Working Paper

Preparedness for 988 Throughout the United States

The New Mental Health Emergency Hotline

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About This Working Paper

Untreated mental health symptoms are a pervasive and persistent public health problem. Around 39 million individuals in the United States identified as having a mental illness in 2019, and of this number, fewer than one-half (45 percent) received treatment. Left untreated, individuals' symptom profiles can worsen to the point of becoming a mental health emergency. Currently, the National Suicide Prevention Lifeline (NSPL) network serves as a national hotline for individuals experiencing mental health emergencies. This network will shift to a three-digit number (988) on July 16, 2022. Although mandated at a national level, the launch of 988 will require substantial effort on the part of state and local agencies to ensure sufficient capacity to handle these calls and connect callers with local mental health emergency services if needed. However, there have been no evaluations to date of the preparedness for the launch of this service. We conducted a survey of 180 officials to ascertain their preparedness for the launch, asking questions pertaining to four domains: strategic planning, financing, infrastructure, and service coordination. This was followed by qualitative interviews with a subset of 15 survey respondents to better understand how their jurisdictions are preparing for the launch of 988.

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Summary

Untreated mental health symptoms are a pervasive and persistent public health problem. Around 39 million individuals in the United States identified as having a mental illness in 2019; of that number, fewer than one-half (45 percent) received treatment. Left untreated, individuals' symptom profiles can worsen to the point of becoming a mental health emergency. Currently, the National Suicide Prevention Lifeline (NSPL) network serves as a national hotline for individuals experiencing mental health emergencies. This network will shift to a three-digit number (988) on July 16, 2022. Although mandated at a national level, the launch of 988 will require substantial effort on the part of state and local agencies to ensure sufficient capacity to handle 988 calls and connect callers with local mental health emergency services if needed. However, there have been no evaluations to date of the preparedness for the launch of this service.

We conducted a mixed methods study of 988 implementation. Our process consisted of a national survey of 180 officials to ascertain their preparedness for the launch of 988 followed by qualitative interviews with 15 survey respondents from jurisdictions identified as more- and less-prepared for the implementation of 988. Findings were organized by four domains: strategic planning, financing, infrastructure, and service coordination.

More than half (51 percent) of survey respondents reported that they were not involved with the development of a strategic plan related to the launch of 988. In interviews, respondents described several sources of guidance that they have used while preparing for 988, such as resources from the Substance Abuse and Mental Health Services Administration, Vibrant Emotional Health, and the National Council for Mental Wellbeing, and many had collaborated with other local and state agencies for planning purposes. However, knowledge of these sources of guidance was not necessarily associated with a greater feeling of preparedness for the transition to 988.

Regarding funding, only around 16 percent of survey respondents reported that they had developed a budget to support 988 operations, and our interviews suggested that jurisdictions intend to blend multiple sources of funds to support 988 and their local continuum of care. Respondents frequently (85 percent) reported that there was a mental health emergency response hotline or call center operating in their jurisdiction, though fewer than half of those hotlines reported that they were part of the Lifeline network. Qualitative interviewees from jurisdictions with a local Lifeline operator did highlight this as a benefit for 988 preparedness, and they felt more confident that call center staff would be knowledgeable about local resources. Of those jurisdictions with hotlines, a majority (55 percent) contained staff specifically trained to interact with children and adolescents, but a minority had training to interact with other special populations such as individuals experiencing homelessness (46 percent) or LGBTQIA+ individuals (45 percent).

Regarding the continuum of mental health emergency care, we found that 48 percent of survey respondents' jurisdictions had a short-term crisis stabilization program and only 28 percent possessed urgent care units for mental health. Moreover, only 22 percent of jurisdictions have crisis call centers or hotlines that can schedule intake and outpatient appointments on behalf of individuals in need. Qualitative interviews similarly drew to the surface concerns about the full continuum of care available to support community mental health needs—ranging from emergency and urgent care to inpatient and outpatient supports.

