officer. In these cases, the 911 call-taker can override the decision of the EMD protocol so that they can send law enforcement in addition to transferring the caller to 988. In these cases, the call-taker will still make the transfer to 988, as the 988 call-takers can sometimes provide support to the caller while they wait for law enforcement to arrive.

Transfers *Back* to 911 from 988

There are some situations in which a caller is transferred to 988, and then the 988 call-taker determines that the caller needs to be transferred back to 911 for dispatch—for example, if the crisis escalates and the caller will not engage in safety planning or cannot guarantee their safety. In this case, the 988 call-taker will call 911 to request dispatch. It is sometimes a new 911 call-taker who answers the call, so the 988 call-taker will provide some basic information about the request for dispatch, but the 911 call-taker does not have to repeat the EMD protocol, as there has already been a determination that an in-person response from law enforcement is needed. In that instance, they can simply ask if anything has changed with the situation and send law enforcement.

In-Person Response Options

As a result of 988/911 interoperability, there are some behavioral health calls that come into the PSAP that can be transferred to 988 and resolved over the phone, avoiding the need for an in-person response. However, there remains a subset of individuals who do need an in-person response, whether they initially called 988 or 911. In this section, we describe the in-person response options, focusing on Sioux Falls and Minnehaha County.

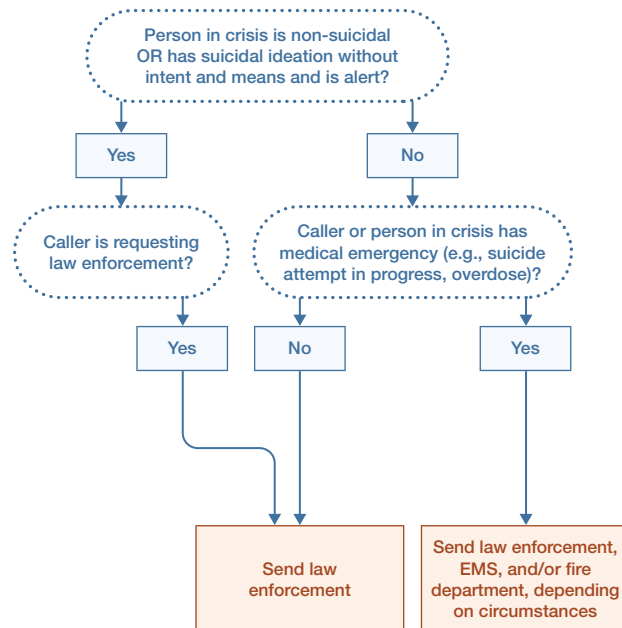
Ambulance or Fire Department

There are certain circumstances in which a behavioral health call will require that an ambulance or fire department be dispatched—for example, if the person is unconscious, not alert, or experiencing a hemorrhage. However, in our discussions, personnel in Sioux Falls indicated that most behavioral health calls result in law enforcement being sent. Therefore, we did not speak to personnel from local EMS or fire departments.

Law Enforcement

Our discussions with stakeholders revealed that most behavioral health calls that require an in-person response will result in law enforcement being sent. In addition, callers sometimes request law enforcement simply because they need transportation—for example, to the local behavioral health center—or because they prefer to have law enforcement come in person.

In other cases, there is a more acute emergency taking place. Once police officers arrive at the scene, they begin to work to determine whether the person might meet criteria for an involuntary psychiatric hold. If not, then the officers work to de-escalate the situation on the scene; determine whether an additional



response team should be called; or transfer the person to additional resources, such as through the local behavioral health hospital. Most law enforcement officers in the Sioux Falls Police Department (SFPD) and Minnehaha County Sheriff’s Office have participated in the basic 40-hour Crisis Intervention Team (CIT) training course (CIT International, undated), and some have voluntarily participated in more-advanced training. This training has helped equip law enforcement officers with skills needed to be able to de-escalate a situation on the scene.

The SFPD has also piloted additional response options. For example, it has a co-responder model, staffed by two law enforcement officers and one clinician from the local CMHC who are able to respond to mental health calls. Because this co-response team is staffed with officers who are typically positioned at schools, it has operated only in the summer (when schools are out). The SFPD also has a Mental Health Community Resource Officer, who is a go-to person for mental health issues and can help provide resources, according to an interviewee. The Community Resource Officer also tries to identify people who are frequently coming into contact with the system to see whether there are other ways to meet their needs.

However, there are also times when the person is experiencing a significant crisis and is suspected to meet criteria for a psychiatric hold. In these cases, the person is eligible to receive a response from the local mobile crisis response team, which is staffed by the local CMHC. Currently, in South Dakota, mobile crisis response teams are dispatched only by law enforcement.

Mobile Crisis Response

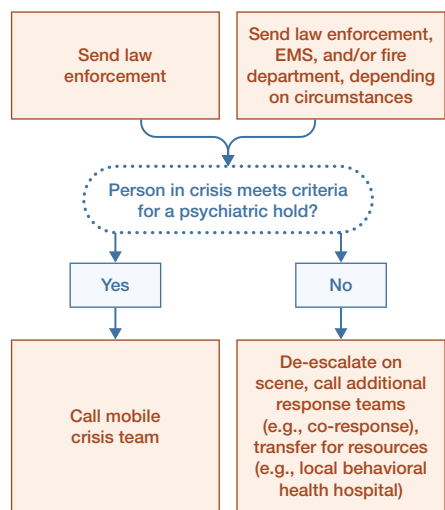
The mobile crisis response team in Sioux Falls is on call 24 hours a day, seven days a week. When law enforcement officers have a case that they think might meet criteria for a psychiatric hold, they will call the mobile crisis response team and provide the individual’s name, the individual’s age, whether the individual is under the influence of a substance, why law enforcement was called out, and what they have noticed since they arrived at the scene. The goal is for mobile crisis to respond to the scene within 20 to 30 minutes of receiving the call from law enforcement.

When mobile crisis arrives on the scene, the goal is to work to de-escalate the situation, determine whether a mental health hold needs to be placed, and work to develop a safety plan with the individual. While on the scene, mobile crisis staff members work with law enforcement to determine which group should take the lead in the response. Some individuals in crisis express a preference to speak to law enforcement, whereas others may become agitated by the police presence and prefer a clinician-led approach. Most individuals who receive a response by the mobile crisis team are able to remain at home, and the mobile crisis team clinicians

follow up the next day to monitor the person’s status and determine whether additional connections to services can be made.

There are also situations in which law enforcement is not sure whether the mobile crisis response team needs to come to a scene. In these cases, law enforcement will sometimes call the mobile crisis team with questions about the situation, and mobile crisis clinicians can provide some consultation to the police officers if there is not a need for them to go to the scene.

As of this writing, mobile crisis services are available only in limited areas of South Dakota (the Pierre area and the Sioux Falls area). South Dakota is a large state with some sparsely populated areas, and this fact presents a practical challenge to the provision of mobile crisis services across the state. There are other services that help address this gap. Some jurisdictions use Avel eCare, which provides law enforcement personnel with a tablet



that connects to a mental health clinician. In addition, the CMHCs in other areas of the state have 24/7 on-call capacity for crisis cases, and law enforcement can reach out to those CMHCs and use them as a resource when responding to individuals experiencing mental health crises. One stakeholder whom we interviewed highlighted the importance of law enforcement in knowing the resources that are available and connecting people to crisis care: “Law enforcement in small town South Dakota, they know their people, they know what their needs are, they know where the resources are.”

Training and Quality Assurance

An important part of supporting effective 988/911 interoperability and effective in-person responses is the provision of training and QA efforts at both the PSAP and the 988 call center. Details regarding staffing and QA efforts were provided by interviewees.

Helpline Center (988)

The Helpline Center is staffed by call-takers who have, at minimum, a master’s degree, often in counseling, social work, or a related field. When they are hired, call-takers participate in a minimum of three to four weeks of classroom training, which includes multiple training methods (e.g., lectures, hands-on practice, simulations provided by Vibrant Emotional Health [the national 988 administrator], review of calls and client scenarios). Training also includes sample scenarios involving calls transferred from 911. Training and ongoing QA efforts continue after the initial training is complete. The training and QA manager monitors one call per shift for call-takers to make sure that they handle calls appropriately. There is a focus on reviewing and debriefing every call that gets transferred to 911. Calls are scored according to structured criteria that include such factors as crisis intervention skills and documentation, and feedback is provided to call-takers. Any manager can also join a call if a staff member encounters a difficult scenario, debrief with a call-taker after a difficult call, or review a specific call that a call-taker flags if they want feedback on how it was handled. Call-takers also have a weekly meeting with one of the 988 managers to address issues that arise.

The training and QA manager also uses information from the QA process to develop new training and to continue to offer professional development to call-takers. For example, recent training has focused on the goal of stabilizing callers without involving law enforcement, and Helpline Center staff have noticed that this training seems to have reduced transfers to 911. One staff member whom we interviewed articulated the philosophy as follows: “You don’t call law enforcement unless you believe that person’s life or someone else’s life is in imminent danger of no longer being amongst the living. . . . You don’t call law enforcement unless you’ve exhausted all other options.”

Metro Communications Agency (911)

PSAP call-takers participate in a two-week training at the state PSAP training academy, followed by approximately half a year of on-the-job training. Training also includes an EMD course and a course on using ProQA (the online EMD system used by Metro), which includes sample scenarios. When there are updates to the EMD protocols, such as the recent update to the behavioral health protocol, the QA coordinator reviews the changes at an in-service training session, which is held multiple times to ensure that people on all shifts can participate. These training sessions are typically two hours in length and include the opportunity for structured training and discussion. Call-takers are also given time to practice the protocols through test calls. When call-takers have questions, they reach out to the QA coordinator or the PSAP deputy director.

Calls to 911 are recorded, and the QA coordinator randomly pulls calls to review. The calls pulled for review can include calls that result in transfers to 988, though there is not necessarily a specific emphasis on pulling these calls. Each call-taker has a specified number of calls reviewed per quarter, and these are scored using a grading rubric developed by ProQA. Feedback is provided to call-takers by email.

Efforts to Serve Diverse Populations

Across our interviews, we asked about efforts that have been made to reach and address the needs of diverse populations, in terms of demographics, languages spoken, immigration status, housing status, clinical conditions, and other characteristics. Stakeholders described a few specific populations that have been the targets of focused outreach efforts to improve access to care, which are discussed here. (Stakeholders also referred to opportunities to improve outreach to certain populations; these are described in the “Opportunities for the Future” section.)

Indigenous Communities

South Dakota is home to nine federally recognized Indian reservations (U.S. Attorney’s Office, District of South Dakota, 2023). Interviewees described some of the challenges that these communities face, including high rates of suicide, lack of transportation, limited access to mental health care, and gaps in the tribal continuum of care. They also spoke of the importance of ensuring the availability of culturally appropriate care—for example, being mindful of preferences for traditional or spiritual approaches to care versus Western approaches. Sioux Falls stakeholders described multiple efforts to better reach tribal communities. South Dakota Urban Indian Health, an Urban Indian Health clinic, recently received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop training related to American Indian culture, which will equip 988 call-takers with skills to work with this population more sensitively. Reservations have their own PSAPs, and 988 call center staff have been trained on the different governance at these PSAPs. The Helpline Center is also working to sign MOUs with these tribal PSAPs, and staff highlighted the importance of building relationships with these PSAPs and ensuring that any MOUs are tailored to their needs. In addition, highly respected members of tribes have contributed to radio messages to increase awareness of 988.

Immigrant Communities and Non-English Speakers

Interviewees noted that there are multiple refugee communities and more than 137 languages spoken in the metropolitan area. Some of these communities have not been aware of the local behavioral health resources. Interviewees also cited the potential stigma of seeking mental health care, which has been found to be a barrier to help-seeking in refugee populations (Byrow et al., 2020). To address these barriers, the Helpline Center has made efforts to provide education related to 988, such as partnering with refugee service organizations and working with the local multicultural center. To address the needs of non-English speakers, both 911 and 988 use LanguageLine, an interpreter service that offers interpretation for more than 240 languages (LanguageLine Solutions, undated). Call-takers reported that LanguageLine was an effective tool.

Facilitators of Planning and Implementation

We were interested in understanding the factors that facilitated the 988/911 interoperability planning and implementation process. When we asked about these factors, stakeholders sometimes shared information

directly related to 988/911 interoperability, but they also shared ways in which the overall continuum of crisis care helps support interoperability. We describe both in this section.

Facilitators Directly Related to Interoperability

Relationships

Many stakeholders highlighted the importance of relationships to effective 988/911 interoperability. Sioux Falls was able to leverage preexisting relationships between several of the partner agencies, especially the Helpline Center and Metro. An interviewee noted that groundwork for 988/911 interoperability had already been laid thanks to the existing relationship between these agencies, and the launch of 988 provided an opportunity to expand on what they had been aiming to do. Another interviewee cited the existing relationships between other partner agencies, such as the CMHCs and law enforcement. Some interviewees noted that relationships are an essential Midwestern value; one person stated, “When you’re in a small state like South Dakota where you enjoy such familiarity, you’re able to work through just about anything. And so I think we have a leg up on a lot of states where people don’t know each other very well.” However, not all relationships predated the launch of 988; interviewees also highlighted the role of the task force that was assembled to support the launch of 988 in building relationships across stakeholder groups.

Implementation Champion

Implementation champions are individuals who “enthusiastically promote and facilitate implementation of an innovation” (Santos et al., 2022, p. 2). Although interviewees in South Dakota did not necessarily use this term, many of them made it clear that the CEO of the Helpline Center was a champion of 988/911 interoperability, and this was a key ingredient to its success. There were many factors that made her an effective champion. For one, she has been with the Helpline Center for more than two decades, and interviewees cited the value of stable leadership. She has also personally taken on the role of forming individual relationships with PSAPs across the state, thus facilitating the signing of additional MOUs. Within Sioux Falls and Minnehaha, the deputy director of Metro has also been a key champion for 988/911 interoperability, and the collaboration between these two leaders was seen as an important facilitator.

Establishment of Clear Expectations, Policies, and Protocols

An important part of 988/911 interoperability is identifying the scenarios that are appropriate for transfer from 988 to 911 and vice versa. Interviewees said that it is essential that call-takers understand the instances in which they should—or should not—make a transfer and apply those criteria consistently. This knowledge can help call-takers feel more comfortable about their role in the transfer process, but it also helps increase the level of trust they have in the other organization. In Sioux Falls and Minnehaha County, these expectations and protocols were formalized in multiple ways. For example, the 911 EMD protocols were designed so that there is a clear disposition for each call after the required information is obtained from the caller; that is, the protocols clearly indicate which calls can be transferred to 988 and which require a different type of dispatch. Roles and procedures are also formalized within the MOUs between agencies.

Ongoing Communication Between Agencies

As previously described, interviewees felt that it was important to build solid relationships between agencies to support the implementation of 988/911 interoperability. In addition, interviewees indicated that ongoing communication among agencies has been critical to the success of 988/911 interoperability. Communication takes many forms and happens on many levels. At the highest level, the statewide task force has continued to meet, though it has reorganized into working groups to address certain topics (e.g., statutes and policies). The task force meets less frequently, but it continues to provide a forum for relaying information between various

services and communities. In Sioux Falls and Minnehaha County, interviewees described regular communication between the leaders of Metro and the Helpline Center, including monthly meetings to review cases to identify opportunities for improvement. Communication also sometimes happens between call-takers of these two organizations; for example, 988 call-takers sometimes follow up with 911 call-takers to learn about the disposition of a transferred case. This type of communication was seen as a way to build bridges between staff members.

Cross-Training Opportunities

We previously described the careful approach to training and QA used by the Helpline Center and Metro. Interviewees noted that, in addition to within-agency training, it was valuable to have the opportunity to attend training with staff of other stakeholder agencies. For example, Helpline Center leadership participates in the state-level training for PSAP call-takers, providing information about 988 and 211 (the local community resource line) from that early stage. Helpline Center staff have also attended in-service training sessions at the PSAP to teach 911 call-takers about safety planning and how 988 handles follow-up. Interviewees reported that this helped 911 call-takers feel more confident that cases will be handled professionally and appropriately when they make a transfer to 988. Both 988 leadership and mobile crisis team staff have done some training of law enforcement to help law enforcement understand the circumstances in which they can use 988 and 211.

Culture of Doing What’s Best for the Public

From our discussions, it was clear that interviewees approached efforts to implement 988/911 interoperability from the perspective of expanding services to better serve the public. As one interviewee noted, “You have to know we’re doing it for the best of the clients and the community.” This shared goal helped establish a baseline level of buy-in; another interviewee noted that no one had to be “voluntold” to support implementation. Because of this commitment to serving the public, stakeholders described a willingness to try new things, see how they worked, and then adjust as needed. As another interviewee put it, “Nothing is off the table.”

Direct Line for PSAPs

Interviewees noted the importance of having a direct phone number for PSAPs at the Helpline Center. This way, the PSAP call-taker does not have to call through the main line, and 988 call-takers can see when a call has come from a PSAP.

Additional Facilitators

The facilitators described above are factors that a jurisdiction could work to implement—for example, training and opportunities for communication between agencies. However, interviewees also described some factors specific to the characteristics of Sioux Falls and Minnehaha County that served as facilitators. These facilitators included the size of the metropolitan area and the availability of local resources: In the words of one interviewee, “We are small enough that we can manage it, but big enough that we have the resources.” Interviewees also noted the value of having a single 988 call center for South Dakota, meaning that decisions regarding the role of 988 could be made more easily and issues could be addressed more quickly.

Strengths of the Overall Continuum of Crisis Care

Interviewees described strengths of the overall continuum of crisis care that helped lay the groundwork for effective 988/911 interoperability and the availability of appropriate in-person responses for callers. These are summarized in Table 2.1.

TABLE 2.1

Strengths of the Continuum of Care in the City of Sioux Falls and Minnehaha County, South Dakota

Agency	Strengths
Helpline Center (988)	<ul style="list-style-type: none"> • 988 follows up with callers, which can ensure that people are connected with support after their call. • 988 is colocated with 211, making it easier to connect callers to needed resources. • Chat and text options are available and allow 988 to serve a broader population.
Law enforcement	<ul style="list-style-type: none"> • CIT training has been embedded in the law enforcement academy for police officers, providing all law enforcement with the foundation to understand when there are behavioral health needs or a person is in an emergent crisis. • The SFPD's Mental Health Community Resource Officer is a dedicated resource for behavioral health needs and can address needs of frequent utilizers.^a • There is a co-responder model in collaboration with CMHC, which can respond to a broader set of calls than the mobile crisis team can.
Mobile crisis	<ul style="list-style-type: none"> • Mobile crisis teams were in place in Sioux Falls for ten years before the launch of 988, giving them a long-standing track record in the community.

^a Interviewees from various agencies used the term *frequent utilizers* to describe people who might call a PSAP or 988 frequently or be in contact with law enforcement several times in a brief window and/or who are being served by several local agencies (e.g., behavioral health, hospitals, and law enforcement).

Lessons Learned from Planning and Implementation

Although there were challenges that arose during the planning and implementation process, the stakeholders in Sioux Falls—and South Dakota more broadly—were able to address these. In this section, we capture some of the lessons learned that were shared during interviews.

Challenge 1: The Experiences of PSAPs and Law Enforcement Departments in Rural Areas Can Be Quite Different from the Experiences of Those in More-Populous Areas

This concern did not pertain to 988/911 interoperability in Sioux Falls and Minnehaha County, but rather to efforts to extend interoperability statewide. Interviewees described how PSAPs and law enforcement in rural areas are used to operating in areas in which there are limited behavioral health resources and are used to handling a wide variety of issues on their own. They may receive few behavioral health emergency calls, so establishing a procedure for 988/911 interoperability may have fewer clear benefits. Also, not all PSAPs use the same structured protocols as Metro, meaning that additional work is needed to determine what cases are the best fit for a transfer to 988.