Our results show that there is room for improvement with respect to strategic planning, financial preparedness, and the availability of services and system coordination. Our interviewees noted that two of the most common challenges they encountered in their 988 planning process were insufficient mental health workforce and a lack of funding, and they separately noted the importance of educating the public about the transition to 988. These findings highlight areas of need that will be relevant for jurisdictions to address prior to the launch of 988 in July 2022, but also in the months that follow. At the same time, interviewees noted that interagency collaborations, coupled with well-qualified local mental health emergency providers, have bolstered the planning process and likely will be an essential part of overcoming current limitations and gaps.

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Chapter 1. Introduction

In 2019, over 39 million individuals in the United States were identified as having a mental illness in the past year; of this number, fewer than one-half (45 percent) received treatment.[1] Left untreated, individuals' symptom profiles can worsen—sometimes to such an extent that these individuals end up in emergency departments or attempt suicide. In 2018 alone, there were 6,905 emergency department visits per 100,000 population for mental health or substance use disorders.[2] Furthermore, rates of suicide have risen steadily between 1999 and 2018.[3] In 2019, suicide was the second leading cause of death among children, adolescents, and young adults ages 10–34 and the tenth leading cause of death for all ages.[4] The total age-adjusted suicide rate in the United States was 13.9 per 100,000 in 2019.[5] Similarly, in 2020 approximately 5 percent of adults 18 years and older in the United States had serious thoughts of suicide.[6] Collectively, these data show that the receipt of early, timely, and appropriate care are significant shortcomings of the U.S. mental health system, and certain populations (e.g., individuals in rural areas, individuals from marginalized groups) may experience disparities in access to care.

One way to improve this situation has been to establish hotlines that individuals can contact in the event of a mental health emergency or helplines that can connect individuals to resources in their community. These resources can be used by individuals who are receiving mental health treatment and by those who are not. In 2005, the National Suicide Prevention Lifeline (NSPL) was established to provide mental health emergency support to callers with availability 24 hours per day, seven days per week (hereafter referred to as 24/7).[7] The year that NSPL launched, it received fewer than 50,000 calls; in 2020, it received more than 2.6 million.[8] The NSPL has also expanded to a broader network of more than 180 call centers—the Lifeline network—that provides such services as emotional support, suicide risk assessment, transfers to emergency services, and referrals to treatment.[9] In select geographies, call responders can deploy mobile crisis response teams that include mental health professionals.[10] Studies of the NSPL have found that the callers are less upset, distressed, and suicidal after engaging with the hotline,[11] and callers report that calling the hotline stopped them from self-harm and kept them safe.[12]

In 2020, Congress enacted the National Suicide Hotline Designation Act,[13] a piece of legislation that established a three-digit number (988) as the mental health emergency corollary of 911. As a result, on July 16, 2022, people across the United States will be able to use 988 to reach the Lifeline network. At its most basic level, 988 is intended to be easier to remember than the current Lifeline number (1-800-273-8255). However, it is also envisioned as a way to reduce stigma surrounding mental health emergencies.

Although Congress has allotted more than $280 million to strengthen network operations and capacity,[14] it is unclear whether and to what extent local jurisdictions throughout the United States are prepared for the potential influx of calls. For example, as of October 2021, only four

states authorized or imposed a surcharge to support 988 operations.[15] This type of fee is collected by telecommunication companies from customers to support the 911 system and could be used in a similar fashion to finance the 988 system. Data from SAMHSA suggest that the demand for the Lifeline network already exceeds capacity.[16] Research suggests that up to 30 percent of calls may go unanswered, and this rate may increase even further in response to a "surge" event, such as the suicide of a high-profile figure.[17]

Vibrant Emotional Health, which operates the Lifeline network, anticipates an increase of at least 50 percent in the number of calls in the first year after 988 launches.[18] According to a recent *New York Times* article, abandonment rates among callers to the Lifeline network (i.e., callers that disconnect within 30 seconds) over the past year have reached a high of 17 percent,[19] with even higher abandonment rates for texters and chatters. NSPL reports have indicated that, when a state or local call center is unable to answer a call, callers are routed to a national backup center, resulting in wait times that are two to three times longer than when a state or local call center is able to answer a call and increased rates of abandonment.[20] Chat messages to the NSPL were also found to be abandoned primarily because of wait times.[21] This further suggests a need for increased call center capacity at local and national levels.

The upcoming launch of 988 has brought attention to the need for a well-resourced and more seamless continuum of mental health emergency services throughout the country. The National Association of State Mental Health Program Directors (NASMHPD) published a guide on mental health emergency services that highlights three key elements:

- **someone to talk to**, which involves having 24/7 crisis call centers
- **someone to respond**, which includes local mobile crisis teams that can respond to individuals whose emergency cannot be resolved through the call
- **a place to go**, which refers to community-based stabilization services.[22]

However, jurisdictions struggle with having sufficient capacity in their continuum of crisis care.[23] If 988 results in improved identification of individuals requiring in-person response or crisis stabilization services, the system will be strained even further.

Seminal sources of guidance on the operation of mental health emergency hotlines and the continuum of crisis care include recent publications by SAMHSA, CrisisNow, and NASMHPD.[24] These reports have aimed to provide a framework for crisis services that can be used nationwide. However, it is challenging to develop guidance that applies to jurisdictions throughout the country. In part, this is because there are inevitable differences in the needs of jurisdictions, depending on such factors as population size and urbanicity. Another complicating factor is variation in how behavioral health services are organized across states. This variability was highlighted by a recent survey conducted by the NASMHPD Research Institute.[25] The survey revealed that the state mental health authority is responsible for coordination of Lifeline Call Centers in 24 states; the remaining states employed one of three alternative models for oversight of hotlines. The survey also identified variation in whether the Lifeline was integrated

with other crisis services; how states planned to integrate their existing hotlines with 988; and how the continuum of crisis services was funded.

Given these potential challenges, we sought to understand how prepared states and counties were for the launch of 988 in early 2022. To answer this question, we conducted a mixed methods study comprising a national survey of 180 behavioral health program directors throughout the United States—at state, regional, and county levels—complemented by semistructured interviews with a subset of 15 respondents. With the quantitative survey, we inquired about preparedness for the launch of 988 according to four dimensions: strategic planning, financing, infrastructure, and service coordination. Each domain corresponds to areas of best practice outlined in the SAMHSA, CrisisNow, and NASMHPD reports. Our intention was to identify areas of strength from which jurisdictions could continue to build momentum, as well as to highlight areas where greater resources are needed. Our qualitative interviews were designed to gain a more in-depth understanding of the 988 planning process, including the features that distinguished jurisdictions as more or less prepared for 988 implementation as determined by survey responses.

Chapter 2. Methods

For this survey study, we conducted an online Qualtrics survey to assess preparedness for 988, which will launch July 16, 2022. The survey was conducted from February 8 through March 17, 2022. After providing informed consent on the initial screen of the survey, participants were presented with 21 questions on their jurisdiction's preparedness. (See Appendix A for the survey items.)

The survey was followed by semistructured interviews conducted with a subset of survey respondents who indicated their willingness to be contacted for a follow-up discussion about their jurisdiction's 988 planning (see Appendix B for the interview protocol). We conducted the interviews in March and April 2022, two to three months before the launch of 988 on July 16, 2022. The RAND Human Subjects Protection Committee approved the study. More detail about each procedure is provided in the sections that follow.

Survey

Overview

Based on a review of best practices for mental health emergency hotlines, including the previously referenced publications by SAMHSA, CrisisNow, and NASMHPD,[26] we selected four domains pertaining to preparedness for 988: strategic planning, financing, infrastructure, and service coordination. These domains, and the specific questions and response categories, were reviewed by topical and survey methods experts internal and external to the RAND Corporation—including leaders at NASMHPD, Vibrant, and academic centers that have specifically investigated the effects of mental health emergency hotlines.

A preponderance of questions followed "yes," "no," "I don't know" formatting. Ordinal questions on preparedness corresponded to a four-point Likert scale: "not at all," "a little bit," "somewhat," "very." Skip logic was also incorporated whenever relevant. For example, if a survey respondent stated that their jurisdiction did not contain a local mental health emergency response hotline, the survey skipped questions pertaining to the characteristics of a local mental health emergency response hotline.