Strategies to address the challenge: It appeared that developing MOUs and operating procedures for Sioux Falls was a somewhat more straightforward process than in other areas of South Dakota, given the existing relationship between the Helpline Center and Metro. However, because the Helpline Center is the 988 call center for the entire state of South Dakota, interviewees reported that there have been additional efforts to formalize relationships with PSAPs across the state. For example, the interviewees said that the CEO of the Helpline Center has personally brokered relationships with PSAPs and law enforcement across the state, with the support of the state 911 coordinator. She has been able to show these rural agencies sample MOUs to demonstrate the procedures that have been put in place with other PSAPs and law enforcement agencies. Then, each MOU is separately tailored to the needs of each agency to ensure that the MOU fulfills the needs of all stakeholders. Interviewees expressed the view that this level of flexibility and adaptability has been an important strategy to bring interoperability to more PSAPs. In addition, the CEO has focused on fostering relationships with each of the PSAPs, often through in-person meetings. This approach has been

another important facilitator. As one stakeholder noted, “It had to be a real individual approach because [otherwise] you’re going to turn people off, and so I think the state has been supportive, but they have allowed us to work [individually], and I think that’s what has been so successful.” The interviewee noted the importance of understanding that what works for different regions will vary depending on such factors as population and local resources. In addition, smaller PSAPs were able to speak with Metro about their experiences with 988/911 interoperability, and interviewees said that they believed that doing so helped ease the concerns raised by these smaller PSAPs.

Challenge 2: Staff and Leadership from PSAPs Expressed Concerns About the Safety of Callers and the Public If Mental Health Emergency Calls Are Handled by 988 Instead of 911

Some PSAP staff and leadership expressed concerns about liability issues that might arise if they transferred a call to 988 and the caller harmed themselves or others. PSAP call-takers also said that they feel ownership over the calls they take and worried about what might happen after they transferred a call to 988; for example, how would that call be handled? What would the qualifications of the 988 call-taker be?

Strategies to address the challenge: The decision to transfer a call to 988—or not—is governed by a specific protocol, so 911 call-takers do not have to exercise their judgment in deciding whether a call should be transferred. Interviewees highlighted this fact as potentially protective against liability. Interviewees from Metro and the Helpline Center also described efforts to provide opportunities for call-takers from each agency to cross-train. Cross-training has given PSAP call-takers a better idea of the training level and tools available to 988 call-takers, increasing their confidence that 988 call-takers can handle a call.

Interviewees also reported that, during the early stages of implementation, PSAP call-takers were concerned that there were many cases that were transferred to 988 but then needed to be transferred back because the situation had increased in acuity. However, Helpline Center staff review every case that gets transferred back to 911 to see whether the call-taker could have done anything differently, and then they use this information to provide additional training to their staff. They also shared information with PSAP call-takers about the percentage of calls that actually need to be transferred back, showing that the number is quite small; according to our interviews, this information appears to have increased PSAP call-taker confidence in transferring calls to 988.

Challenge 3: PSAPs and Law Enforcement Can Face Barriers to Sharing Case Outcomes, Which Can Include Protected Criminal Justice Information, with the Helpline Center

Helpline Center staff said that they find it useful to learn about the outcomes of cases that they need to transfer to 911 and that receive an in-person response from law enforcement. One reason this can be helpful is that knowledge of case outcomes can help 988 call-takers adjust their approach to future callers and know whether there are additional situations that could be managed by 988. However, some case outcomes can include sensitive criminal justice data that cannot readily be shared.

Strategies to address the challenge: Stakeholders began discussing this challenge in advance of the 988 launch, bringing everyone together in one room. As one stakeholder noted, “email doesn’t work” for this type of sensitive discussion. The stakeholder group built in sufficient time for preplanning, raising questions, and allowing attorneys from relevant agencies the opportunity to review legal aspects of the issue. A solution that was developed with the SFPD resulted in the development of a web form that police officers can use to submit limited information to the Helpline Center about the resolution of the case, including who responded (i.e., law enforcement, mobile crisis team, or co-response team) and the outcome (i.e., transported with a mental

health hold, transported without a mental health hold, or de-escalated), though it is not mandatory at this time. To determine what data could be shared from Metro, the city attorney needed to be involved. Decisions regarding data-sharing were codified in the MOUs between the relevant organizations.

Opportunities for the Future

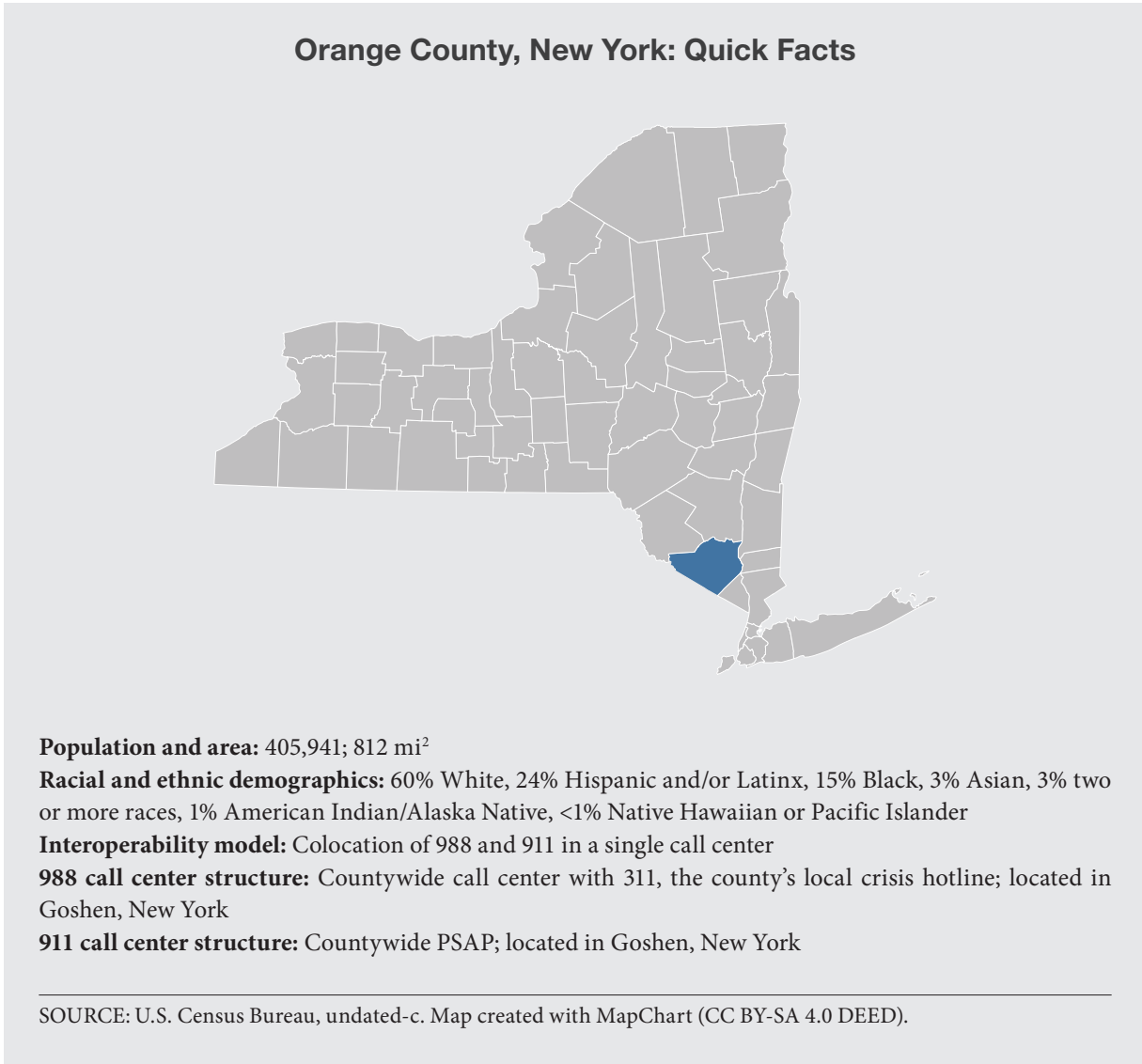
Although the existing model of 988/911 interoperability in Sioux Falls and Minnehaha County has many strengths, interviewees discussed some opportunities that they have identified for the future. Some of these relate to local 988/911 interoperability, and others relate to the vision of having 988/911 interoperability implemented statewide. Knowledge of these future priorities might help other jurisdictions anticipate some of the considerations that arise after the initial stages of implementation. These include the following:

- **Considering changes to operation of mobile crisis teams in the state, which currently are dispatched only by law enforcement.** Some interviewees suggested that there could be instances in which mobile crisis teams could be appropriately dispatched by the Helpline Center rather than having to be called by law enforcement. However, they noted that there are many additional decisions that would need to be made if this were the case, including decisions about (1) the situations in which mobile crisis teams would feel safe responding to calls on their own (e.g., presenting concerns, time of day); (2) training for dispatchers to ensure that appropriate referrals were made; and (3) logistical considerations, such as staffing coverage and insurance.
- **Providing ongoing training related to the new decision rules regarding transfers from 911 to 988.** Some 911 call-takers noted that the new EMD protocol sometimes seems like it results in a disposition that is different from what the call-taker expects (e.g., it indicates that a call should be transferred to 988 when the call-taker perceives a need for law enforcement). PSAP staff said that there are ways that call-takers can handle those situations in the moment, such as by sending law enforcement in addition to transferring a call to 988 if they are concerned. But ongoing review of these types of cases might help point to additional training needs. Some call-takers also expressed concerns that the new questions can feel repetitive, which can frustrate callers, and worried that such explicit questions about self-harm might increase the likelihood that the caller *does* self-harm. However, there is research to the contrary (Dazzi et al., 2014), and helping address these concerns might further increase the comfort of 911 call-takers with interoperability and the existing protocols.
- **Ensuring the availability of supportive services for callers.** Some interviewees noted the importance of having additional services in the community beyond behavioral health care. For example, one person noted that many of the clients served by the co-response teams come from local homeless shelters and transitional housing facilities, and two interviewees highlighted the need for more housing options for clients.
- **Continuing to develop specialized resources for certain populations.** Interviewees noted that South Dakota has been ahead of the curve with the implementation of 988, as they felt well prepared for the launch in July 2022. As described above, organizations within the state have made efforts to reach out to certain subpopulations, including indigenous and immigrant groups. However, staff members across agencies noted that there are other populations that they are working to reach, such as D/deaf and hard-of-hearing callers; young adults and teens; lesbian, gay, bisexual, transgender, queer, and more (LGBTQ+) individuals; elderly populations; rural communities; and veterans. This outreach is consistent with broader nationwide efforts to provide tailored services to these populations.

Benefits of 988/911 Interoperability

Finally, across our interviews, interviewees highlighted their perceptions of the benefits of 988/911 interoperability. One perceived benefit is that 988/911 interoperability creates a “no-wrong-door approach”; whether a person experiencing a crisis calls 988 or 911, interoperability ensures that the caller receives the appropriate type and level of care. The relationship between 988 and 911 has also led to instances in which the two services are able to complement each other; for example, even if 911 has to dispatch law enforcement, it sometimes connects callers with 988 to de-escalate or support them while they wait for law enforcement to arrive. In addition, interviewees said that when calls can be diverted from 911 to 988, callers are often provided with a broader variety of resources, including referrals to behavioral health care, referrals to 211, and follow-up calls. Finally, stakeholders noted that transferring behavioral health calls from 911 to 988 has helped free the resources of 911 call-takers and law enforcement, allowing them to respond to other emergencies. One interviewee summarized the benefits as follows: “It’s good for the individual, it’s good for the patient, it’s good for the system, it’s good for everybody.”

Orange County, New York



Our second case study site was Orange County, New York. For the past four years, Orange County has had its Orange County Crisis Call Center (i.e., 311) and 911 PSAP collocated within the same call center. In 2020, the county was able to build on existing infrastructure and add the Lifeline to the existing crisis call center, and it transitioned the Lifeline to 988 in 2022. Although 988 calls are answered by the Orange County Crisis Call Center, county agencies focus on publicizing 311 given its geolocation ability and awareness of it in the com-

munity relative to the Lifeline. Interviewees noted that the call center receives significantly more 311 calls than 988 calls per month, in part because 311 launched prior to 988 with an extensive local advertising campaign that included billboards, radio ads, and distribution of flyers at community events. 311 also receives a number of calls for information because of the well-known 311 nonemergency line in New York City. 311 and 988 procedures and services are nearly identical, with the exception of some administrative duties. Therefore, in the discussion that follows, we focus on both 311 and 988 (and, within 988, procedures for local callers specifically) and their roles in interoperability with 911.

Planning for 988/911 Interoperability

Until 2019, Orange County operated a multitude of separate ten-digit helplines and warmlines for behavioral health services,¹ including for mobile response and peer support, and other services, ranging from domestic violence support to homelessness response. Interviewees noted that, in 2017, the New York State Office of Mental Health asked counties to develop a plan and designate agencies to provide and bill for mobile and telephonic behavioral health crisis services under a newly available Medicaid Managed Care Crisis Intervention Benefit. Simultaneously, the Orange County Department of Mental Health (OCDMH) embarked on an addiction treatment system process-improvement initiative that included a weeklong system-mapping exercise (Waller et al., undated). Interviewees said that this exercise and the subsequent report made clear that the local police chiefs' association and law enforcement agencies wanted a simple process and a single point of contact for the behavioral health system. OCDMH then decided to consolidate local helplines into one number: 311 (Miller and Trimble, undated). A newly created Orange County Crisis Call Center would answer for 311 and, in 2020, would become part of the Lifeline, which was the predecessor to 988. As planning developed, leaders at OCDMH, with key support from the county executive and leadership at the Division of Emergency Communications (Orange 911), decided that colocating 311 with 911 would be beneficial for resource-sharing and oversight of services.

In the lead-up to the launch of colocation in 2019, county and 911 officials worked with three partner nonprofit agencies that would be colocated with the PSAP at the Emergency Operations Center: the Crisis Call Center, the Mobile Response Team (MRT) program, and peer specialist services. Interviewees noted that, having worked together for decades, these agencies had long-standing relationships that laid the groundwork for this effort; for example, MRT and law enforcement have collaborated for more than 30 years. For a year, these agencies met weekly, formed agreements, established phone lines, and reconfigured and added 311 call-takers to the CAD system to support colocation. Orange 911, which operates the countywide PSAP, provided an in-kind donation of space for the Crisis Call Center at the Emergency Communications Center, including space on the 911 floor for 311 call-takers, starting with three stations and expanding to five, as well as office space for 311 management, MRT staff, and peer support workers.

Interviewees said that once 311 and 911 were colocated in 2019, interoperability between them began in an informal manner. (Formalized policies and procedures were implemented later—in 2020 for 311-to-911 transfers and in 2023 for 911-to-311 transfers.) Informal processes entailed a call-taker asking for help from supervisors while on a call—for example, putting a 911 call on park (i.e., on hold but with the ability for someone else on the phone system to answer the call) and having a 988 supervisor pick up the call. Developing formal 311-to-911 call diversion criteria and a call process map took one year of weekly meetings between leaders in the county, 911, the Crisis Call Center, and MRT. Crisis Call Center and MRT leadership in partic-

¹ A *warmline* is a hotline that can provide support to people experiencing mental health symptoms. Warmlines typically have a focus on noncrisis situations and are generally staffed by peer workers (National Alliance on Mental Illness, 2021).

ular reviewed calls in the CAD system to help develop the call diversion criteria. These negotiations involved coming to a consensus on the definition of *imminent risk*, as described below, and on when to dispatch law enforcement or MRT, culminating in MOUs between agencies and an approved call process map.

Initially, interviewees reported that transfers from 911 to 311 were infrequent and occurred on an ad hoc basis. However, creating this diversion policy was described as more straightforward and primarily involved the Crisis Call Center leadership, the commissioner for 911, and the deputy commissioners for police, fire, and EMS, who worked through developing the protocols, ensuring adherence to 911 regulations. Getting support from the police chiefs' association was described by one interviewee as "a lot easier" than expected, in part because of existing work with mobile crisis, homelessness, and other services. Once a policy was agreed on in August 2023, the 911 team made the necessary CAD changes and 911 call-takers began asking questions from the Columbia-Suicide Severity Rating Scale (Posner et al., 2011) and transferring nonimminent, nonviolent calls to 311. The official policy states that doing so will help improve customer service and assistance for people calling with mental health crises by providing the appropriate agency to respond to the situation (Orange County Division of Emergency Communications, 2023a).

Interoperability Processes

Figure 3.1 summarizes the basic process of transferring calls between 911 and 311, as well as decision points and the roles of call-takers, dispatchers, law enforcement, MRT, and peer specialists. In this section, we provide more detail about each of the steps, which is synthesized from data obtained in our interviews and a review of local policy documents (see Table A.2 for all documents reviewed).

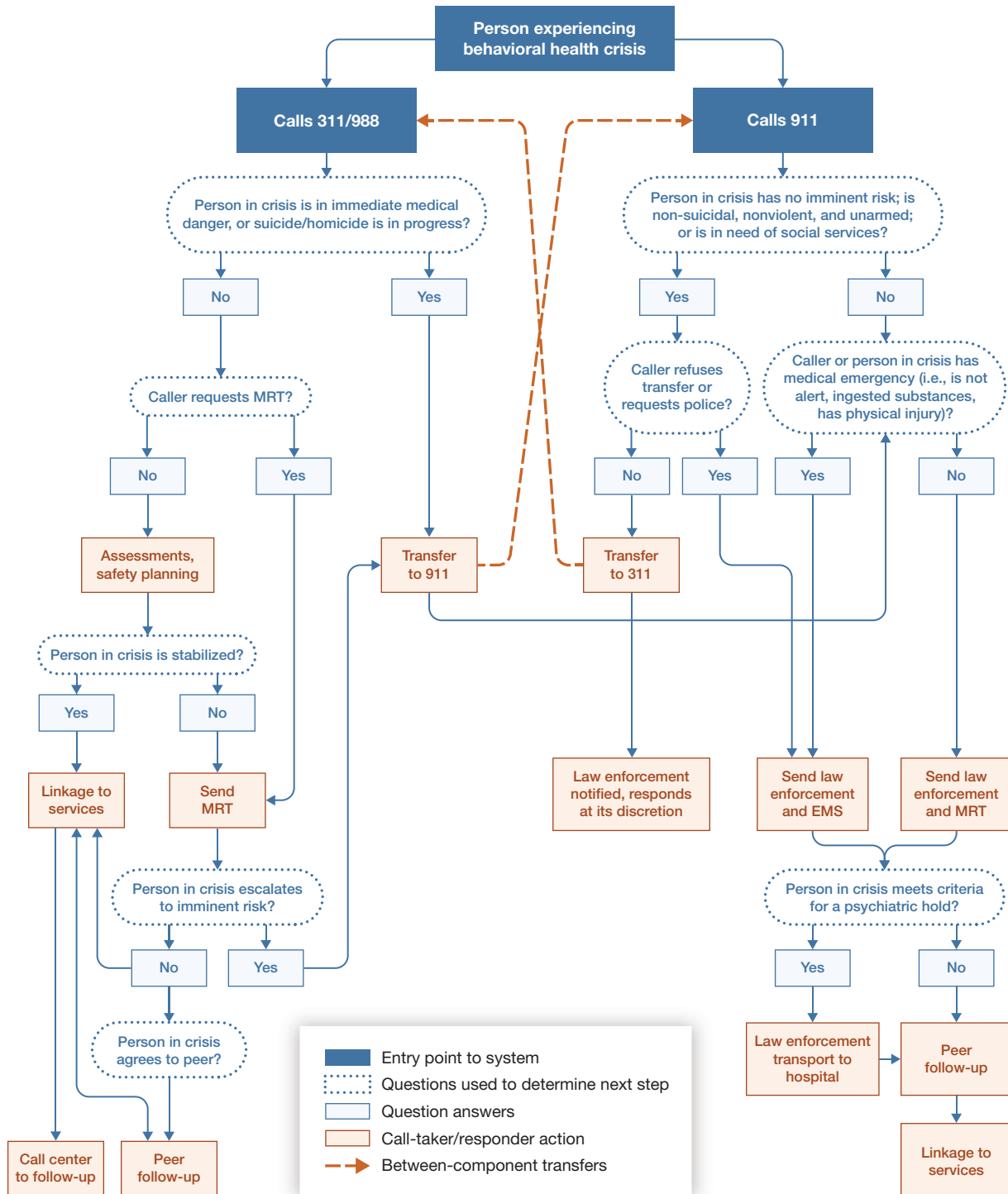
Calls Transferred from 311/988 to 911

Initial Phone Call and Assessment of Caller Needs

When a call comes into the Crisis Call Center via 988 or 311, a crisis call-taker gathers demographic information; identifies the location if the caller is willing to share; provides supportive listening; and assesses whether the call poses an "imminent risk" and, therefore, should be transferred to 911. This information is gathered conversationally. For both 988 and 311, *imminent risk* is defined as "immediate danger of [the person in crisis] harming or killing themselves or someone else, now or within the next 24 hours; imminent medical danger from substance use withdrawal, drug or alcohol poisoning or overdose; or an individual has already taken some action with the intent to end their life or someone else's life" (Orange County Crisis Call Center, undated). Although 988 and 311 are separate programs within the call center and call-takers are assigned to and answer calls for only one line, the two programs provide similar services and operate on the same CAD system as 911. However, interviewees noted that, compared with 311 calls, 988 calls tend to be more acute, with callers who are more likely to be at imminent risk.