Participants and Procedures

We sought to distribute the survey to programmatic leads of public-sector mental health agencies at state, regional, and county levels. Coordinating with NASMHPD, we developed an inventory of program directors at the state level. Following this, we reviewed information on the composition of jurisdictions for mental health services within states. For example, such states as

Texas contain regional mental health authorities, which we contacted. By comparison, such states as California have agencies corresponding to each county, which we contacted. In total, we were able to develop an inventory of 690 mental health program directors at the state and county levels throughout the United States. In addition, NASMHPD circulated an e-mail that included a link to the survey to a listserv comprising mental health program directors, who represented our intended audience for survey completion.

Prospective participants were invited to complete a brief, confidential survey on preparedness for 988 and offered a $10 Amazon gift card code for their time. An initial invitation to participate was circulated February 8, 2022, followed by weekly reminders over the subsequent six weeks. The inclusion criterion was that the respondent was identified as a state or county behavioral health director. There were no exclusion criteria for survey respondents to be included in the sample.

Measures

In developing the survey, we were interested in understanding jurisdictions' plans for the launch of 988. In addition, we assessed aspects of their current mental health crisis hotline model and crisis continuum of care, given that national guidance documents have encouraged states and counties to prepare for the launch of 988 as one component of the continuum of crisis care. The survey comprised four sections described next.

Introduction

Respondents were asked four questions regarding overall preparedness for the launch of 988: how important the respondent believes it is that their agency be prepared for the transition to 988; level of preparedness with respect to staffing, financing, infrastructure, and coordination of services; current status of crisis stabilization bed capacity; and the major entry points for someone receiving mental health crisis care.

Strategic Planning and Financing

We inquired whether respondents' agencies and corresponding jurisdictions had been engaged in the development of a strategic plan (response options included "yes," "no," or "I don't know"). Respondents who indicated "yes" were asked to indicate which of seven specific provisions the strategic plan included, the options being starting, maintaining, or expanding local 24/7 crisis call centers; educational and marketing materials about the introduction of 988; and plans for clinical services, personnel, and infrastructure in conjunction with 988 emergency response.[27] Respondents could check all that applied. In a similar manner, regarding financing, we first asked whether respondents' agencies and corresponding jurisdictions had developed a budget for supporting 988 operations (response options included "yes," "no," or "I don't know"). Those who indicated "yes" were asked whether the budget contained each of six specific

provisions, which overlayed with strategic planning topical areas (e.g., educational materials, personnel). Respondents could check all that applied.

Range of Services

Questions in this section focused both on infrastructure and coordination of services. Regarding infrastructure, we asked eight questions about the availability of local or regional crisis call centers and hotlines and their characteristics. These questions focused on whether the jurisdiction currently has a local or regional crisis call center, whether such call centers are part of the Lifeline network, the modes of communication supported, whether there is 24/7 staffing, whether staff are paid personnel or volunteers, whether staff have been trained on suicide interventions or to interact with special populations, and whether hotline staff must speak two languages fluently. We also inquired about other aspects of the continuum of crisis care, including the presence of 24/7 mobile crisis response teams, mental health urgent care clinics, short-term residential crisis stabilization programs, and training for crisis responders.

Last, we asked about aspects of data collection that might support service coordination. This included a question about whether the jurisdiction collects data on metrics such as emergency department wait times and psychiatric bed availability. It also included a question about data collection by the local crisis call center (if one exists), including call volume, number of referrals made, and time to answer. Finally, we asked if crisis call center responders can schedule intake and outpatient appointments for individuals in need.

Statistical Analysis

We calculated one-way frequencies for each set of survey responses. We quantified these statistics in aggregate across all survey responses and separately for each level of survey response (i.e., county level agencies versus state-level ones). In the results section, aggregate responses are recorded. Appendixes B through E contain values separated by whether the survey respondent was a state- or county-level director.

Key Informant Interviews

Overview

To complement the survey, we were interested in gaining an in-depth understanding of the ways that counties and states have been planning for 988 implementation. We therefore conducted semistructured interviews with a subset of individuals who completed the survey. We were particularly interested in understanding experiences in jurisdictions that survey responses indicated were well-prepared and in those jurisdictions that responses indicated were least-prepared. Our goal was to understand the factors that jurisdictions take into consideration as they prepare for 988 implementation, the features that were common in both more- and less-prepared jurisdictions, and factors that seemed to differentiate more- and less-prepared jurisdictions.

Participants and Procedures

To identify potential interviewees, we included a final item on the survey asking respondents to indicate whether they would be open to participating in a brief follow-up interview to discuss their experiences with 988. In total, 23 individuals from ten states indicated that they were willing to be contacted about an interview (about 13 percent of survey respondents). We characterized each jurisdiction's 988 implementation preparedness using a subset of survey items: questions about how prepared they were with respect to staffing, financing, infrastructure, and coordination of services. Jurisdictions indicating they were "somewhat" or "very" prepared on two or more of the four domains were classified in the more-prepared group; those indicating they were "not at all prepared" on two or more domains were classified in the less-prepared group.

When selecting potential interviewees, we were also careful not to overrepresent a single state, especially because there were only ten states represented. To do this, we interviewed a maximum of two individuals from a given state. We also examined the population of the jurisdiction that each potential interviewee represented, with the goal of obtaining variation with respect to population and urbanicity. In total, we invited 17 individuals to participate in interviews, nine from less-prepared jurisdictions and eight from more-prepared ones. Of that number, 15 agreed to participate in interviews: eight from less-prepared jurisdictions and seven from more-prepared ones. This included one interviewee from a state-level agency and 14 from county-level or regional agencies.

Measures

We developed a semistructured interview focused on six topics. The first section requested background information on the interviewee, their agency, and the agency's role in preparing for 988. The next three sections were structured around the continuum of emergency mental health services, asking about planning and preparedness related to (a) the 988 hotline, (b) mobile emergency teams, and (c) emergency receiving and stabilization services. The fifth section featured questions related to resources, staffing, and equity considerations. The final section focused on overall strengths and limitations of the 988 planning process.

In addition to centering on the continuum of emergency mental health services, interview questions were designed to be complementary to the survey items. For example, the survey asked respondents to indicate whether they have a mental health emergency hotline and, if so, whether it was part of the Lifeline network. Interviewees from jurisdictions with a regional Lifeline network call center were then asked questions about whether the call center is prepared for the launch of 988, how they anticipate the launch to affect call volume, and challenges they have experienced in preparing their call center. Interviewees from jurisdictions without a regional Lifeline call center were asked how 988 calls from their jurisdiction will be handled and to describe any challenges they foresee.

Interviews lasted up to 45 minutes, and participants were eligible to receive a $50 gift card for their participation (not all participants were able to accept a gift card because of constraints of their government employment). Each interview was conducted by two project team members: one lead interviewer and one notetaker. Interviews were recorded; we took detailed notes during the interviews and used the recordings to fill in detail and identify verbatim quotes for analysis.

Qualitative Analysis

Our goal with analysis was to quickly extract policy-relevant, timely findings from jurisdictions, understanding that many jurisdictions' 988 planning was evolving in the lead-up to July 16.

We analyzed the interviews using rapid qualitative analysis (RQA),[28] an approach that enabled us to extract key findings during the same period that interviews were conducted. RQA is well-suited to research on topics that are quickly evolving, where the goal is to explain a process or phenomenon and extract actionable findings.[29] Consistent with an RQA approach, we developed a coding spreadsheet that reflected our key themes of interest, which were largely identified deductively based on the interview protocol. For example, themes included "guidance used to prepare for 988," "agencies collaborating for the launch of 988," and "funding 988." Regarding the coding process, after each interview, the lead interviewer extracted key findings related to each theme and summarized them in the analysis spreadsheet. The notetaker would then review the coding to ensure completeness and accuracy. The coding team met regularly during analysis to discuss themes that were emerging, and the researcher leading the coding task regularly reviewed the coding spreadsheet to ensure consistent application of themes.