If a caller is *not* at imminent risk, there are multiple options for response, including support over the phone; referrals to services, including peer support; and mobile crisis response. For example, if a caller has suicidal ideation but does not have a plan or a weapon, call-takers will engage in safety planning and provide the "least invasive intervention," involving 911 as infrequently as possible, according to one interviewee. Call-takers may conduct assessments, such as the Patient Health Questionnaire-9 (a self-report depression measure; see Kroenke, Spitzer, and Williams, 2001) or the Level of Care for Alcohol and Drug Treatment Referral (a tool used to assess the appropriate level of treatment for individuals with substance use problems; see O'Grady et al., 2019), and provide referrals to services (e.g., substance use disorder [SUD] or mental health treatment, food assistance, housing services) or dispatch MRT or peer support teams as appropriate.

FIGURE 3.1
Orange County, New York, 988/911 Interoperability Summary



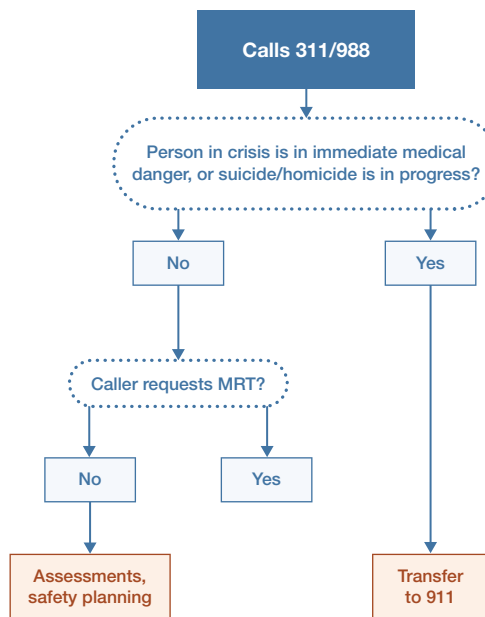
For example, if an individual with an identified SUD does not agree to a treatment referral, the call-taker will offer to dispatch peer support services.

If a caller *is* deemed to be at imminent risk, then the call will be transferred to 911. Call-takers follow protocols that are sometimes unambiguous (e.g., ingestion of a substance will trigger a transfer to 911), whereas other situations might require a judgment call.

How the Transfer to 911 Occurs

When a call is transferred to 911, the 311/988 call-taker will create a CAD incident using a “911 Transfer” CAD type code, which allows the 911 call-taker to view some details of the incident (that is, details not protected by the Health Insurance Portability and Accountability Act [HIPAA]). The 311/988 call-taker will then transfer the caller to 911 while remaining on the line to introduce the caller, including the person’s name and address if available, and describe the situation to the 911 call-taker. If a caller at imminent

risk does not provide an address, 911 staff will search via major phone companies to identify an address. At that point, the 911 call-taker can dispatch an in-person response. Interviewees said that the response is most frequently law enforcement, though occasional cases require the fire department or EMS. The 311/988 call-taker may stay on the line to assist the 911 call-taker, provide emotional support to the caller, and/or dispatch MRT along with police, the fire department, or EMS. No situation would warrant a 911-transferred call being transferred back to 311/988.



Calls Transferred from 911 to 311

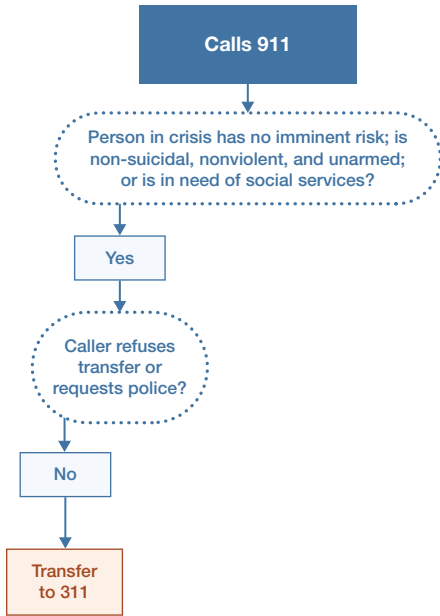
Initial Phone Call and Assessment of Caller Needs

The Orange County Emergency Communications Center uses nationally recognized, structured EMD protocols to determine the appropriate response for a caller. During the planning for 988/911 interoperability, however, the Orange 911 team was able to customize parts of the protocol related to nonemergency mental health calls and add questions from the Columbia-Suicide Severity Rating Scale to assess whether the caller could be transferred to 311.

When a call comes into 911 reporting an “emotionally disturbed person” (the terminology used in law enforcement standards), the 911 call-taker will ask structured questions, and, if the caller has not threatened or attempted suicide, the call-taker will process the call via Emergency Priority Dispatch Card 121, titled “Mental Disorder,” and ask all questions outlined in that protocol until the appropriate pathway for referral is reached. If the caller is deemed nonviolent and unarmed, the call-taker will transfer the caller to the Crisis Call Center for further assistance. Additionally, nonemergency calls for services, including food, housing, intellectual or developmental disability, and child care services, can be transferred to the Crisis Call Center. These calls will also go through structured EMD protocol questions before being transferred to 311.

How the Transfer to 311 Occurs

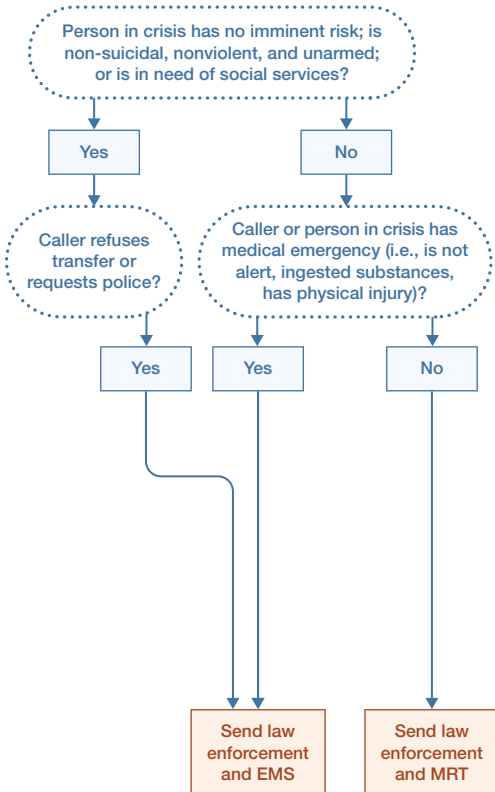
When a call is transferred to 311, the 911 call-taker will connect the call via a “911 transfer to MH” button on the phone’s speed dial (*MH* refers to *mental health*). The call-taker will follow the transfer procedure outlined in the CAD system, then select “referral” in the Emergency Priority Dispatch system. A CAD incident will be



created under the code “Mental Health Referral~Law,” which will create a call to the Crisis Call Center. The 311 call-taker will see this call in CAD as “911 Diversion~Mental Health” and be able to view the incident details and take over the call. The corresponding law enforcement agency will also be notified of the incident and can respond at its discretion. If the Crisis Call Center does not answer the transfer in five rings (approximately 30 seconds), the 911 call-taker will select an option called “Not OMEGA” and dispatch the relevant law enforcement agency. This option is also used if a caller meets the criteria for a transfer to 311 but requests a police response instead. If a caller refuses to be transferred to 311 and safety may be an issue, even if the caller does not explicitly request police, the 911 call-taker will select “caller refused OMEGA process dispatch units” and process the call in the CAD system, and dispatch will determine the appropriate entity to respond (e.g., law enforcement, EMS).

In-Person Response

Orange County has maintained access to a strong network of mobile responders for many years that includes MRT and peer support services, which co-respond with law enforcement when needed. Co-response requests can be made by law enforcement or MRT.



Law Enforcement

Discussions with Orange County agencies revealed that police chiefs in the region from both urban and rural localities were supportive of colocation and interoperability from the beginning of the planning process. Law enforcement had worked with MRT and other local service providers for years and understood the benefits of behavioral health call diversion. As one interviewee described, a “peaceful resolution of whatever is going on out there is beneficial to everybody.” Another interviewee from a police department described that, as of two years ago, police would always respond to calls, but now they try to determine whether police are truly needed, encourage individuals to connect to mental health services, or provide referrals to 311. As noted above, with the new 911-to-311 diversion policy, police departments are notified of the transfer but are given discretion as to whether to respond. For example, police may respond if a department is aware of the situation or person requesting services and believes that the presence of police is warranted.

A call in which the caller is at imminent risk of harm to themselves or others requires an in-person response by a law enforcement agency, of which there are 32 in the

county. The state police department also covers six small municipalities and responds in those places. There are several sections of New York State Mental Hygiene Law (NYS MHL) that have a direct impact on both MRT and law enforcement response. According to NYS MHL § 9.41, peace officers and law enforcement officers have the power to detain an individual for a psychiatric assessment if the individual exhibits signs of mental illness and behaves in a manner that is likely to cause significant harm to themselves or others. If necessary, the officers will transport the individual to a hospital. Two additional laws, NYS MHL § 9.45 and NYS MHL § 9.58, allow physicians or qualified mental health professionals (QMHPs) who are members of an approved mobile crisis outreach team (in Orange County this is MRT) to direct the removal of any person to a hospital for the purpose of evaluation. At times, MRT requests law enforcement support because of known safety issues, and at other times police request MRT co-response because of known or suspected mental health needs. Under subsection (d) of NYS MHL § 9.37, it is the responsibility of law enforcement to transport the individual in crisis to the hospital. Ambulance services are also authorized to transport such individuals, but, given the lack of local ambulance availability and the safety concerns present during some responses, police do most of this kind of transportation.

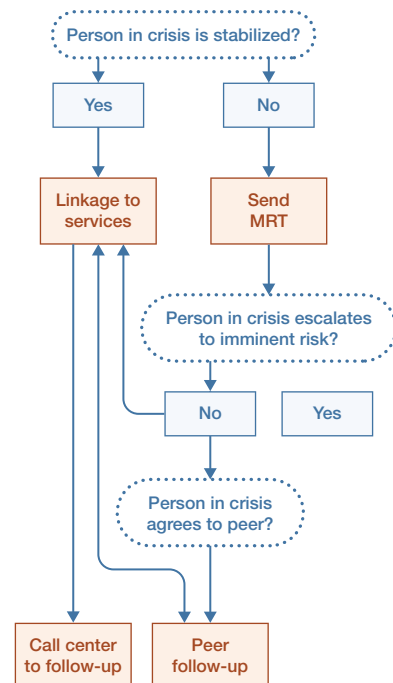
Law enforcement may also be able to de-escalate a situation and connect an individual to services. At times, officers call for MRT to respond to support an individual or provide referrals to peer specialists or 311. The county received funding to train senior officers in the CIT model (CIT International, undated). Ten of 32 police departments partnered with the county to implement CIT programs. These departments received stipends to help cover overtime costs for an officer to cover the shift of the designated officer who was participating in CIT training. Participating departments provide reports to a group that includes the Crisis Call Center CIT coordinator colocated at the Emergency Communications Center, who ensures follow-up with each individual and initiates peer support and other services as needed. The remaining police departments have a number of CIT-trained officers, and all officers going through the academy now receive CIT training.

Three police departments have also piloted a program embedding peer support specialists in their stations. To participate in the pilot, these departments had to express interest and demonstrate a need for the program, based on volume of behavioral health calls. Peer specialists can join officers on mental health-related calls, and, once officers clear the scene, peers can lead and provide emotional support to individuals and connect them to services. Peer colocation and ride-alongs are up to police discretion.

Mobile Response Team Program

Orange County has a long history of mobile clinical response to behavioral health crises. The current mobile response agency has worked in the region for more than 50 years and has a strong relationship with local law enforcement. MRT is involved in the police academy and teaches new recruits about the instances in which they should consider calling MRT: As one interviewee put it, “You are not clinicians, and we don’t want you to be. Call us; that’s our job.” MRT also works with peers to ensure follow-up care for individuals in need of additional support.

Since the colocation of crisis services, MRT has been dispatched by the Crisis Call Center in response to calls to 311. In some instances, MRT responds to calls from community members. However, law enforcement personnel can also call 311 to request that MRT meet them at a location or follow up with an individual. MRT also follows up on all CIT reports.



MRT is dispatched via Rover, a mobile application that is also used by 911 to dispatch law enforcement. When dispatched, MRT receives the location of and demographic information about the caller, whom MRT is able to contact prior to arrival to provide notice. Operating in teams of two—three teams during the day and two at night—MRT aims to respond in 30 to 45 minutes across the county. MRT clinicians, counselors, and/or peers assess clients and provide stabilization, safety planning, and referrals to service with the goals of promoting community stabilization and avoiding unnecessary police interactions and hospitalizations. Clinicians have the ability to assess an individual to determine whether they meet criteria of NYS MHL 9.58, which gives physicians or qualified mental health workers the authority to direct the removal of any person to a hospital for the purpose of evaluation. If the individual does meet criteria, MRT issues the necessary NYS MHL 9.58 paperwork to the police department to request involuntary transport to the hospital by law enforcement or an ambulance. Involuntary transport to the hospital does not guarantee admission; hospitals are required to assess individuals to determine whether they meet criteria for admission. At the end of a call, MRT enters the outcome into the Rover app, which transmits the information back to the CAD, which is monitored by the Crisis Call Center. If MRT requested a peer through Rover, PeerRx—another mobile app—is used to dispatch an appropriately credentialed peer support specialist. Peer support specialists follow up on everyone they receive referrals for. If there is any indication of violence, MRT responders will either bring police with them or call them for backup; however, MRT staff expressed comfort with responding to many calls alone, particularly for individuals known to the agency.

Peer Support Specialists

Peer support specialists, or workers with lived experience with behavioral health conditions who are trained to provide nonclinical support, have played an essential role in the Orange County continuum of care for decades. As interviewees described, “peers can speak the language of what someone is going through,” and their goal is to engage with individuals, particularly frequent utilizers of services,² by addressing their broader needs.

Peer specialists can be requested by the Crisis Call Center, MRT, or police departments and are dispatched by the Crisis Call Center via PeerRx. Crisis Call Center call-takers can put requests into PeerRx for callers who are not at imminent risk and need additional support. MRT can also enter requests for peer specialists into the Rover app, which communicates back to the Crisis Call Center to initiate the referral. Police departments can submit referrals to the Crisis Call Center, which again contacts peers through PeerRx. MRT and police departments often refer individuals to peers in situations in which individuals do not need to go to the hospital. Within ten to 20 minutes, a peer will be assigned to the client, and the peer aims to follow up with the client within 24 to 48 hours and work with the individual for up to 30 days. Peers are also often referred when individuals refuse to go to the hospital after nonfatal overdoses. This is common in some communities in Orange County. Once connected to an individual, the peer will engage with the individual to encourage them to get the help they need to avoid a future overdose incident. For example, one interviewee noted instances in which law enforcement has responded to and revived the same individual with Narcan more than a dozen times; in these cases, it is the peer who responds to the individual when they are not in crisis, builds a relationship with them, and successfully connects them with SUD treatment services. Peer specialists provide individualized services, which can include connection to treatment; medication assistance; food delivery; and development of goals and a Wellness Recovery Action Plan, a peer-delivered self-management intervention to achieve those goals (Cook et al., 2012).

² In this context, *frequent utilizers* are people who might call a PSAP or 988 frequently or be in contact with law enforcement several times in a brief window and/or who are being served by several local agencies (e.g., behavioral health, hospitals, and law enforcement).

Training and Quality Assurance

Orange County stakeholders discussed the ways in which training and QA have supported 311/988 and 911 interoperability. This discussion included not only the roles of 311/988 and 911 call-takers but also those of in-person responders (i.e., law enforcement, MRT, peers, EMS).

Emergency Communications Center (Crisis Call Center and 911)

Interviewees said that Crisis Call Center staff are onboarded as call-takers for both 988 and 311. Some staff are specifically funded by Vibrant, so they are required to answer for 988. Call-takers undergo extensive training that covers more than two dozen topic areas to prepare them for the variety of calls that come into the center. Training topics include use of the Columbia-Suicide Severity Rating Scale on calls, as well as motivational interviewing (Hettema, Steele, and Miller, 2005), safety planning (Stanley and Brown, 2012), HIPAA compliance (Centers for Disease Control and Prevention, 2022), mandated reporting (Mathews, 2015), and working with specialized populations.

911 call-takers spend one year training, from the classroom to the 911 floor, working with each department, including police, the fire department, EMS, and 311. Some interviewees reported that training on behavioral health calls and crisis de-escalation was sufficient, whereas one expressed that training on mental health was minimal. Through the partnership with 311, 911 call-takers are offered additional training, including Applied Suicide Intervention Skills Training (LivingWorks, undated). This additional training is not required of 911 call-takers, but some interviewees reported taking advantage of the opportunities, and one interviewee recommended that this training be required. With the new 911-to-311 call diversion policy, there was not specific training, but a training bulletin was posted on the call-taker computer system and on a bulletin board. The policy was also emailed to all police chiefs in the county, some of whom shared the communication with their staff.

Regarding QA efforts, both Orange 911 and the Crisis Call Center review calls on a weekly basis, specifically the locations of calls, number of calls transferred, and any high-risk needs to address. Interviewees said that these agencies independently review calls, with the reviews taking place in an intentionally separate way because 988 and 311 are covered by HIPAA. 911 call review includes audits, in which supervisors listen to call recordings and provide feedback to call-takers. Similarly, for 311/988 calls, each call-taker gets one call audited per week, two weeks, or month, depending on how many hours they worked, and can request to listen back to calls. A licensed supervisor also pulls recordings to review, both at random and those that are particularly long. Interviewees described the process as an opportunity for strengths-based learning, to encourage growth and empower call-takers to improve. In addition, regular check-ins focus on call-taker wellness, providing breaks and celebrating successes.