Our analysis focused on the themes that most directly complemented topics covered by the survey. We did not expect that our interviewees would be representative of the broader population of behavioral health leaders and jurisdictions across the country, given our purposeful selection criteria (i.e., individuals from more- and less-prepared jurisdictions) and self-selection into the pool of potential interviewees. Therefore, rather than reporting frequencies of each theme across interviewees, our analysis focused on describing the range of responses that were expressed.[30] During the analysis process, we reviewed the summaries related to each theme across interviewees and then wrote narratives describing the range of responses. For example, when describing the guidance that interviewees used to prepare for 988, we identified some of the more-common sources of guidance, but we also focused on describing the full range of sources that jurisdictions drew on in order to understand similarities and differences between jurisdictions that reported being more versus less prepared for the launch of 988. For particular themes, we were also interested in whether findings were different between the more-prepared and less-prepared jurisdictions.

Chapter 3. Results

In total, we contacted 688 individuals. Of the 688, we received a response from 180, for a response rate of 26 percent. Within the 180, there were 16 state program directors and 133 at county or regional levels. The remaining 31 did not report their title. In total we received responses from officials in 23 states.

Strategic Planning

Survey Responses

The first survey domain covered in our survey was related to strategic planning for 988. In Table 3.1, we report frequencies on strategic planning for the launch of 988 by the respondent's agency and jurisdiction. We found that survey respondents most frequently reported that it was very important (83 percent) to be prepared for the launch of 988. That said, less than one-half of respondents (41 percent) reported their agency being involved in the development of a strategic plan for the transition.

Around 84 percent of those with a strategic plan reported that their plan contained content on starting or maintaining operations at one or more local or regional 24/7 crisis call centers or hotlines. Over three-quarters (78 percent) reported that they had a strategic plan to engage a diverse array of stakeholders with the 988 emergency response. Fewer respondents reported having a strategic plan that contained service coordination between 988 and 911 emergency response (67 percent), infrastructure in conjunction with 988 (64 percent), clinical services (60 percent), educational and marketing materials (58 percent), and/or clinical personnel (51 percent).

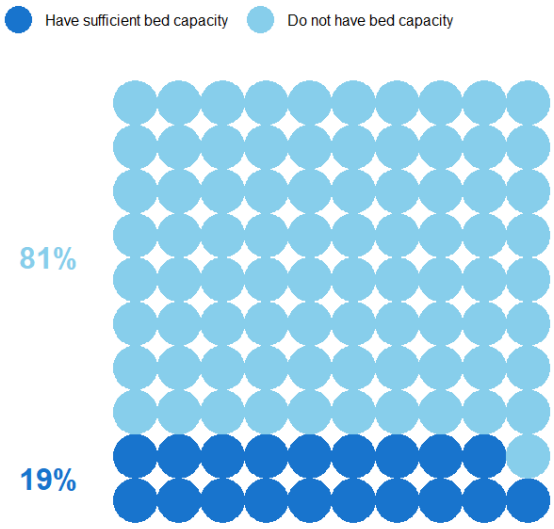
Table 3.1. Importance, Preparedness, and Financing of Crisis Care

Questions and Response Categories	Number of Respondents	Percentage
How important do you think it is that your agency be prepared for the transition to 988?		
Not at all important	1	0.56%
A little bit important	4	2.22%
Somewhat important	25	13.89%
Very important	150	83.33%
Has your agency been involved in the development of a strategic plan for the transition to 988?		
Yes	73	40.56%
No	92	51.11%
I don't know	12	6.67%
Missing	3	1.72%
Does the strategic plan include:		
A plan for starting (or maintaining operations at) one or more 24/7 crisis call centers or hotlines	61	83.56%
A plan to engage diverse stakeholders in conjunction with 988 emergency response	57	78.08%
A plan for service coordination between 988 and 911 emergency response	49	67.12%
A plan for infrastructure in conjunction with 988 emergency response	47	64.38%
A plan for clinical services in conjunction with 988 emergency response	44	60.27%
A plan for educational and marketing materials about the introduction of 988	42	57.53%
A plan for clinical personnel in conjunction with 988 emergency response	37	50.68%

NOTE: Percentages are based on total respondents, not just those who reported having a strategic plan. The percentages on what the strategic plan includes is restricted to the sample of respondents that reported having a strategic plan (n = 73).

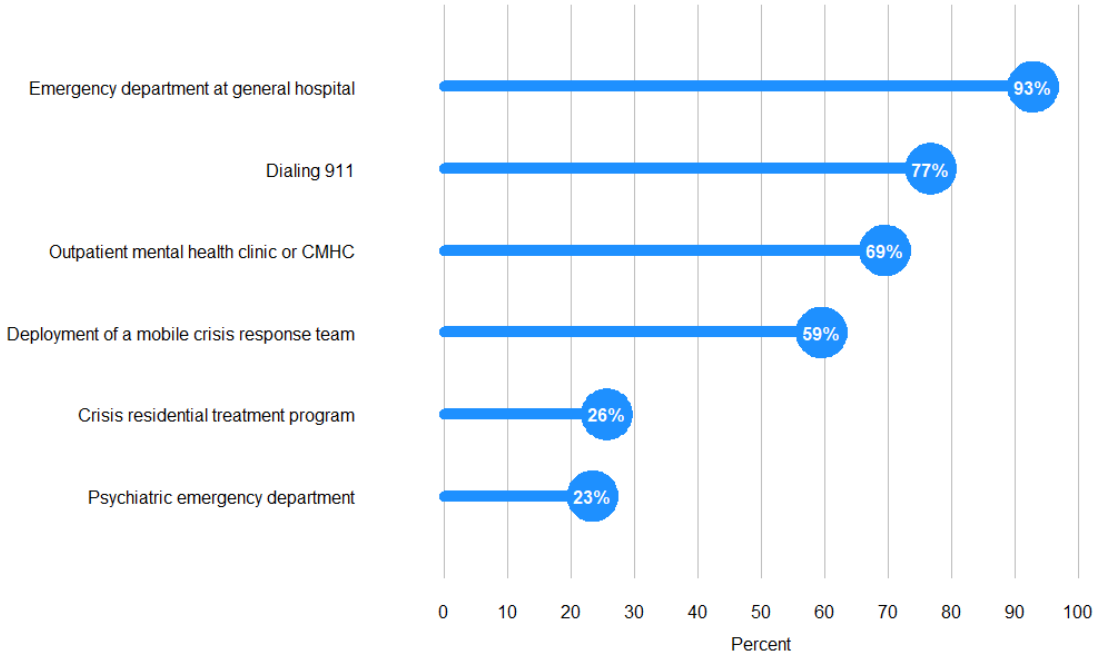
Relatedly, we inquired about the current capacity of psychiatric beds in a jurisdiction and about alternative entry points for someone receiving care for a mental health emergency in the respondent's jurisdiction. Whether the locality has a strategic plan could be influenced by what the current bed capacity is for the jurisdiction and by the supply for treatment in the jurisdiction. In Figure 3.1, we illustrate that around 81 percent of respondents' jurisdictions did not have sufficient crisis stabilization psychiatric bed capacity. These beds are critical because they serve as the front line of care for people who call in with a serious mental health crisis, and they are expected to be needed once 988 is rolled out. In Figure 3.2, we report the major mental health emergency entry points for someone receiving care for a mental health emergency in survey respondents' jurisdictions. Nearly all respondents (93 percent) reported that emergency departments at a general hospital were a major entry point for someone receiving care for a mental health emergency. Dialing 911 (77 percent), outpatient mental health clinics or community mental health centers (77 percent), and/or deployment of a mobile crisis response team (59 percent) each were reported by over one-half of respondents. The least-reported entry points were crisis residential treatment programs (26 percent) and psychiatric emergency departments (23 percent). We expect that the rate for psychiatric emergency departments is low because there are relatively few specialty psychiatric emergency departments.

Figure 3.1. Status of Crisis Stabilization Psychiatric Bed Capacity in Agencies' Jurisdiction



NOTE: The survey question asked was: "Currently, what is the status of crisis stabilization psychiatric bed capacity in your agencies' jurisdiction?"

Figure 3.2. Major Entry Points for Someone Receiving Care for a Mental Health Emergency



NOTE: The survey question asked was: "Currently, what are the major entry points for someone receiving care for a mental health emergency in your agencies' jurisdiction (check all that apply)? CMHC = community mental health center.