In-Person Response

Interviewees said that law enforcement in the county is encouraged to complete additional training for behavioral health crisis intervention. Beyond the ten CIT-funded departments that have designated CIT officers, CIT training is encouraged countywide, providing officers with 40 hours of mental health crisis de-escalation training. All recruits at the county police academy also go through CIT training. MRT always has at least one licensed clinician on the responding team. Peer specialists can complete different New York state certification tracks, including to become a Certified Peer Specialist (for those with lived experience of mental health conditions; see Ponte, 2023) or a Certified Recovery Peer Advocate (for those with lived experience of SUD; see New York State Office of Addiction Services and Supports, undated). Peers in Orange County also receive

hands-on training and shadowing experiences with MRT and law enforcement teams and are able to start after approximately one month of training; they have the ability to add certifications over time.

Law enforcement and MRT are also involved in call QA processes. MRT leadership meets with 311 leadership to audit calls for QA purposes. Similarly, for 911 calls, both 911 and law enforcement review calls to understand areas of improvement. Often, the outcome of a call is not necessarily shared back with the call center or call-takers. One police department also discussed sending weekly emails to the county behavioral health team with reports, including those on repeat callers, and expressed the importance of the county in following up with individuals and adapting services in response to emerging issues.

Efforts to Serve Diverse Populations

As with our interviews in Sioux Falls and Minnehaha County, we asked stakeholders in Orange County about their efforts to reach diverse or underserved populations. In Sioux Falls, stakeholders discussed their efforts to reach specific racial/ethnic and cultural groups. In Orange County, responses focused on the ways stakeholders have reached individuals with distinct diagnostic or service-related needs, although it was noted that these disproportionately affect people of color in the county and that there is a need for more culturally responsive services.

Frequent Utilizers of Crisis Services

Interviewees said that Orange County has a significant number of repeat callers to 911 or 311, as well as individuals who are in frequent contact with law enforcement, MRT, or peer services. Interviewees described these individuals' needs as complex, but not necessarily at the acute inpatient level at which most facilities in the county operate. Instead, individuals might need multiple streams of assistance to address wider structural issues with which they grapple (e.g., transportation, housing).

To better reach these community members, interviewees said that representatives from the Crisis Call Center, MRT, and peer agencies meet with OCDMH weekly to discuss and coordinate services for each individual, identify services the individual is already employing, and work to find broader and more-permanent solutions for the individual instead of relying on 911 and other emergency-level services. At least one police department sends weekly reports to the county on repeat callers so that the behavioral health agencies can develop a plan to address these callers' needs. Interviewees described opportunities to further bolster coordination with the greater continuum of care, such as enhanced contact with case managers.

Individuals with SUD

Substance use and overdose, particularly related to opioid use disorder, was described as one of the most significant issues in Orange County; however, interviewees reported that neither the local 988 nor 311 receive many substance use-related calls, and the people who do reach out tend to be family members or service providers reaching out on someone's behalf. Interviewees described stigma and lack of treatment services, particularly for youth, as barriers to care. Another issue pertains to connecting people to inpatient treatment programs. This issue is not unique to Orange County. Detox and rehabilitation centers do intakes during business hours, which are not always when individuals are ready to seek treatment.

Interviewees described a variety of strategies that the county has implemented to better serve individuals with SUD, in particular those with opioid use disorder and co-occurring conditions. With federal funding given to the local department of health, the county funds a peer-delivered nonfatal overdose response program. Law enforcement agencies notify the Crisis Call Center of these cases; however, this reporting is

voluntary and can be inconsistent. When notified, the call center works with partner agencies to assist the individual and dispatch a peer specialist via PeerRx. The peer will then visit the individual within 24 to 48 hours, providing information and outreach bags with Narcan and fentanyl test strips, training the individual and family to use the items, and offering treatment services. The county has also begun to coordinate more closely with Hope Not Handcuffs, a program to which participating police departments and a volunteer network refer individuals for treatment, allowing them to avoid criminal prosecution (Families Against Narcotics, undated). Finally, the county is participating in the Columbia University HEALing Communities Study, a National Institutes of Health initiative to address opioid overdose deaths in New York state (among others) (El-Bassel et al., 2020).

Additionally, interviewees said that the county uses available data from the Overdose Detection Mapping Application Program (High Intensity Drug Trafficking Areas, undated), medical examiner confirmed overdose data, and data collected by the Orange County Health Department to determine where the greatest levels of needs are throughout the county. These data have shown the highest needs to be in urban areas, which have high overdose death rates and high behavioral health response rates. The Orange County Call Center implemented marketing campaigns to target these areas and continues to participate in community events in these communities to provide outreach and improve access to services.

Facilitators of Planning and Implementation

Facilitators Directly Related to Interoperability

Colocation of Services

Colocation was reported to be a facilitator to interoperability; one interviewee described colocation as “a beautiful collaboration.” Located in the same room and using the same phone and CAD system, Orange 911 and Crisis Call Center staff are in constant communication. As one interviewee expressed, “We can’t pretend they don’t exist.” Although not all interviewees expressed colocation as essential to interoperability, colocation was frequently described as beneficial for many reasons, including building the rapport and trust needed to transfer calls. One interviewee noted that the behavioral health system would not have had the necessary funding to purchase its own CAD system or the Rover app, so shared technology is another important benefit that results from colocation. A 311/988 call-taker described having 911 call-takers nearby as giving 311/988 call-takers a “sense of security” and said that 911 call-takers also ask them for support. Moreover, interviewees described the Emergency Communications Center as a “one-stop shop” that allows staff to connect to a variety of services from one center.

Local Political and Leadership Support

Local elected, government, and nonprofit leadership support for interoperability was perceived to be essential to interoperability in Orange County, according to our interviews. When asked what other jurisdictions would need to implement a similar infrastructure, one interviewee responded,

The main thing is you’re going to have to build buy-in from the chief political officer wherever you are; if it’s the mayor, the chief executive, they have to have that kind of vision that this is something we want to do. Then your department heads who are controlling the actual operations have to be on board with it too. So to me, it’s always having the right people in the right place.

Existing Relationships and Continued Collaboration

Interviewees said that the existing relationships between county agencies, law enforcement, mobile response, and peer support services have also facilitated interoperability. Having worked together for years, these agencies have built rapport, trust, and shared goals. Weekly meetings among agencies were described as essential for interoperability. Agency representatives are in frequent communication about a variety of topics, from high-level processes to individual client cases, working to troubleshoot issues and connect clients to their needed services. Interviewees described relationships as the key to success; one person noted, “It takes a village to assist someone. You can’t do it alone.”

Funding and Other Resources

To support colocation and interoperability, county agencies have leveraged a variety of long-term funding streams, mostly from state and local sources. The county allocated state reinvestment grant funds and general funds to phone and other equipment and technology costs and to ongoing support for agencies operating the call center, mobile crisis, and peer services. Crucially, the Emergency Communications Center provided an in-kind donation of floor and office space to support colocation. County staff have also requested and received funding from the county executive to support the continuum of care and have received appropriations from a local assemblywoman for hiring a CIT coordinator and expanding peer and MRT services. Local support for these services was described as critical for program sustainability.

An Established No-Wrong-Door Approach

According to interviewees, a no-wrong-door approach and culture is embedded in Orange County’s continuum of care, in particular as part of the WELCOME Orange initiative for a Comprehensive Continuous Integrated System of Care (Minkoff and Cline, 2004).³ This initiative set shared values and standards of collaboration across agencies so that anywhere individuals access care, they are welcomed and referred to the appropriate agency that can best meet their needs. These standards are formalized in all agency contracts. When new staff are onboarded to any agency in the system, they go through a half-day orientation to the initiative. Beginning in 2013, WELCOME Orange set the groundwork for interoperability.

Strengths of the Overall Continuum of Crisis Care

Interviewees discussed strengths of Orange County’s overall continuum of care and how it supports 311/988 and 911 interoperability. For example, 311 plays an essential role connecting people to resources throughout the community. This has included support provided during times of emergency (e.g., during the coronavirus disease 2019 [COVID-19] pandemic and in response to local flooding in summer 2023). 311 also connects people to shelters after hours, has domestic violence survivor support resources, and has access to food pantry hours and locations.

In addition, interviewees said that following up with individuals is an expectation at the call center. Every caller is offered a follow-up call from the call center to ensure that their needs were met and they were connected to the necessary resources. Peer support specialists also follow up with their clients, sometimes months after their cases are closed, to check in them and see whether they need any new or additional resources. This level of follow-up is embedded in the peer support model in Orange County to ensure that people do not fall through the cracks after receiving initial support. Strengths of the overall continuum of care are summarized in Table 3.1.

³ *WELCOME Orange* stands for “Working to Encourage Leadership and Collaboration Of Multi-Disciplinary Service Providers Enhancing healthy living in Orange County” (Orange County, New York, undated).

TABLE 3.1
Strengths of the Continuum of Care in Orange County, New York

Agency	Strengths
Crisis Call Center (311/988)	<ul style="list-style-type: none"> • 311 and 988 are part of an agency with connections to a wider array of services, including rape and domestic violence crisis services, and served a crucial role during the COVID-19 pandemic, connecting people to resources. • 311 is colocated with 911, mobile response, and peer support services, which bolsters collaboration among the agencies. • Call-takers offer follow-up to every caller and aim to follow up with each caller up to three times.
Law enforcement	<ul style="list-style-type: none"> • CIT training is embedded in the law enforcement academy for police officers. Ten police departments implement a CIT partnership with the county, which entails training all officers and, after relevant calls for service, submitting CIT forms to the county for follow-up services. • The county has a co-responder model that is operated in collaboration with peer support specialists.
MRT	<ul style="list-style-type: none"> • The program has existed for more than 30 years and has a long-standing collaborative working relationship with law enforcement and peer support specialists.
Peer support specialists	<ul style="list-style-type: none"> • Peers can work with individuals for as long as they need to reach their goals and will follow up months later to check on individuals.

Lessons Learned from Planning and Implementation

As described above, colocation was highlighted by interviewees as an important facilitator to interoperability. However, Orange County faced certain challenges when determining how colocation would work, and an understanding of the solutions it identified could be of value to other jurisdictions considering interoperability.

Challenge 1: The CAD System Needed Configuration for 311 and 911 to Successfully Colocate

Once colocation was agreed on, interviewees described several other elements that needed to be established. Staff needed to determine how to build the necessary technological infrastructure for interoperability, and they faced challenges with establishing 311 as a regional phone number, setting up 311/988 call-takers on the same CAD system as 911 call-takers, and allowing for call transfers.

Strategies to address the challenge: An in-house team dedicated to technological changes was described by interviewees as essential to implementing colocation and interoperability. This team had to get approval from multiple phone companies to route local phone calls to 311. A 911 QA manager and dispatch trainer served as a liaison between Orange 911 and the Crisis Call Center. Over a three-month period, this individual worked closely with the PSAP's internal information technology (IT) team to develop a personalized CAD system for 311/988 call-takers that included a specialized set of codes to suit 311 calls. Like the PSAP, 311 codes all of its calls in the CAD system. Although the PSAP uses the IAED EMD protocols, the PSAP was able to customize parts related to nonemergency mental health calls.

Challenge 2: Sensitive Information on Callers Had to Be Safeguarded

With 911 and 311/988 staff colocated on the same floor and sharing a CAD system, interviewees reported that agencies had to prioritize the protection of sensitive information, in terms of both public safety information (on the part of 911) and protected health information (on the part of 311/988). Behavioral health agencies have to comply with HIPAA, whereas public safety agencies do not. For public safety agencies, the CAD

system provides access to Criminal Justice Information Services (CJIS) data (Federal Bureau of Investigation, undated). New York state law bars individuals with felony convictions from accessing CJIS.

Strategies to address the challenge: Ensuring the safeguarding of sensitive information and formalizing data-sharing was a lengthy process, according to interviewees. For data within the CAD system, agencies worked with the in-house IT team to develop safeguards to protect information entered into this system. For example, CAD incidents originating from 911 can be seen by law enforcement in the respective municipality, and 311 staff wanted to be sure that law enforcement did not have access to protected health information about the caller that 311 staff might enter into the system. Therefore, when 311 call-takers receive a transfer from 911, they open a new CAD incident in the system. This step ensures that any data that they enter on the caller are accessible to the 311 call-takers only. The county also received funding to upgrade software to improve data-sharing and safeguarding. Regarding staff hiring, interviewees noted that the Crisis Call Center had to create more-stringent requirements than the operating agency as a whole so that those with felony convictions would not have access to the call center floor. Other positions within the Emergency Communications Center were not subject to this rule, with individuals with any criminal conviction evaluated on a case-by-case basis. Ultimately, the three agencies signed MOUs with one another, as well as with the county, to formalize communication and data-sharing.

Challenge 3: It Took Time to Merge the Workplace Cultures of 911 and 311/988 Staff

Both Orange 911 and Crisis Call Center staff described challenges adjusting to colocation, frequently referring to these challenges as “growing pains.” In a 24/7 workspace that 911 staff call “their home,” sharing a small kitchen, a bathroom, and other spaces was difficult at first. On the other hand, Crisis Call Center staff were brought into a fast-paced environment that had long-standing relationships. 311/988 call-takers were used to lengthy phone calls, often at night, whereas 911 staff were used to quiet evenings. Both agencies also described cultural differences in the handling of traumatic situations (e.g., public safety staff members’ use of dark humor as a coping mechanism) as a challenge they faced in colocating.

Strategies to address the Challenge: Over time, call-takers and staff reported that they began to see each other as partners and became more comfortable with transferring calls through regular communication, having meals and celebrating holidays together, and building rapport. To build a common culture, 311/988 call-takers were given uniforms similar to the 911 uniforms. At first, 311/988 dealt with high turnover, but once staff remained at the call center, it became easier to build relationships and trust, and call-takers began to rely on one another for assistance with calls. Despite the growing pains, leadership worked to address issues and remained committed to colocation. As one interviewee described, “You are breaking cultures, and you are bringing two cultures together.”

Opportunities for the Future

Interviewees were asked to describe key priorities for the future of crisis services in Orange County. In addition, we identified opportunities based on key interview themes. These opportunities include the following:

- **Advocating for policy changes to enhance staffing of the continuum of crisis care.** Each agency interviewed discussed personnel and staffing shortages as an ongoing challenge. The county also pointed to the need for more racial and ethnic diversity in staffing. Both the PSAP and Crisis Call Center expressed concerns with burnout and turnover. A significant barrier, in particular, was that hours worked at the Crisis Call Center do not count toward social work licensure requirements because of state guidelines,

making it difficult to attract call-takers working toward a degree in social work, who would otherwise be a good fit for the role. Staffing shortages at local hospitals and for mental health professionals have also affected mobile crisis and law enforcement's ability to help people in crisis. At the local level, the PSAP has advocated for salary increases as one strategy to enhance staffing levels but acknowledged that this strategy is not sufficient. The Crisis Call Center is urging policy change at the state level, advocating for call center work, particularly for 988, to qualify for social work license requirements. Peer support specialists are also advocating for better compensation and benefits.

- **Exploring remote capabilities for Crisis Call Center call-takers.** Although colocation was described as beneficial, remote capabilities for call-takers might also be needed, particularly during times with staffing shortages or an unusually high call volume. In the event of inclement weather or a disaster that prevents staff from coming into the call center, 911 calls can be routed to local police departments and 988 calls are sent to a national backup center, but 311 has no backup. Off-site call-taking is a challenge due to use of the CAD system, so interviewees noted the importance of identifying ways to implement a 311 backup.
- **Continuing to enhance the work and include perspectives of frontline workers, especially peer support specialists.** The dynamic between peers and other organizations was reported to have evolved over the years, with peers earning more recognition in the professional sphere. Nevertheless, peers discussed wanting to take part in the decisionmaking process and expressed a hope for continued growth in recognition as important members of the behavioral health team.
- **Expanding in-person response options, including mobile response and peer specialist teams and CIT-participating police departments.** Enhancing MRT program teams was reported to be a key priority to reduce response times and serve in more settings, especially schools and courts. Peer specialist teams are also looking to expand to more frequently co-respond with MRT and to develop additional co-response partnerships with police departments. With only ten law enforcement agencies participating in the county's official CIT program, the county is encouraging additional agencies to join this initiative as well.
- **Promoting services to the community.** The county has limited funding for marketing purposes; however, interviewees reported that many services are not widely known in all areas of the county, creating a barrier to treatment. Although calls to 311 have increased in recent years and some marketing of 311 on billboards and to schools and on social media does exist, additional promotional activities, including radio advertisements and flyers in all parts of the county, could help enhance community awareness of and connection to services. Moreover, public education on 911 and the appropriate uses of 911 was noted as a future goal.
- **Building the availability of local supportive services.** Orange County agencies work closely together to bring comprehensive social services to those who are the most vulnerable in the community. Nevertheless, interviewees frequently spoke about the limited availability of those services, particularly around crisis stabilization, youth SUD treatment, transportation, food, and housing. Bolstering resource availability is also critical to meet the complex needs of frequent utilizers of services in the county. Mental health urgent care centers might offer future opportunities. With only two centers in the county now, one interviewee reported that "20 more" are needed. Increased access to psychiatrists and youth treatment options, particularly for SUD, is also needed, as are additional transportation options, given that law enforcement was described as a "very high-paid taxi service." Lastly, food insecurity was reportedly a growing challenge, and housing has been a perpetual issue for people with behavioral health concerns in the county. Local, state, and federal investments in these domains could help alleviate the more systemic challenges that individuals in crisis face.

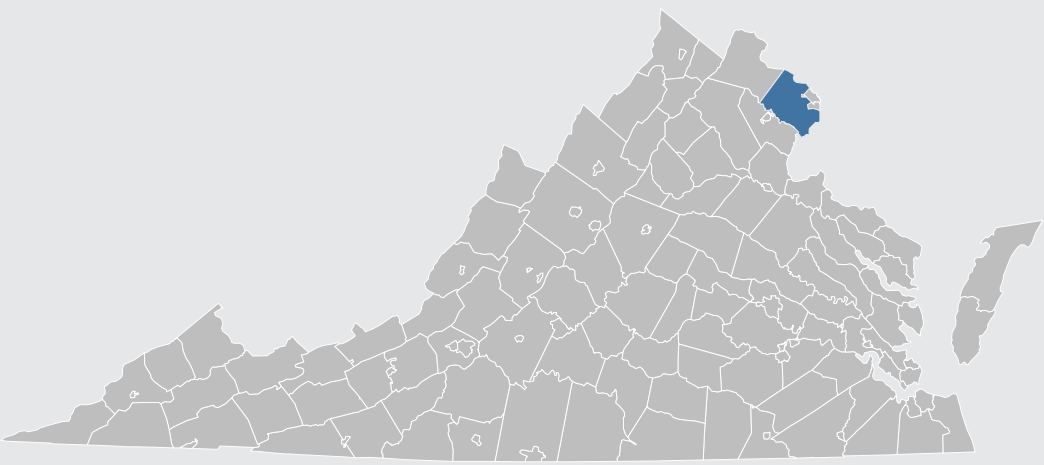
Benefits of 988/911 Interoperability

Interviewees described 311/988 and 911 interoperability as beneficial for many reasons. The benefits of interoperability were displayed during a natural disaster in summer 2023. 311 and 911 shared responsibility for managing the emergency response following flooding in the county. Interviewees reported that interoperability allowed for better management of incoming calls, diverting nonemergency, service-oriented calls to 311 and public safety calls to 911 and enabling these professionals to focus on their strengths for the community. Interoperability also means that there is “no wrong door,” allowing callers to receive the help they need where they are and, ideally, avoid the criminal justice system. Therefore, one interviewee shared, there is “no negative to it.” Agencies are able to maximize resources and build capacity across the continuum of care. As one interviewee described,

The colocation is about collaboration, right. We all, our agendas look a little different, but at the end of the day, it’s all about serving the person in front of us. And when we can remember that, we might have growing pains getting there, but that helps us to remember why we’re doing what we’re doing, right. We want to maximize resources; we want to be responsive to the people that we collectively serve.

Fairfax County, Virginia

Fairfax County, Virginia: Quick Facts



Population and area: 1,138,331; 391 mi²
Racial and ethnic demographics: 49% White, 21% Asian, 17% Hispanic and/or Latinx, 11% Black, 4% two or more races, <1% American Indian/Alaska Native, <1% Native Hawaiian or Pacific Islander
Interoperability model: Transfer ability between 988 and 911
988 call center structure: Regional crisis call center in Northern Virginia; virtual center with remote call-takers
911 call center structure: Countywide PSAP; located in Fairfax, Virginia

SOURCES: U.S. Census Bureau, undated-a. Map created with MapChart (CC BY-SA 4.0 DEED).

Our third case study site was Fairfax County, Virginia. Fairfax County launched its 988/911 operations in June 2023, and its process includes a transfer between 911 and a regional 988 call center.

This case study site is distinct from the other two sites in a couple of ways. First, Sioux Falls and Minnehaha County's and Orange County's respective decisions to implement 988/911 interoperability were based on local momentum and desire to support interoperability. In Fairfax County, interoperability planning began after the passage of a state law, the Marcus-David Peters Act. Second, implementation of interoperability is quite recent in Fairfax, having launched on June 28, 2023. Because 988/911 interoperability is so new, there are not as many lessons learned from its implementation at this point. But given how recently the

planning process concluded, we learned about successful planning for interoperability in rich detail. Therefore, in the sections that follow, we summarize both the planning process and the 988/911 interoperability procedures, but the lessons learned focus largely on the planning process.

Planning for 988/911 Interoperability

As mentioned above, planning for 988/911 interoperability in Fairfax County began after the passage of the Marcus-David Peters Act, which was signed into law in November 2020 and amended in 2022. Passed in the wake of the death of a young Black teacher who was killed by police during a mental health crisis in 2018 (DBHDS, undated-b), the legislation requires that localities implement a Mental Health Awareness Response and Community Understanding Services (Marcus) Alert system that includes the following: (1) diversion of behavioral health calls from 911 to a regional crisis call center (RCCC), (2) agreements between law enforcement and mobile crisis teams, and (3) availability of a specialized law enforcement response for instances in which law enforcement responds to behavioral health calls (DBHDS and Virginia Department of Criminal Justice Services, 2022).¹

Implementation of Marcus Alert is happening in a phased approach across the state. For the purposes of 988 and Marcus Alert, the state is divided into five regions, each with a dedicated RCCC, which connects 988 to local resources. The first phase required implementation of Marcus Alert by December 1, 2022, and the state largely focused on localities with community services boards (CSBs) that were willing to volunteer to meet this initial deadline. The second phase of implementation focused on the largest CSBs in each of the five regions of Virginia; Fairfax County, as part of region 2, is included (DBHDS and Virginia Department of Criminal Justice Services, 2022). These locations were required to launch Marcus Alert–related plans by July 1, 2023.

The Marcus Alert legislation created structured guidelines for localities to follow when developing a comprehensive plan, which includes county protocols for 911 call diversion, mobile crisis, and specialized law enforcement responses. The plans center around a four-level triage framework (DBHDS and Virginia Department of Criminal Justice Services, 2022, pp. 10–12):

- **Level 1:** These scenarios are considered “routine” and include individuals who do not have homicidal thoughts, intent, or behavior. They might have suicidal ideation but not plans or means. These are calls that can be transferred to the RCCC for resolution, with no in-person response needed.
- **Level 2:** These are “moderate” scenarios in which the person might require an in-person response but can be covered by clinician-led or other non-law enforcement options. These are cases in which the individual does not have homicidal thoughts, intent, or behavior and in which there are thoughts of suicide without a plan or access to weapons.
- **Level 3:** These are “urgent” scenarios in which a person may be experiencing acute psychosis, aggression, homicidal ideation, self-injury, and/or suicidal thoughts with a plan and access to means. For level 3 scenarios, the state encourages localities to still consider behavioral health–only options, though co-response models may be considered as well.
- **Level 4:** Level 4 scenarios are “emergent” and require law enforcement or EMS to be dispatched immediately. These cases include active suicide attempts or assaults on others, as well as situations in which firearms are present.

¹ All counties in Virginia are required to implement these plans, with the exception of counties with populations less than 40,000, for which portions of implementation are optional (Robinson and Leamon, 2023).

As noted, a key element of Marcus Alert protocols involves diversion of 911 calls to RCCCs (i.e., 988/911 interoperability). The five RCCCs in Virginia, which were part of the Marcus Alert legislation, answer calls to 988 and are required to be able to deploy mobile crisis and other services (General Assembly of Virginia, 2021). The RCCCs expanded on the existing infrastructure of call centers that were handling calls to the Lifeline before the launch of 988.

Although the legislation and guidance from the state created a framework for the planning process, interviewees reported that this was not a substitute for the work of bringing together stakeholders to develop policies, procedures, and definitions of key terminology locally (e.g., *imminent risk*). For example, although the state provides a structured framework, counties have some discretion in further defining each level and in determining what local resources should be provided for each scenario.

In Fairfax, the planning process was led by the Fairfax–Falls Church CSB, the behavioral health authority for the region.² Although the Marcus Alert legislation passed in 2020, Fairfax County had been focused on providing a “Diversion First” approach since 2016. The Diversion First initiative was designed to provide alternatives to incarceration for people with behavioral health conditions or developmental disabilities with the goal of connecting people with needed treatment and other community-based supports (Fairfax County, Virginia, Sheriff’s Office, undated). Components of Diversion First include CIT-trained police officers; a co-responder program, in which a team comprising a CIT-trained police officer and a crisis intervention specialist from the CSB responds to behavioral health calls; a Community Response Team (CRT), which is a collaboration between the CSB and the Fairfax County Fire and Rescue Department; peer recovery specialists; pretrial release; jail-based behavioral health services; the Mental Health Docket; the Veterans Treatment Docket and Drug Court; and community-based treatment and housing, among other elements (Fairfax County, Virginia, 2023b). According to interviewees, the existence of Diversion First meant that Fairfax County was able to leverage existing partnerships among relevant stakeholders, as well as an existing set of community services, when it began planning for 988/911 interoperability.

In preparation for the implementation of 988/911 interoperability (and the other components of Marcus Alert), stakeholders in Fairfax held biweekly meetings for a year. Stakeholders included representatives from county agencies, as well as representatives from agencies within the cities and towns of Fairfax County. For example, the Fairfax County Police Department and the Fairfax County Department of Public Safety Communications (the primary PSAP) were key planning partners. However, representatives from the police departments of the City of Fairfax, the City of Falls Church, the Town of Herndon, the Town of Vienna, George Mason University, and Northern Virginia Community College were also key to this process; these departments operate secondary PSAPs and participate as partners in the work. Planning also involved representatives from the Fairfax County Fire and Rescue Department and the City of Fairfax Fire Department.

Interviewees reported that one key aspect of the planning sessions was developing common understandings of certain terms, such as *imminent risk*. Although Marcus Alert levels are defined by the state, Fairfax County stakeholders still had to determine how these levels would be implemented operationally. (E.g., what specific scenarios qualify as level 2 versus level 3?) They also had to determine how existing local resources would work with those required by Marcus Alert. For example, Fairfax County already had its local Mobile Crisis Unit, operated by the Fairfax–Falls Church CSB, but Marcus Alert required the incorporation of regional mobile crisis teams that could be dispatched by the RCCC. Therefore, decisions had to be made as to the specific scenarios in which the CSB Mobile Crisis Unit would be dispatched versus the regional mobile crisis team.

² The delivery of community-based behavioral health and developmental disability services in Virginia is overseen by a system of 40 CSBs and behavioral health authorities. They provide direct services and contract with community-based providers (Virginia Association of Community Services Boards, Inc., undated).

In addition to these large group planning meetings, interviewees described separate “synergy sessions” that were held to bring together staff of the primary and secondary PSAPs and the RCCC to develop processes relevant to call transfers.

In addition to the group planning that took place, individual agencies had to make updates to their own operations. For example, stakeholders from 911 discussed the updates that were made to their CAD system. They knew that they needed a way to reliably pull reports on the disposition of behavioral health calls to fulfill state reporting requirements and guide local implementation. Therefore, they programmed the Marcus Alert disposition levels into the CAD system, and they are now able to pull reports based on that field. Similarly, the RCCC updated its phone system to allow PSAPs (as well as law enforcement in the field) to call and directly reach a call-taker who has been trained on handling PSAP calls. The PSAP and the RCCC also worked together to determine what a transfer should look like in practice.

As mentioned above, after a year of planning, Fairfax County implemented 988/911 interoperability on June 28, 2023. Now that implementation is underway, the planning group continues to hold post-implementation meetings to ensure that implementation continues to go as planned.

Interoperability Processes

In this section, we provide a detailed breakdown of the process of transferring calls between 911 and 988, including decision points and the roles of call-takers, dispatchers, law enforcement, mobile response teams, and peer specialists. Figure 4.1 summarizes this process. In other jurisdictions, we were able to rely more on call-takers’ experiences handling calls, in addition to written protocols. Because implementation of 988/911 interoperability was fairly new at the time we conducted the interviews, Fairfax County had limited examples of how the process worked in practice, so our description of 988/911 interoperability relies more heavily on written plans and policies—though this section does reflect a synthesis of information shared during interviews and our review of written documents, especially the plan submitted to the state (see Table A.2 for all documents reviewed).

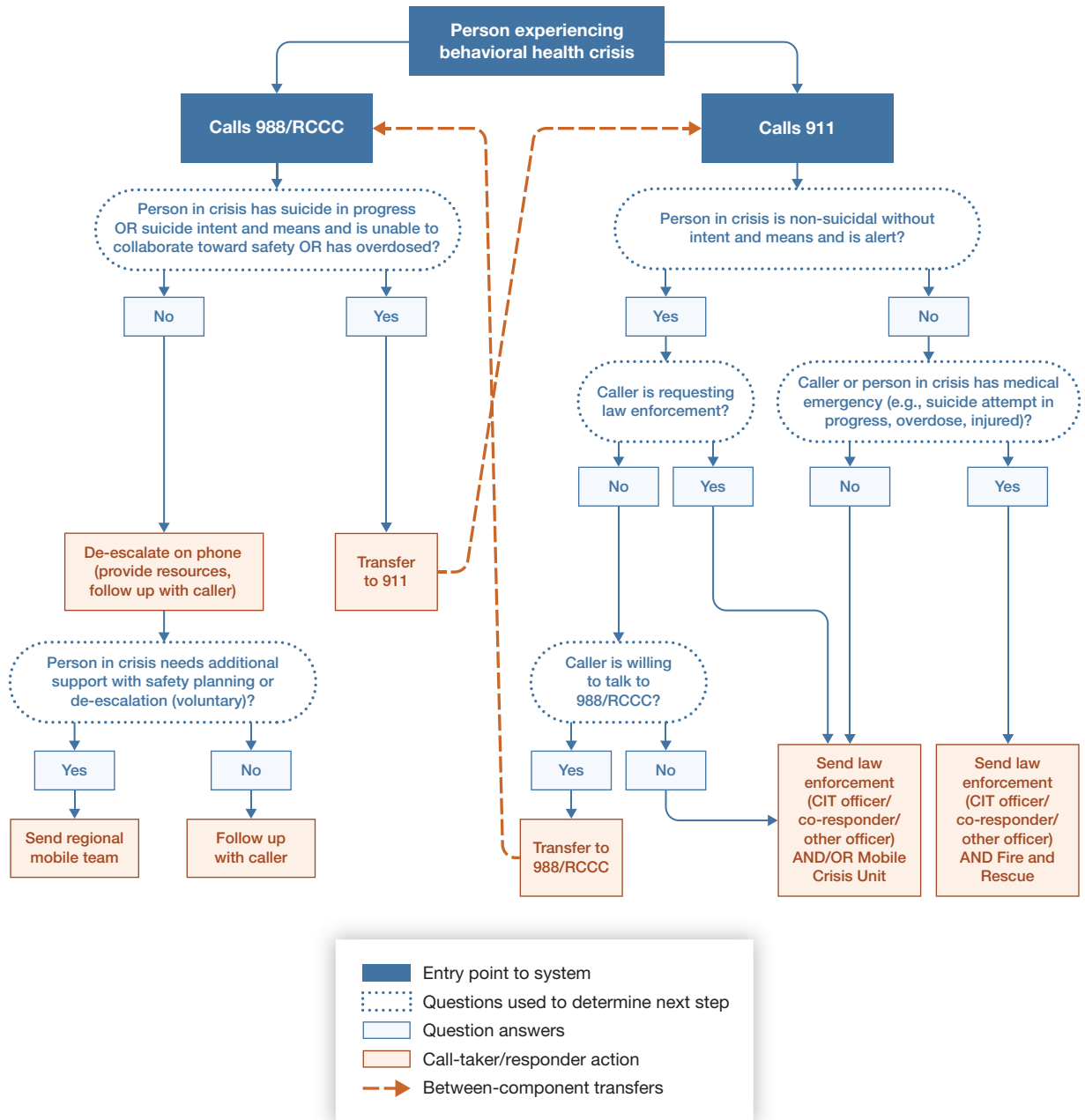
Calls Transferred from 988 to 911

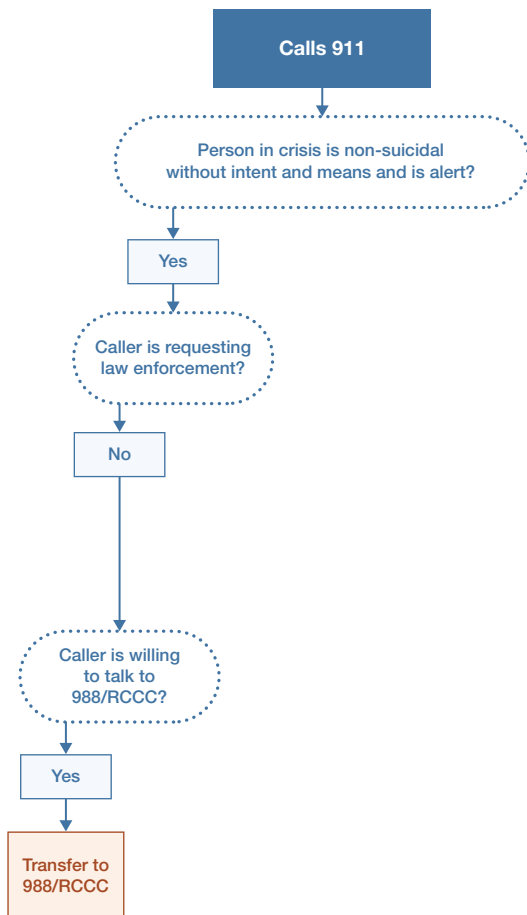
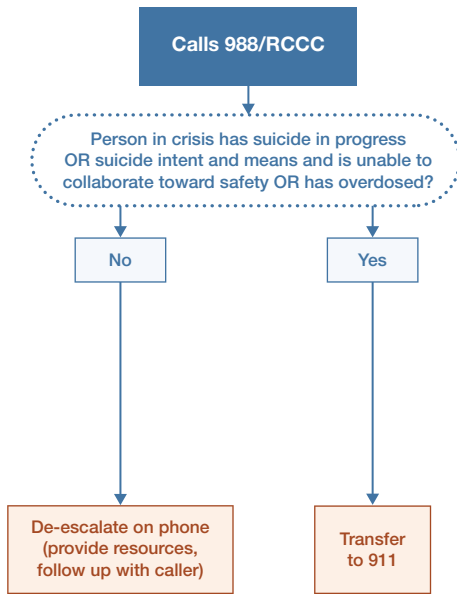
Initial Phone Call and Assessment of Caller Needs

After the 988 Crisis Worker answers the call, they work to build rapport with the caller. The Crisis Worker goes through a structured protocol that includes risk assessment and specific questions related to immediate safety and suicide. The Crisis Worker asks these questions throughout the conversation while building rapport, emotionally supporting the caller, and working toward a plan for safety in the community or additional services as needed.

The Crisis Worker initiates a transfer to the PSAP closest to the caller if there is a concern about the caller’s immediate safety, if the caller is at risk of harming themselves or others, or if they have already taken action to end their life. The Crisis Worker will also transfer the call to the PSAP if there is an overdose or a medical emergency or if someone is threatening to harm themselves but is not willing or able to collaborate toward safety or refuses to receive help despite the imminent risk of death or harm. Once the Crisis Worker detects that a police response might be necessary, they introduce the idea to the caller, as their goal is to keep the caller informed about the next steps (though there might be unique situations in which this is not the case, such as if another person is at risk in the situation).

FIGURE 4.1
Fairfax County, Virginia, 988/911 Interoperability Summary





How the Transfer to 911 Occurs

When a call needs the support of the PSAP, the 988 Crisis Worker will often begin by notifying their supervisor through the phone system, and the supervisor will begin listening to the call. This allows the supervisor to then initiate the PSAP 911 transfer or conference call so that the call-taker can continue to support the caller. The PSAP considers any call transferred from the RCCC to be a call with imminent risk. If the caller’s address is unknown, 911 and 988 staff will partner and attempt to locate the caller so that they can send EMS or law enforcement to the appropriate location. In an ideal situation, 988 will also provide a brief description of the situation when they transfer the call (e.g., emergency medical information, factors related to scene safety), though they might transfer without delay if there is a medical emergency. The 988 Crisis Worker often tries to stay on the call with the caller until law enforcement arrives.

Calls Transferred from the PSAP to 988

Initial Phone Call and Assessment of Caller Needs

All jurisdictions in Virginia, including Fairfax County, use the same four-level triage framework for assessing calls. The planning group developed specific guidance for each disposition level, and this guidance helps PSAP call-takers and responding public safety resources make the appropriate response decisions for potential behavioral health calls. The guidance developed by the planning group used the framework provided by the state, described above in the “Planning for Interoperability” section. Briefly, levels 1 and 2 encompass calls that involve lower-level behavioral health concerns that do not require a public safety response. For levels 3 and 4, the calls have higher-level behavioral health concerns that include imminent risk and safety concerns. In Fairfax County, PSAP call-takers work to gather information about whether the caller has suicidal thoughts, a plan, access to means, and intent to use those means; is experiencing homicidal thoughts, behaviors, or intent; is under the influence of substances or otherwise experiencing an altered mental state; has engaged in self-injurious behavior; and is willing to participate in their own care or safety. These factors are all assessed as part of the standard list of triage questions used by the PSAP.

If the person in crisis has suicidal thoughts but no plan, access to means, or intent; has engaged in minor self-injurious behavior that does not require medical attention; is not under the influence; and does not have safety or medical concerns, then they are considered appropriate for a transfer to 988.

However, if there are such factors present as active psychosis or aggression, active self-injurious behavior with a medical risk, suicidal thoughts with a plan and access to means, an active suicide attempt, homicidal thoughts, or an assault in progress, an in-person response is more appropriate. The specific in-person response will be determined by the circumstances of the case (e.g., if there is a medical emergency, Fire and Rescue is dispatched) and availability of specialized response teams (e.g., if the co-responder team is not available, a CIT officer or another law enforcement officer may dispatch instead).

How the Transfer to 988 Occurs

Once the call-taker has determined that a call is eligible for transfer to the RCCC, the call-taker will inform the caller that they can be transferred to an RCCC to speak with a trained professional to better assist them. Transfers happen only on a voluntary basis, so if the individual decides that they would prefer not to be transferred to 988, the call-taker can also provide information about the CSB and other behavioral health services. If the call-taker believes that some type of in-person response is needed, they can dispatch law enforcement, including a CIT-trained officer. If the caller *is* willing to be transferred, then the PSAP 911 call-taker will call the RCCC using a single-button transfer on the PSAP call-handling system. The transfer occurs as a three-way call in which the PSAP call-taker provides initial information to the 988 call-taker, including the caller's name, location, contact info, and a brief description of the issue. This is more information than 988 might typically obtain from a call-taker, but it is seen as valuable because callers who are being transferred from a PSAP can be at higher risk for escalation. For this reason, the RCCC places a priority on connecting those callers to Crisis Workers right away. At that point, the PSAP call-taker provides their identifying information to the Crisis Worker, disconnects the call, and documents the outcome in the CAD system.

Transfers Back from 988 to the PSAP

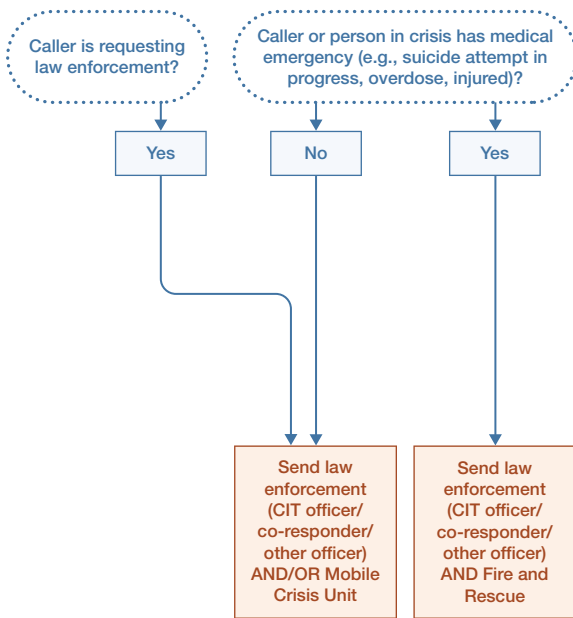
If a caller specifically requests a police response once the individual is transferred to 988 but does not meet the criteria for a mobile crisis response, the Crisis Worker will do their best to de-escalate the situation. If the caller insists on police, then the Crisis Worker will transfer the caller back to the PSAP. The Crisis Worker will facilitate the police response by collecting location information to streamline the process once the caller is transferred back to the PSAP. However, according to our discussions, this was a low-frequency outcome at the time we conducted interviews; at least one interviewee noted that they had not heard of this happening yet, though we did not have the specific data to support this.

In-Person Response

Fairfax County has various options for in-person response, ranging from law enforcement to co-responders to mobile crisis teams for behavioral health needs and for people with intellectual disabilities.

Law Enforcement

If the PSAP call-taker determines that a caller meets the criteria for level 3 or 4 or if the caller requests an in-person response, then law enforcement will be dispatched. Fairfax County has three types of law enforcement options in this circumstance: CIT-trained officers, co-response teams (described in the next subsection), and other law enforcement officers. When the dispatch occurs, call-takers check to see whether CIT-trained officers or a co-response team is available for dispatch. In addition to their basic police training, CIT-trained officers have 40 hours of mental and behavioral health training, including de-escalation of persons in crisis. If CIT-trained officers are not available, other law enforcement officers will be sent to respond. A one-page



guide was created and provided to officers explaining the different levels of response (1–4) for Marcus Alert reporting, and the CAD system requires a behavioral health disposition.

If an individual requires a higher level of care, law enforcement officers will provide transportation to the Merrifield Crisis Response Center (MCRC) at the Sharon Bulova Center for Community Health. This center has crisis services, medication management, 23-hour beds, and medical and care management services. Interviewees noted that more than 2,000 people are transported to the MCRC by law enforcement each year, and there have been more than 3,600 diversions from potential arrest since 2016, so the MCRC is seen as an effective diversion option.

There are also situations in which law enforcement responds to an incident in the community and finds that it is a less serious behavioral health

incident than initially anticipated by the PSAP or that there is a behavioral health component to the call that was not initially clear to the PSAP. In these instances, officers can refer the community member to the RCCC. In addition, law enforcement has worked with the RCCC to develop a first responder priority line that law enforcement can use to contact the RCCC directly.

Co-Response Teams

PSAPs can also dispatch the Fairfax County co-responder teams. As of October 2023, Fairfax County Police Department has four co-responder teams that operate out of the Sharon Bulova Center for Community Health. The initial locations for the co-responder teams were decided in a work group that convened in 2020 and were based on heat maps of high-volume call areas. Each team consists of a CIT-trained law enforcement officer and a clinician, responds to 911 calls in progress, and operates from 12 p.m. to midnight. The co-responder team scans the police channels and monitors the CAD to see whether there is a call that might benefit from its support, and it responds to the call in conjunction with other law enforcement officers.

Co-response teams are often sent to higher-risk situations in which there is active aggression, psychosis, or suicidal thoughts with a plan and intent. Once a co-response team arrives on the scene, one of its primary goals is to assess the level of risk so that it can determine the appropriate course of action for the individual. As it approaches each case, the co-response team determines who should lead the response. For example, sometimes the officer is able to establish rapport more easily than the clinician, and sometimes the reverse is true. However, the goal is for the team to develop enough rapport with the individual that the clinician can ultimately do an assessment. Using the assessment, the co-response team can identify the most appropriate next step for the individual—for example, hospitalization, a 23-hour bed, or a referral to the RCCC. The co-response team may also engage the mobile crisis response teams; for example, if an individual has an intellectual or a developmental disability, the co-response team may reach out to the Regional, Education, Assessment, Crisis Services, Habilitation (REACH) team (described in the next subsection).

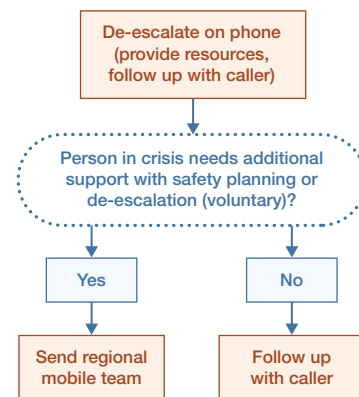
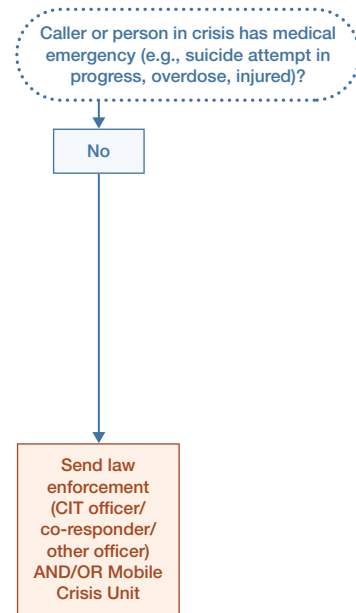
In addition to co-responder teams, Fairfax is piloting a telehealth program. Officers are provided with a tablet that is used to connect with a clinician.

Mobile Crisis Response Teams

Fairfax County has two mobile crisis response team options within its continuum of care. The CSB Mobile Crisis Unit is operated by the Fairfax–Falls Church CSB and is staffed by clinicians and peers. Its existence predates the Marcus Alert legislation; it has been in operation for decades in Fairfax County. There is one team for the county, and it can take up to 45 minutes to respond because it is a non-law enforcement response team. Theoretically, the Mobile Crisis Unit can be called out by the PSAP, but it is more likely for the Mobile Crisis Unit to receive referrals from police officers in the field, community members or family members, other CSB employees, hospitals, or jails. The Mobile Crisis Unit is available from 8 a.m. to midnight and is typically called out to more-urgent behavioral health scenarios. It can also be called to scenes even when the person in crisis has not provided permission, which is different from the regional mobile crisis teams described below. On scene, the Mobile Crisis Unit can provide crisis intervention services but also assess whether someone might need a higher level of care (e.g., hospitalization).

The other mobile crisis teams are the regional mobile crisis teams, including the Community Regional Crisis Response (CR2) and REACH programs, which are dispatched by the RCCC (CR2, undated; Northern Virginia Regional Projects Office, undated). The regional mobile crisis teams respond to individuals experiencing an active crisis and those who are at risk of hospitalization. These individuals might have a history of suicidal ideation or plans, but they have to be willing to participate in safety planning. The teams provide a short-term brief intervention that includes engaging in safety planning; securing the environment (e.g., through the use of medication locks); coordinating with family members; providing cognitive behavioral therapy, relaxation, mindfulness, and breathing techniques; and providing warm hand-offs to long-term services. REACH specializes in responding to individuals with intellectual or developmental disabilities (including people who might have co-occurring mental health disorders).

The regional mobile crisis teams are available 24/7 and are typically deployed in cases in which someone needs a quick, same-day mental health intervention. These may include situations in which an individual is in distress, has suicidal ideation and/or a plan but does not have intent or means, and has been unsuccessful in their efforts to safety-plan with a 988 call-taker—less-acute scenarios than the CSB Mobile Crisis Unit handles. The teams are staffed by clinicians, QMHPs, and peers and respond individually (in the case of a licensed clinician) or in pairs. The individual in crisis must provide their agreement for one of these teams to be sent. Once they are on the scene, in addition to de-escalating the situation and providing services as described, these teams can provide direct referrals to adult transition homes and adult and youth therapeutic homes. Both regional mobile crisis teams work on community stabilization and provide follow-up care, following clients for seven to 14 days. The teams provide backup for one another and cross-train.



Fire and EMS

Although our discussions with Fairfax County stakeholders largely focused on the response of law enforcement and mobile crisis teams, there are situations in which Fire and Rescue teams will be dispatched instead. Specifically, if there is a medical emergency or an injury, such as an overdose, a suicide in progress, or an injury resulting from an assault or firearm violence, Fire and Rescue will be dispatched. Fire and Rescue is also a partner in providing community response through the CRT. As described previously, this team involves collaboration between Fire and Rescue and the CSB, and it focuses on providing outreach and care coordination to frequent utilizers of these types of public safety services.

Training and Quality Assurance

Interviewees reported that training and QA efforts have played a key role in establishing 988/911 interoperability and ensuring that not only call-takers but also in-person responders, such as law enforcement and mobile response teams, are equipped to effectively handle behavioral health crisis calls.

Department of Public Safety Communications (911)

In accordance with industry standards and the Virginia Department of Criminal Justice Services, PSAP call-takers complete a ten-week training course followed by 12 weeks of on-the-job training. During academy training, there is one day of training related to callers with suicidality.

According to interviewees, when the Marcus Alert process launched, several training activities took place. Department of Public Safety Communications (DPSC) and a 988 subject-matter expert attended a PSAP roll call meeting to educate call-takers about 988. Call-takers received training on the transfer process, covering such topics as when to refer a caller to 988 and how to implement the transfer. Training bulletins and documents included screenshots of DPSC CAD system modifications.

Reviews of calls and recordings are part of the QA process. Per 911 telecommunications industry standards, certain PSAP call types are reviewed. The ongoing QA program at the PSAP does not explicitly focus on behavioral health calls, but these calls can end up being reviewed via the PSAP's standard process. Calls for which the call type and disposition do not match are flagged for review. All calls are recorded, and, as one interviewee said, "there's no escaping scrutiny," but the PSAP aims to use the reviews as opportunities for improvement. Members of leadership reported that they work to keep call-takers up to date with policy changes and give them the support that they need.

In addition to call reviews, interviewees said that CAD system data are important to QA efforts. PSAP leadership reviews data on 988 transfers. The IT team plays a key role in developing reports from the CAD system. These reports must be submitted to the state, which requires certain metrics to be collected, though the PSAP includes additional fields of interest. These include prevalence of call types, times, locations, transfers, non-transfers, calls that received a CIT response, and disposition (i.e., Marcus Alert levels 1, 2, 3, and 4). Call disposition was determined to be the main way to collect and track data and was made a mandatory field on a Mobile Computer Terminal disposition entry, which now allows for two dispositions instead of one. In turn, the PSAP uses the data to understand "what could we do differently, you know, in house, but what could they do differently in the field as well."

Regional Crisis Call Center (988)

In Fairfax County, 988 is administered by HopeLink Behavioral Health and is a virtual work environment with Crisis Workers located around the state and country assigned to specific lines. These include individuals

assigned to the regional (i.e., Northern Virginia) phone line so that they are well versed in the local resources and response options. Other Crisis Workers are assigned to national services the organization is a contractor for, such as the 988 Youth LGBTQ+ chat line and the national chat or phone backup lines, as the center also operates as a national backup center.

Interviewees said that the call center is largely staffed by paraprofessionals. RCCC leadership noted that it is critical that staff are dedicated to the mission, adding that individuals with experience in mental health, particularly personal experience, can often be more effective than those with a specific academic degree. As one interviewee stated, “you can’t train anyone, just anyone, to be a crisis worker; they have to come with these competencies,” which include tolerating and coping with distress.

All Crisis Workers at the call center receive six weeks of training, followed by on-the-job training. This experiential learning includes a minimum of three one-on-one sessions with a trainer to practice using technology and procedures. In the lead-up to the launch of interoperability, additional Crisis Workers were hired and trained on the process. The Crisis Workers who were trained to handle PSAP transfers are largely responsible for answering calls on the direct line from the PSAP or law enforcement. The direct lines were described as helpful for tracking calls coming from these agencies.

In terms of QA, several 988 call center staff play a role. The call center director oversees operations, ensuring that calls are being answered. Supervisors do real-time, silent monitoring on shift to ensure that call-takers are following policies and procedures. The QA team reviews recordings or transcripts and is required by Vibrant to review 3 percent of calls and submit reports using call assessment scoring. All call-takers must maintain above an 80 percent on the Vibrant assessment, which they described as including such factors as active engagement, use of open-ended questions, and offering appropriate resources. Chats are also assessed, reviewed, and scored, and feedback is provided to staff.

In addition, the call center conducts regular data reviews. Weekly data are collected on call volume, wait times, abandon rate, and length of calls. Monthly data are collected on calls transferred to and from the PSAP. With regard to these call transfers, the center provides feedback to the PSAP, particularly to help 911 better distinguish between lower-level calls, since a “level 1” call versus a “level 2” call can be difficult to discern, according to interviewees. Thus far, it seems that calls are being transferred appropriately; one interviewee noted, “I can’t recall an instance that’s been escalated to me where it was like this was completely inappropriate from a PSAP.” Some of these data are required to be collected and reported by Vibrant; however, the call center collects additional information for its stakeholders, with whom staff share monthly reports. Staff also share data on request.

In-Person Response

Law enforcement officers’ training on behavioral health begins in the academy and then is expanded primarily through the CIT training program. Interviewees estimated that about 40 percent of officers with the Fairfax County Police Department are CIT-trained, and the other law enforcement departments have committed to training at least 20 percent of officers in CIT, consistent with state Marcus Alert requirements. CIT training is voluntary to ensure that officers who participate are truly invested in the work. As one interviewee noted, “CIT is a specialized response, and it should not be something that every officer has.” In addition, all Fairfax County Police Department officers receive behavioral health training through the Criminal Justice Academy and mandatory Marcus Alert training.

Staff for mobile crisis teams must hold at least a QMHP registration or a bachelor of arts degree in a health care–related field, and there is a preference for those licensed in social work or working toward a license. Peer support staff on REACH teams must attend a mandated state training during which they receive certification.

Interviewees described some cross-training that occurs between law enforcement, mobile crisis, and co-responder teams. For example, for the co-responder program, officers needed to complete training to

learn the program documentation and HIPAA regulations “so that officers understand [the] clinical world,” according to an interviewee. The Office of the County Attorney was instrumental in developing this training.

On the co-responder clinical side, staff completed a one-day cross-training at the police academy during which clinicians walked through scenarios and received feedback on how to keep themselves safe and on who would have the lead in these situations (i.e., the clinician or the officer; the latter when there is a safety issue). Interviewees noted that there were plans for another daylong training focused on firearms and stress inoculation, which is training focused on how to prepare for and respond to real-life scenarios, including situations involving firearms and other intense situations. This training was reported to be helpful given that formal safety training for clinicians in the field is limited, so these opportunities build clinicians’ comfort level both with and without law enforcement present.

With regard to QA, interviewees noted that law enforcement plays an essential role in entering the call disposition (i.e., a Marcus Alert level 1, 2, 3 or 4) in a timely and accurate manner. This information is important for assessing whether low-level calls are being appropriately diverted to 988 whenever feasible and whether police and mobile crisis teams are responding to the right types of calls. This information was also described as useful for adjusting the operational hours for the co-response teams to the times they are most needed. Interviewees described the need for better data collection and more buy-in to improve the data from the field.

At the CSB level, leadership also monitors data to identify concerns, reviewing call resolutions, call drops, and mobile crisis dispatches. The planning group of various agencies continues to meet to review case highlights; however, the CSB noted challenges given the limits on the ability to share patient identifying data across partners.

Efforts to Serve Diverse Populations

When asked about their efforts to reach and serve diverse or underserved populations, interviewees in Fairfax County noted that one area of focus to date has been outreach to individuals with diagnostic or service-related needs.

Frequent Utilizers of Crisis and Behavioral Health Services

Interviewees from various agencies described frequent utilizers. As mentioned earlier, *frequent utilizers* are people who might call a PSAP or 988 frequently or be in contact with law enforcement several times in a brief window and/or who are being served by several local agencies (e.g., behavioral health, hospitals, and law enforcement). These are individuals who might, for instance, call repeatedly without a specific emergent need but then decline a transfer to 988. Interviewees said that there is not a single formula to better reach these populations. Crisis response teams aim to refer these individuals to care coordination. Response teams have been able to connect with these individuals by going out to visit them many times, bringing food, or finding the right staff member whom an individual may “click with,” according to an interviewee. As noted above, there also a team (CRT) that provides outreach, engagement, and care coordination services to frequent utilizers of public safety services. In addition, there are postcrisis follow-up teams, which include peer support specialists, for engagement and linkages to follow-up care when needed. Ultimately, one interviewee said, “It takes patience, and understanding, and persistence.”

Facilitators of Planning and Implementation

Facilitators Directly Related to Interoperability

State Legislation and Guidelines

Many interviewees noted that the state framework was helpful for implementation. They found it to be a valuable tool for establishing common language. The four-tier triage framework gave stakeholders a specific target to use in their planning and helped the county determine how to capture and report on data. In addition, the state provided planning materials around implementing the legislation, including templates for the county planning documents and guidance on how to approach each protocol. Interviewees also noted that having state-level legislation made implementation happen sooner than it would have otherwise.

Dedicated Project Manager and Champion

The legislation required that localities coordinate through the local CSBs and that the CSBs oversee the planning process. In Fairfax County, they selected a project manager who did not come from a clinical or public safety background, but rather came with strong project management expertise. In this way, interviewees noted, this individual was able to serve as a boundary spanner across disciplines that were involved in planning. Interviewees noted that the fact that the project manager did not come from a clinical or public safety background helped this person serve as an “honest broker” who was there to help connect the dots between all of the participating agencies.

A primary role of the project manager was to facilitate meetings, which were held biweekly during the planning phase and continue to occur on a quarterly basis now that implementation has occurred. To help the group move toward its shared goal, the project manager used a specific model for change management: ADKAR (awareness, desire, knowledge, ability, and reinforcement; see Wong et al., 2019). Interviewees noted that the project manager was able to strike an appropriate balance between giving stakeholders a chance to share their perspectives and concerns, working to create common ground across disciplines, and ensuring that the planning group was making decisions in accordance with state legislation and in a timely manner to ensure that it met the state’s deadline.

Another County to Use as a Model

Fairfax County was part of the second wave of counties that implemented Marcus Alert protocols. There were five counties that had volunteered to be in the first wave, which had the goal of launching interoperability by December 2022. One of these was Prince William County, which borders Fairfax County to the southwest. Prince William County is served by the same RCCC as Fairfax County, operated by PRS, Inc. (which is now transitioning to become HopeLink Behavioral Health and which also serves three other regions of the state). This means that the RCCC had experience with 988/911 interoperability, including establishing a backup direct line to 988 for first responders. In addition, because Prince William County was in the first wave of implementers, it had developed its Marcus Alert plan, and this fact was noted in interviews as helpful because there was a blueprint that Fairfax County could learn from. Fairfax County reported that it has also been able to look to Prince William County to see what can happen after the initial implementation period and anticipate issues that might arise (e.g., declines in the number of people being referred to the RCCC after early implementation).

Relationships

In Fairfax County, interviewees described the relationships that exist between the PSAP, law enforcement, the fire department, and the clinical partners as robust. Interviewees described how there is already an established foundation of trust, which makes it easier to introduce new policies or implement change. An inter-

viewee noted that organizations can struggle with change, made even more complex when it requires coordination across multiple organizations; entities must grapple with who oversees which aspects and need to cede control of certain ways of doing things. In Fairfax County, because people already worked together and trusted each other, the Marcus Alert planning process was perceived to be more seamless.

As described before, several organizations were part of the planning process, including the PSAP, the fire department, EMS, law enforcement, and the Mobile Crisis Unit. Interviewees noted that everyone was kept in the loop and had a say in the decisionmaking process. Once it was time for implementation, all of the organizations reportedly had buy-in, had contributed to the decisions, and had been part of the process since the beginning. They continue to have ongoing meetings and share information. The nature of the work is collaborative and includes meeting with both state and private hospitals. As one interviewee said, “No one is working in a silo.” Another interviewee noted that having strong relationships between organizational leaders was valuable, because leadership was able to help with systemic decision points.

Diversion First Approach and County Support of Alternatives to Law Enforcement

As described above, Diversion First was a countywide initiative that began in 2016. Since that time, Fairfax has made concerted efforts to offer alternatives to incarceration to people with behavioral health issues that come into contact with the legal system. This culture of diversion was described as a key facilitator. In addition, as part of the Diversion First initiative, Fairfax had already mapped out its services using the Sequential Intercept Model, which describes points in the legal system (or *intercepts*) at which people with mental health needs can be placed in community-based treatment rather than further penetrating the criminal justice system (Munetz and Griffin, 2006). As part of this process, Fairfax had mapped out the availability of services at early intercepts (i.e., intercept 0 [community-based services] and intercept 1 [law enforcement]) and knew that additional resources were needed. Interviewees said that this mapping process helped demonstrate the importance of interoperability.

Interviewees noted that the Fairfax County Board of Supervisors became more interested in crisis response models in summer 2020 and wanted to focus on improving crisis response. A cross-system work group was convened, which helped lay the groundwork for interoperability so that when Marcus Alert passed, much of the work had already begun. As a result, brief “micropilots” were launched. The first micropilot effort involved the primary Fairfax County PSAP. CSB clinicians received an orientation to PSAP operations and systems and monitored calls for service that could potentially receive behavioral health responses (i.e., possible co-response, possible de-escalation over the phone, case management or linkage to other behavioral health services). During this process, it was determined that a significant percentage of calls for service could have benefited from a behavioral health response, according to interviewees. A later phase involved a team comprising a CSB clinician and a CIT police officer responding to behavioral health–related calls for services three days per week. During the co-response micropilot, clinicians rode in police cars with law enforcement officers for the first time. One clinician said that their whole perspective changed on law enforcement in a favorable way. It was a revelation that the on-the-ground experience in the police car shifted the cultural narrative between the two types of professionals. This model was identified as a catalyst to build trust and is now an embedded program, with the two co-response teams operating throughout the county.

Strengths of the Overall Continuum of Crisis Care

Although the Marcus Alert legislation spurred the planning for 988/911 interoperability and implementation of the four-tier framework, interviewees noted that the county conceptualizes this work as part of an effort to build a coordinated crisis response system in Fairfax County. The effort to build the crisis response system began with the Diversion First initiative, and, although Marcus Alert may have contributed to the ongoing evolution of the crisis response system, leadership described the importance of thinking more broadly than

Marcus Alert. From our interviews and document review, it appears that Fairfax is committed to building a no-wrong-door approach to care in the county. There are many ways in which this approach is clear from Fairfax’s planning documents. For example, the county developed a case flow that allows calls to be diverted to 988 from the PSAP, but it has also formally considered the possibility of law enforcement officers assessing level of risk while they are in the field and connecting community members to the RCCC. Fairfax County has conceptualized its continuum of care as more of a circle than a line: No matter where or when a person encounters the system, they will make their way to the right service.

As a result of this approach, Fairfax County interviewees described several existing resources that they can draw on for people experiencing mental health crises. When asked about community resources with which to connect callers, one interviewee reported that “there’s good infrastructure here.” Table 4.1 summarizes community resources across the continuum of care.

TABLE 4.1
Strengths of the Continuum of Care in Fairfax County, Virginia

Agency	Strengths
PSAP	<ul style="list-style-type: none"> The PSAP has a newly established Behavioral Health Liaison (BHL) role. This is a clinician who is colocated in the PSAP and can consult with PSAP call-takers on mental health calls; review the mental health history of callers (by accessing the county mental health record system using a computer that is separate from the CAD system to maintain confidentiality) and provide insight into what response might be appropriate; or talk directly to callers who might benefit from being connected to resources. This new role is designed to provide another mechanism for serving nonemergency and emergency callers who have behavioral health needs.
RCCC	<ul style="list-style-type: none"> In addition to receiving calls transferred from the PSAP, the RCCC is promoted as a resource to which officers in the field can connect community members.
Law enforcement	<ul style="list-style-type: none"> Approximately 40 percent of Fairfax County Police Department officers are trained in CIT, meaning that they are well prepared to respond to mental health crises in the community.
Co-response teams	<ul style="list-style-type: none"> Co-response teams can often respond more quickly than mobile crisis teams if an urgent response is needed, given their location at two stations in the county, which were selected because they were in high-need areas.
Mobile response	<ul style="list-style-type: none"> Regional mobile crisis teams can address people with mental health conditions and intellectual and developmental disabilities. Moreover, because there are multiple providers available, they can provide backup to one another. Because Fairfax had an existing mobile crisis response team prior to the passage of the Marcus Alert legislation, the county was able to identify complementary roles for that team (which focuses on more-serious cases) and the regional mobile crisis teams (which focus on less-serious cases).
CSB	<ul style="list-style-type: none"> The CSB operates multiple outpatient and residential behavioral health care locations. One of these, the Sharon Bulova Center for Community Health, offers a variety of services, including 24/7 emergency services, a crisis response center, screening and assessment, outpatient services, medication-assistance SUD treatment, and a peer resource center. These can be important resources for callers who need follow-up care after a transfer to 988 or mobile crisis intervention. In addition to being staffed with clinicians, the Sharon Bulova Center has a CIT team with two to three police lieutenants on-site. This team helped forge and strengthen relationships between the CSB and the Fairfax County Police Department, which has been valuable in the planning and implementation of 988/911 interoperability.

Lessons Learned from Planning and Implementation

Fairfax County faced certain challenges when determining how interoperability would work, and an understanding of the solutions it identified could be of value to other jurisdictions considering 988/911 interoperability.

According to an interviewee, there is a “vast difference in risk tolerance” between the PSAP and 988. In crisis work, calling a PSAP is the last resort. At the PSAP, callers’ needs generally necessitate an immediate response. Trying to align and coming to an agreement on risk of safety and suicide was described as a major part of the planning process, as was protecting the community while maintaining licensure, liability, and standards for PSAP and behavioral health staff.

Challenge 1: Call-Takers Had Concerns About Liability in the Event of Adverse Outcomes

PSAP call-takers expressed concern about what would happen if they transferred a call to 988 and then the situation escalated and resulted in harm to the caller (or someone else).

Strategies to address the challenge: Interviewees said that concerns regarding liability and call outcomes were a key topic of the training provided to call-takers in advance of the launch. The training emphasized that PSAP call-takers should focus on obtaining the necessary information from callers using current protocols and use that information to make a response decision. Call-takers were told that, if they had any uncertainty about a case, they did not need to transfer the call to 988. Finally, leadership emphasized that the intention was not to make the call-taking job harder and aimed to give the call-takers “confidence that [leadership and] the system is here to support them.”

Challenge 2: Although the Commonwealth of Virginia Provides Some Funding for Marcus Alert Implementation, the Costs of Implementation Exceed What the State Is Able to Provide

Virginia has allocated \$600,000 to CSBs for one year of Marcus Alert planning, followed by \$600,000 annually to support implementation (DBHDS, 2022). However, interviewees noted that implementation of 988/911 interoperability and the other elements required by Marcus Alert is costly considering the increase in resources and personnel needed across the numerous agencies involved.

Strategies to address the challenge: Although funds from the state have been limited, interviewees described ways the county supports 988/911 interoperability through local funding and in-kind resources. For example, the primary PSAP has CAD and telephony teams that were able to support the additional programming required to tailor their systems. Without this in-house resource, interviewees reported, programming the Marcus Alert disposition levels and developing custom reports could have been more time- and resource-intensive. Interviewees also described the willingness of Fairfax County to invest in mental health resources, which is partly why there was already a robust system of care to tap into. It is also important to note that Virginia was the first state to establish a 988 telephone surcharge (Hepburn, 2021), which supports a crisis call center fund.

Challenge 3: Stakeholders Had to Find Common Ground on the Definition of Imminent Risk

Another important element of the planning process identified by interviewees was coming to a consensus on the definition of *imminent risk* and what factors would lead to a level 1, 2, 3, or 4 determination. Each stake-

holder reportedly approached this discussion from their own personal experience and disciplinary lens (e.g., a law enforcement lens versus a crisis services lens versus a behavioral health lens), and different groups were described as having varying levels of risk tolerance.

Strategies to address the challenge: The definition for *imminent risk* was decided in the collaborative planning meetings. In these meetings, interviewees said that the four-tier state-level framework provided meeting participants with the target that they needed to reach (i.e., definitions for each urgency level). Stakeholders then discussed the ways in which their agencies or disciplines approach decisions regarding risk, acknowledging that some disciplines (e.g., behavioral health) have a greater level of risk tolerance than others (e.g., PSAPs). As part of these discussions, interviewees said, stakeholders had to be willing to explore such topics as safety for the caller and the community, licensure and professional standards, and liability. After laying this groundwork, stakeholders were able to reach a common definition by discussing sample cases and their proposed approaches. Interviewees emphasized the importance of developing a common language as part of this process, rather than each group of stakeholders defaulting to the language used within their discipline. As one interviewee noted, “That way, when you say something, the other person, as much as possible, is hearing what you’re saying and understanding what you’re saying, so that minimizes that misinterpretation.”

Challenge 4: Fairfax Had to Organize a Large Group of Stakeholders Across the County and the Cities and Towns Within the County to Prepare for Marcus Alert Implementation (Including 988/911 Interoperability) on a Timeline Established at the State Level

Fairfax is a populous region with a number of local agencies that had a key role in planning for the implementation of the local Marcus Alert plan, including 988/911 interoperability and the relevant in-person response options. Although many of these agencies had existing relationships, due in part to Diversion First, interviewees said that there were time-sensitive decisions that had to be made and many groups that needed to reach consensus.

Strategies to address the challenge: As mentioned, one of the key facilitators for planning was the hiring of a project manager who, according to an interviewee, could serve as a “boundary spanner” in that they did not come from a public safety background or a clinical background. As a result, the project manager was able to serve as an “honest broker” when difficult discussions had to take place between the RCCC, PSAPs, law enforcement, and clinicians. During the planning process, interviewees described the importance of understanding the cultures of the different stakeholder agencies and using meetings to “mak[e] space for not just the logistical, but for the philosophical and cultural.” It was also important that the group had enough lead time for the planning process, which allowed group members to build trust with one another and approach planning as a step-by-step process. The planning discussions were also described as an important opportunity to engage the smaller jurisdictions within Fairfax County so that they felt equally as engaged as the larger county partners (e.g., the primary PSAP). One interviewee noted that another important part of these planning discussions was to have people in the room who have experience in the field, rather than just people who have “the title” in their organization.

Opportunities for the Future

Although implementation was underway for only three months at the time of our site visit, we nevertheless wanted to gain insight into the future of crisis services in Fairfax County. We asked interviewees to describe their priorities, and we also identified opportunities that emerged from our analysis across interviews. These

opportunities largely focused on building the availability of social services, along with the necessary staff and training to do so, and included the following:

- **Bolstering training, including cross-training opportunities, for staff across agencies.** Some interviewees expressed that Marcus Alert training for PSAP call-takers—both current workers and new hires—is sufficient, whereas others described the need for refreshers on call documentation, scripts, and the transfer process. Although training was not perceived to be a heavy lift for call-takers whose roles have not dramatically changed, interviewees noted some challenges around the use of accurate call dispositions, or outcomes, and a need to address these. Law enforcement received separate training on Marcus Alert, and one interviewee reported a need for more-consistent training across agencies, as well as cross-training.
- **Reaching non-English speakers.** Currently, 911 callers who speak languages other than English cannot be transferred to 988 unless there is a call-taker on duty who speaks the given language. Otherwise, the PSAP uses LanguageLine; if the call needs to be transferred to 988, the PSAP call-taker needs to stay on the line for the duration of the call in order for LanguageLine to also transfer over. Moreover, 988 interviewees reported that it was difficult to emotionally connect with non-English speakers when using language services like LanguageLine. To close this service gap, building a more diverse workforce was noted as a key but challenging priority given low pay in the industry. For example, individuals who speak languages other than English could receive higher pay in career paths other than crisis services.
- **Developing specialized resources for additional populations.** Some interviewees noted challenges or gaps in service for certain populations. Although REACH specializes in services to individuals with intellectual and/or developmental disabilities, CR2 sometimes needs to serve individuals with these disabilities and individuals with personality disorders. However, they sometimes encounter challenges serving these populations because they have less specialized experience and more-limited resources. A lack of options was also reported for “in-betweeners”: those who are not in imminent danger but also cannot wait weeks for care. Services for youth with SUDs and for people with serious mental illness were also reported to be particularly lacking.
- **Assessing feasibility of 988 georouting.** As discussed during our other site visits (in Minnehaha County, South Dakota, and Orange County, New York), the lack of geolocating or georouting calls to 988 presents a challenge for localities to promote 988, connect callers to local resources, and dispatch mobile crisis teams if necessary. As a result, Fairfax County reportedly markets its local ten-digit number in addition to 988. Exploring the ability to *georoute* calls (i.e., route them to the nearest 988 call center) was reported to be a future priority, one that SAMHSA and the Federal Communications Commission are exploring (Federal Communications Commission, 2022). Georouting was described by 988 staff as a “nice middle” option (as opposed to *geolocating*, or identifying the exact whereabouts of callers, as is done with 911 calls).
- **Enhancing staffing and capacity across the continuum of care.** Several interviewees noted the importance and challenge of ensuring appropriate staffing levels. PSAP interviewees reported that staffing is the “biggest challenge” and an “industrywide problem” given the lengthy amount of time it takes to become a call-taker (six months) and dispatcher (one year). PSAP staff noted that more co-response teams were needed and that, in a “perfect world,” they would always dispatch co-responder teams. For 988, staffing is also a challenge given the increase in calls with the launch of 988 and the emotional toll of the work and turnover. Capacity will become a major concern if 988 must respond to significantly more 911-originating calls. A remote work environment and the fact that “pay isn’t bad,” in the words of one interviewee, have meant that the quantity of applicants has not been an issue, but not all of those applicants have been an appropriate fit for the role.

- **Building a stronger social safety net.** Beyond specialized services, many individuals coming into contact with the crisis system have socioeconomic needs, such as housing, food, and transportation, which can be very difficult to address. One interviewee noted that suicide and crisis are much larger than behavioral health issues and are closely tied to economic issues and poverty, and the call center “cannot hold that”; that is, the call center is not equipped to address these issues. And, as one clinician co-responder explained, funding exists for crisis response, law enforcement, and emergency services, but there are larger questions about what happens after the crisis ends.

Benefits of 988/911 Interoperability

988/911 interoperability was described as beneficial for many reasons throughout our interviews and across stakeholders. The PSAP receives about 1 million calls per year, and an estimated 25 to 35 calls per day are related to mental health. As noted by an interviewee, law enforcement might not always make the best decisions when sent to address mental health crises. Similarly, the interviewee noted, someone in crisis might not react well when faced with an armed response. Diverting the call to 988 has the potential to avoid an adverse outcome, such as the individual in crisis or the responder being hurt. In addition, from the perspective of law enforcement, receiving fewer calls has freed up resources to focus on public safety. One law enforcement officer noted the positive impact of these innovations on the community, saying, “I never made an impact before [participating in these programs]—well, I made negative impacts, taking people to jail, arresting them, or giving them tickets. Now, I can have a positive impact on people’s lives every day.”

Finally, interviewees said that a partnership between 988 and the PSAPs encourages a wider conversation on the agencies’ processes and how to work together to solve problems. The partnership creates an open line of communication and data-sharing that is crucial in meeting people’s needs no matter where in the system they access care. Improved tracking of mental health calls with statewide consistency using four levels of risk was seen as particularly useful for data-gathering and helps cities and counties see the reality of the ongoing mental health needs in their communities. Marcus Alert has provided an opportunity for agencies to build trust and increasingly collaborate. Interviewees noted that there seem to be more opportunities to help people.

Conclusion

This report summarizes models of 988/911 interoperability used by three sites: the city of Sioux Falls and Minnehaha County, South Dakota; Orange County, New York; and Fairfax County, Virginia. We selected these sites to represent a variety of jurisdiction characteristics. For example, the sites vary with respect to population size, population density, demographic composition, and geographic location. They also vary with respect to how many 988 call centers there are in the state and whether there is a local call center, how many PSAPs and law enforcement agencies there are, how many and what types of mobile crisis teams there are and how those resources are dispatched, and whether 988/911 interoperability efforts were initiated at a local level or required by state policy. Our intention in choosing three distinct sites that vary across these dimensions was to describe different approaches to 988/911 interoperability. In addition, it allows other jurisdictions to understand the ways in which local resources and characteristics might shape their own models of 988/911 interoperability.

Cross-Site Findings Related to Effective Planning and Implementation

Through our document review, interviews, and site visits, we learned that there were unique elements to each model of interoperability, including the planning and implementation process. At the same time, there were also some shared lessons learned across sites that have the potential to serve as a road map for other jurisdictions that are looking to implement 988/911 interoperability.

Planning and implementation should be collaborative. Across sites, we learned that relationships and collaboration were important ingredients to the success of 988/911 interoperability. Planning efforts often involved a diverse set of contributors, including representatives from 988 call centers and PSAPs; law enforcement; mobile crisis; peer support specialists; behavioral health services; and, in some cases, people with lived experience with crisis services or the behavioral health system. It was important for these groups to develop a shared language, similar standards, and mutual respect. Some sites also had additional planning or QA efforts specifically involving the 988 call center and PSAP, highlighting the importance of a strong partnership between those two organizations.

In addition to collaboration in the planning process, it is important to continue nurturing relationships among partner agencies to ensure effective implementation of 988/911 interoperability. In our three sites, the planning groups often continued meeting after interoperability had been implemented, though the frequency of meetings sometimes decreased and the focus of those meetings shifted to implementation issues (e.g., ensuring that all cases appropriate for transfer from 911 to 988 were being transferred). Another opportunity for ongoing collaboration is cross-training across agencies—for example, having PSAP staff provide training for 988 call-takers and vice versa.

Having a local champion for 988/911 interoperability is an important facilitator for planning and implementation. Although planning and implementation should be collaborative, we also found that it can be most efficient and effective when there are one or two people who serve as local champions. This con-

cept is supported by the broader literature related to implementation strategies (Santos et al., 2022), which are the practices that organizations can use to maximize the likelihood that they successfully implement an evidence-based practice (Proctor, Powell, and McMillen, 2013). The person serving in the role of champion varied across sites. For example, in South Dakota, it was the CEO of the Helpline Center; in Fairfax, it was a project manager who could serve as a boundary spanner because they did not have a background in clinical services or law enforcement. But the common factor across sites was that the champion was someone who could set the priorities for planning and implementation, convene local stakeholders, broker difficult conversations, and chart a path toward the ultimate goal of 988/911 interoperability.

988/911 interoperability requires more than protocols for transferring calls between 988 and 911. On its surface, the most basic element needed for 988/911 interoperability is a set of protocols and procedures for identifying calls that 911 call-takers should transfer to 988 and vice versa. However, it was clear from the sites that we visited that interoperability must be considered within the larger continuum of crisis services available in the community. Even if many calls transferred to 988 can be resolved on the phone, there will always be callers who require an in-person response. For this reason, planning for 988/911 interoperability is likely the most effective when it is part of a larger effort to build a robust continuum of care in the community, as in Fairfax.

Jurisdictions can rely on existing tools when planning for 988/911 interoperability. When we developed our data collection protocols for this study, we relied on *988 Convening Playbook: Public Safety Answering Points (PSAPs)* (NASMHPD, undated-b), which outlines the key decisions and competencies that should be considered when developing a plan for 988/911 interoperability. There is a complementary document specifically for 988 call centers: *988 Convening Playbook: Lifeline Contact Centers* (NASMHPD, undated-a). These documents guide jurisdictions to consider partnerships (e.g., between PSAPs and 988 call centers, as well as other partners in the continuum of care); call processes, including the decision points, processes, and technical mechanisms for transfers; and training, data collection, and data-sharing. Our site visits confirmed that decisions on these topics were the key decisions that needed to be made during the planning process. The specific decisions made in each domain may vary from site to site, as we found through our case studies, but these do appear to be the critical decision points. Therefore, these guides should serve as a valuable resource for jurisdictions working toward 988/911 interoperability.

In addition to these general guides, one of our sites (Fairfax) benefited from the fact that 988/911 interoperability was being required at the state level. The state provided planning guides and resources, which helped structure the planning process. As more states move to require 988/911 interoperability, these types of planning resources could be of value to local jurisdictions. But these resources can also benefit jurisdictions in other states; for example, the Commonwealth of Virginia has posted many of its planning documents online (DBHDS and Virginia Department of Criminal Justice Services, 2022), and they could be applicable to cities and counties outside Virginia.

Formalizing policies, procedures, and documents is essential. Interviewees talked about the importance of formalizing processes. Doing so is one way to address concerns about liability, which were raised across sites; that is, call-takers will feel more comfortable transferring a call if they know that they are following an established procedure and are not expected to make more-subjective decisions in the moment. MOUs were also essential to laying the groundwork for data-sharing across agencies, which in turn informs QA efforts. Jurisdictions should be prepared for the process of developing these agreements to take time, as they often require the involvement of agencies' legal departments and knowledge of other laws and policies (e.g., the ways in which HIPAA; the Code of Federal Regulations, Title 42; or CJIS data policies apply to data-sharing between 988 and 911).

Limitations

There were certain limitations to our study that should be considered when interpreting these findings. First, it is important to understand the purpose of our case study approach, which was to provide an in-depth exploration of three sites. Caution should be exercised when generalizing the findings from these three sites to other jurisdictions. It will be important for jurisdictions looking to implement 988/911 interoperability to consider the match between their local resources and characteristics and those of the sites presented when determining whether there might be a model that fits their needs. However, jurisdictions can feel comfortable thinking about adaptations that might need to be made to the models presented in this report to better fit their local contexts.

Second, our findings reflect a snapshot in time at the point at which data were collected. However, each of the three sites continues to evolve and refine its local procedures. In addition, there are certain topics that were less covered by our study. One of these is funding. Although funding is essential to 988/911 interoperability, funding models and sources can vary substantially across jurisdictions. Therefore, although we asked for basic information regarding funding of 988/911 interoperability and local in-person response options, we do not detail findings related to funding in this report. In addition, although we explored questions related to data collection, data system interoperability, and use of data for evaluation, we provide limited detail related to data systems in this report given some of the limitations to data collection, described in the previous section.

Finally, the purpose of our case studies was to illustrate and explore three models of 988/911 interoperability. However, interoperability is still fairly new, and, although more jurisdictions are looking to implement interoperability procedures, there is not enough evidence to suggest what the most effective models are. Although there is somewhat more evidence related to different in-person response models, such as CIT-trained officers, co-response units, and alternative response models (e.g., clinician only), there remains a need for higher-quality research to determine what models are most effective (Balfour et al., 2022; Marcus and Stergiopoulos, 2022; Shapiro et al., 2015). For this reason, our findings provide insight into implementation and processes, but any statements related to effectiveness or the most important implementation conditions are based on our interviews with stakeholders, not on data demonstrating outcomes.

Takeaways for the Future of Interoperability

Priorities Identified by Sites

All of our sites were selected because they already have well-established protocols for 988/911 interoperability. However, we also found that sites are continually looking for ways to fine-tune their processes and optimize the services available in their communities. For example, sites are continuing to explore ways to conduct outreach to underserved and/or high-need members of their communities, including youth and older adults, LGBTQ+ populations, and people with SUDs. Sites are also navigating issues related to staffing in their local crisis care, behavioral health, and public safety workforces.

Data Collection and Evaluation

Although individual agencies at the sites we studied are often collecting data internally, there are opportunities to figure out how to leverage cross-agency data. Leveraging these data can be challenging because of such issues as the need to safeguard protected health information or the need to limit sharing of sensitive public safety data, but doing so remains a priority for sites. This type of data collection is important because it can be used not only for quality improvement efforts but also for more-formal evaluation of the implementation

and effectiveness of the local continuum of care. At the most basic level, data collection could include tracking data related to incoming calls, calls transferred, and outcomes of those calls (e.g., was there an in-person response?). However, more-rigorous and longer-term tests of effectiveness are also important; for example, what happens after the call ends? Are there any differences in treatment uptake depending on whether or not a call is transferred? Does interoperability decrease rates of arrest and incarceration among individuals with behavioral health concerns? What is the impact on suicide rates (Collins et al., 2023)?

Education for Community Members

As noted previously, although it appears that knowledge of 988 and its purpose is growing, there is still a large percentage of individuals who are unfamiliar with 988 (Velázquez, 2023). This fact points to the need to advertise 988 to community members. Reeducation about 911 also might be warranted, given that many calls to 911 are for nonemergencies (Dholakia, 2022), which can tie up valuable resources. In addition, community members and organizations have raised concerns about police being dispatched following a call to 988 (Velázquez, 2023) and the potential for adverse outcomes when this happens (Bossing et al., 2022). These concerns might reduce the chances that a community member will call 988 when they are in distress. Transparency about the interoperability between 988 and 911 might help assuage concerns on the part of community members and help them to make more-informed decisions about when to call 988 versus 911 and to know what might happen when they call each number (Pope and Compton, 2022).

Broader Landscape of Crisis Care Reform

It is important to consider our findings within the larger context of crisis care reform, 988 implementation, and efforts to achieve 988/911 interoperability. For example, SAMHSA and the Federal Communications Commission have been exploring mechanisms for georouting 988 calls (SAMHSA, 2023), which will help ensure that callers are connected to services located near their current locations rather than their area codes. Other states, such as California, are exploring state-level requirements for 988/911 interoperability (California Health and Human Services Agency, 2022). Such organizations as the University of Chicago Health Lab are leading community-engaged efforts to reimagine the role of 911 in emergency crisis response (Transform911, undated-a). Having case studies like those presented in this report might help jurisdictions plan for 988/911 interoperability locally, even as this landscape continues to evolve.

Drawing from Existing Research to Refine Local Models

Even though it might take time for evidence to accumulate as to the most-effective models of 988/911 interoperability, jurisdictions can draw from research on particular components of the crisis care continuum, including data related to

- suicide screening and the predictive validity of screening measures (Simpson et al., 2021) (e.g., what are the situations in which the Columbia-Suicide Severity Rating Scale has the strongest predictive validity? What are the scenarios in which it might not adequately detect suicide risk, such as among people who end up being admitted to an emergency room?)
- safety planning, including the importance of training staff to be comfortable in developing safety plans, especially as the number of entities who might be involved in safety planning grows beyond 988, because even trained clinicians cite a desire for more training (Moscardini et al., 2020)
- types of alternative response (Transform911, undated-b) and co-response models (International Association of Chiefs of Police/University of Cincinnati Center for Police Research and Policy, undated), as

well as the evidence base examining the effectiveness of these models (and limits to the existing evidence)

- factors that facilitate the implementation of new practices, such as identifying an implementation champion, providing training to relevant stakeholders, supporting people who deliver the new practice, and providing technical assistance (Waltz et al., 2015). These strategies can also be used to support the sustainment of new practices, even after the initial implementation phase has passed (Proctor, Powell, and McMillen, 2013). Examples of implementation strategies can be found in, e.g., Balis and colleagues' 2022 article focused on implementation strategies in community settings (Balis, Houghtaling, and Harden, 2022).

Although local jurisdictions might not always have the capacity to stay abreast of the evolving state of the science related to mental health crisis care, there are many organizations, such as NASMHPD, SAMHSA, and Vibrant, that compile relevant resources that might help communities translate the science into practice.

Methods

Our project used a case study approach to understand different ways in which jurisdictions have approached the interface between 988 and 911 and to identify relevant facilitators, barriers, and equity-related considerations that shaped each jurisdiction's approach.

Site Selection

To identify sites, we collaborated with NACo. NACo was funded by The Pew Charitable Trusts to spotlight the work of counties that have implemented innovations and reforms to improve 911 handling of and response to behavioral health crises. NACo began by identifying a preliminary list of 26 sites that implemented an innovative emergency system response to behavioral health crisis calls, including 988/911 interoperability. These counties were selected on the basis of geographic spread across the United States and model of interoperability (e.g., including sites that have the ability to transfer calls between 988 and 911, have an embedded clinician, and have colocated crisis or 988 centers and 911 call centers).

From this initial set of 26 sites, NACo identified a subset of 13 sites. This process was informed in part by considerations related to geography: The initial set of 26 sites sometimes included multiple counties in a single state; when that was the case, only one county was retained for the reduced list of 13 sites. NACo also focused on retaining variation with respect to model of interoperability. Members of the NACo and RAND study teams collaborated to conduct initial discussions with stakeholders from each of the 13 sites to obtain more details about the model used in each county and the status of implementation.

Drawing on these discussions, we evaluated each site on a set of 11 dimensions, summarized in Table A.1. These dimensions are based on our review of key 988 and 911 interoperability resources (e.g., Gulley et al., undated; NASMHPD, undated-b), as well as our prior research on 988 preparedness (Cantor et al., 2022).

Given that we selected three case study sites, it was not possible to maximize variability across all of these dimensions. Therefore, we prioritized the first three dimensions when selecting sites: (1) population density/urbanicity, (2) model for 988/911 interoperability, and (3) recency of establishing 911/crisis line interoperability.

Using the criteria described above, we selected three of the 13 sites to invite to participate as case studies: Sioux Falls and Minnehaha County, South Dakota; Orange County, New York; and Fairfax County, Virginia. All three sites agreed to participate.

Data Collection

We drew on three primary data sources for each case study.

TABLE A.1
Site Characteristics Considered in the Site Selection Process

Dimension	Proposed Subdimensions
1. County population density/urbanicity	<ul style="list-style-type: none"> • ≥75 percent urban • 50–74 percent urban • <50 percent urban • (Using Census data)
2. Model for 988/911 interoperability	<ul style="list-style-type: none"> • Ability to transfer calls between 988 and 911 call centers • Embedded clinician • Colocated 988 and 911 call centers • Other model
3. Recency of establishing 911/crisis line interoperability	<ul style="list-style-type: none"> • Within the past 18 months • More than 18 months ago
4. Geographic region	<ul style="list-style-type: none"> • Northeast • Southeast • Midwest • West • Southwest
5. Sociodemographics	<ul style="list-style-type: none"> • Racial/ethnic composition (considering percentages across groups), based on American Community Survey data • Median household income, based on American Community Survey data
6. Timing of 988 site joining the Lifeline network	<ul style="list-style-type: none"> • Pre-988 legislation • Post-988 legislation
7. Availability of data on 988/911 interoperability	<ul style="list-style-type: none"> • Yes • No
8. Funding source	<ul style="list-style-type: none"> • Received grant funds to support implementation • Relied primarily on local existing resources
9. State funding mechanisms for 988	<ul style="list-style-type: none"> • Has 988 surcharge • Does not have 988 surcharge
10. Organization of 988 call centers in state	<ul style="list-style-type: none"> • Statewide call center • Regional or local call centers
11. Organization of behavioral health in state	<ul style="list-style-type: none"> • Centralized state behavioral health authority • Local/regional behavioral health authority • Other

Document Review

We requested documents from each site that were relevant to 988/911 interoperability, including policy and procedure documents, MOUs, interagency agreements, data-sharing agreements, and training materials. We used these documents to begin mapping out the process by which 911 and 988 interfaced in each jurisdiction and to understand who the stakeholders were, what their roles were, and how their roles were formalized. Documents reviewed for each site are summarized in Table A.2.

Qualitative Interviews with Staff of Relevant Agencies

Participants

We recruited representatives from multiple stakeholder groups, including local 911 leadership and 911 dispatchers, local 988 leadership and 988 staff, representatives of local mental health and law enforcement agencies, law enforcement responders or co-response teams, mobile crisis response teams, and local advocacy groups and/or community-based organizations. At each site, we had two key points of contact who helped us identify the relevant agencies and staff members from each agency.

TABLE A.2
Documents Reviewed Across Sites

Site	Documents
City of Sioux Falls and Minnehaha County, South Dakota	Hansen, undated; Helpline Center, undated; Helpline Center, 2023; Helpline Center and Metro Communications Agency, 2022; IAED, 2023; Metro Communications Agency, 2022a; Metro Communications Agency, 2022b; South Dakota Department of Social Services, 2022a; South Dakota Department of Social Services, 2022b; South Dakota Suicide Prevention, undated.
Orange County, New York	Miller and Trimble, undated; Orange County Crisis Call Center, undated; OCDMH, undated; OCDMH, Access Supports for Living, Inc., Independent Living, Inc., and Mental Health Association in Orange County, Inc., 2019; Orange County Division of Emergency Communications, 2023a; Orange County Division of Emergency Communications, 2023b; Orange County Mobile Response Team, 2023.
Fairfax County, Virginia	CR2, undated; DBHDS, undated-a; DBHDS, undated-b; DBHDS, 2021; DBHDS, 2022; DBHDS and Virginia Department of Criminal Justice Services, 2022; Fairfax County, Virginia, undated-a; Fairfax County, Virginia, undated-b; Fairfax County, Virginia, 2023a; Fairfax County, Virginia, 2023b; Fairfax County, Virginia, Sheriff's Office, undated; Fairfax-Falls Church Community Services Board, undated; Northern Virginia Regional Projects Office, undated; Robinson and Leamon, 2023; General Assembly of Virginia, 2021; Masters, 2022.

Interview Protocol and Procedures

We developed a semistructured interview protocol with the goals of gaining an in-depth understanding of the process by which 911 and 988 interface and exploring strengths, limitations, and equity considerations related to the local approach. Our interview protocol was designed in a flexible manner so that the specific questions were tailored to the particular individual or group of individuals participating in each discussion. Individual interviews lasted up to 60 minutes and group interviews lasted up to 75 minutes. We structured our interview protocol around the core competency domains described in *988 Convening Playbook: Public Safety Answering Points (PSAPs)* (NASMHPD, undated-b), and we included additional questions to capture challenges and facilitators of 988/911 implementation, equity considerations, and lessons learned from implementation. In the city of Sioux Falls and Minnehaha County, South Dakota, we interviewed 20 people; in Orange County, New York, we interviewed 19 people and attended a weekly meeting with seven to ten community leaders; and in Fairfax County, Virginia, we interviewed 28 people.

We took detailed notes during the interviews. When interviewees provided permission, we also recorded the discussions to fill in gaps in our notes.

Site Visits

We conducted two- to three-day visits to each of the case study sites. While on site, we aimed to conduct as many of the interviews as possible. We were also able to conduct unstructured observations of call centers, which provided additional insight into staffing patterns and diversion processes; to attend meetings of 988 and 911 staff to observe how staff interacted and addressed emerging issues; and, at one site, to attend a ride-along with the co-response team. Every site visit was attended by at least two members of the project team.

Data Analysis

We had a two-stage approach to analysis. The first stage focused on the individual sites. A key goal of this work was to understand the nuances of the interface between 911 and 988 in each jurisdiction. Therefore, we developed detailed process maps for each jurisdiction to demonstrate how behavioral health emergency calls were handled. These process maps (Figures 2.1, 3.1, and 4.1) depict the role of each agency, points of interagency communication, and decision points that affect the way a call flows through the local system.

For each site, we drafted a process map based on our document review, qualitative interviews, and site visits and then shared the draft version with a small group of stakeholders at the site to ensure its accuracy before finalizing it.

In addition to developing process maps, we conducted formal coding and analysis of the qualitative interview data. To analyze the data, we used rapid qualitative analysis (Taylor et al., 2018), an approach that is well suited to research on topics that are quickly evolving and in which the goal is explain a process or phenomenon and extract actionable findings (Taylor et al., 2018). We developed a coding spreadsheet that reflected our key domains and themes of interest, which were identified deductively using the interview protocol. When we coded interviews from the first site visit, our team met regularly to discuss the application of each code and level of detail for coding, and we modified the coding form and guidance as needed to ensure consistency across coders. Then, two members of the research team coded each interview from each site to ensure completeness and accuracy. We had a separate analysis spreadsheet for each site, and this formed the basis of our analysis. Each interview was numbered for the purpose of analysis.

Findings in each site-specific chapter of this report are based on data integrated across each of our methods (i.e., the document review, qualitative interviews, and site visits). After drafting each case study, we shared the description with stakeholders from the respective site to ensure the accuracy of all information presented in these chapters.

Although the primary goal of a case study approach is to gain an in-depth understanding of the procedures within a given site, we anticipated that there might also be lessons learned across the case study sites. Therefore, our second stage of analysis was to synthesize findings across sites.

Abbreviations

CAD	computer-aided dispatch
CIT	Crisis Intervention Team
CJIS	Criminal Justice Information Services
CMHC	community mental health center
COVID-19	coronavirus disease 2019
CR2	Community Regional Crisis Response
CRT	Community Response Team
CSB	community services board
DBHDS	Virginia Department of Behavioral Health and Developmental Services
EMD	Emergency Medical Dispatch
EMS	emergency medical services
HIPAA	Health Insurance Portability and Accountability Act
IAED	International Academies of Emergency Dispatch
IT	information technology
LGBTQ+	lesbian, gay, bisexual, transgender, queer, and more
Marcus	Mental Health Awareness Response and Community Understanding Services
MOU	memorandum of understanding
MRT	Mobile Response Team
NACo	National Association of Counties
NASMHPD	National Association of State Mental Health Program Directors
NYS MHL	New York State Mental Hygiene Law
OCDMH	Orange County Department of Mental Health
Orange 911	Division of Emergency Communications (Orange County)
PSAP	public safety answering point
QA	quality assurance
QMHP	qualified mental health professional
RCCC	regional crisis call center
REACH	Regional, Education, Assessment, Crisis Services, Habilitation
SAMHSA	Substance Abuse and Mental Health Services Administration
SFPD	Sioux Falls Police Department
SUD	substance use disorder

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