Interview Responses

Sources of Guidance Used for 988 Planning

As part of our interviews, we asked interviewees to share their sources of guidance for planning the transition to 988. Most commonly, interviewees received guidance from a state-level department of mental or behavioral health or from county directors of mental or behavioral health. A few interviewees participated in a state-level 988 planning committee or task force, although doing so was not always associated with a greater feeling of preparedness for the transition to 988. Interviewees also highlighted a variety of national sources of information including SAMHSA, Vibrant Emotional Health (the administrator of the NSPL), and the National Council for Mental Wellbeing—specifically, their Roadmap to an Ideal Crisis System.

Although interviewees relied on a variety of sources for guidance, a few interviewees expressed concern about the lack of consistent guidance provided by their state (as noted by county and regional officials) or the federal government. This concern was shared by interviewees from both more-prepared and less-prepared jurisdictions. For example, one interviewee, who had indicated their jurisdiction was more prepared for 988, said,

> I don't feel like there was a lot of federal guidance on this, and I feel like there should have been more. We have a federal initiative being handed down, and we were told that—I felt like we were handed coloring sheets and a box of crayons and [like they said] "here you go." I think when you're rolling out something like this, when it affects our folks with mental health, we have to be—we have to do it with intention, and we have to make sure that people are consistent.

Another interviewee from a less-prepared jurisdiction said,

> I feel like I have a reasonable grasp of what [988] is meant to be, and then I have a reasonable grasp of our local function of what we do and how we do it, and then I just have a giant disconnect between the concept over here [of 988 and the continuum of services] and the reality over here.

Other county and regional representatives expressed a need for more lines of communication and more data- and information-sharing from their state and for more sharing of best practices from other states and counties.

Collaborations in Support of 988 Implementation

We also asked interviewees to describe the types of agencies with which they had collaborated in planning for the transition to 988. Nearly all had been in communication with state and county departments, particularly departments of mental or behavioral health, emergency medical services (EMS), and law enforcement. Interviewees also frequently emphasized the importance of collaborating with local service providers, often relying on their expertise in the strategic planning process. These organizations included crisis line operators and crisis service providers, Certified Community Behavioral Health Clinics, hospitals, and homeless service providers and shelters. Although many interviewees were working closely with law

enforcement on preparing for 988, some people noted a lack of concrete plans on service coordination between 988 and 911.

Role in Public Education and Marketing of 988

Relatedly, interviewees expressed uncertainty about public education and marketing of 988. Some interviewees described local plans to market use of 988—for example, one interviewee shared plans of publicizing 988 on the county's website and social media, and another shared plans of promoting through their region's faith-based community. However, others felt there was little guidance on public education—specifically, whose role it is to educate the public and how to best do so. There was uncertainty about whether anything (and if so, what) would be publicized at the state and national levels and how that might affect call volume. Others expressed concerns about public confusion on the purpose of 988—for example, if it would be used as a warm line (i.e., a help line for people experiencing non-emergency mental health concerns) rather than a crisis line. Many jurisdictions were also determining how to handle existing local crisis line numbers, with some jurisdictions eventually transitioning to using only 988 for mental health emergency calls and others keeping their existing local phone number operational but routing calls to Lifeline network call centers to avoid confusion among residents.

Financing

Survey Responses

Next, we report on responses related to the financing of 988 and whether respondent agencies and jurisdictions had a budget to support 988 operations (Table 3.2). Only 16 percent of respondents reported that their agency had established a budget for the transition and long-term support of 988. We conclude that there is likely not a sufficient and clear source of funding because relatively few survey respondents reported having one.

Of those with a budget (n = 29), most (72 percent) reported that they have a clear and sufficient source of funding for one or more local or regional 24/7 crisis call centers or hotlines. Fewer than one-half of those with a budget reported having a clear source of funding for clinical personnel in conjunction with 988 emergency response, clinical services in conjunction with 988 emergency response, educational and marketing material about the introduction of 988, or infrastructure in conjunction with 988 emergency response. Relatedly, we inquired about whether the state in which respondent agencies resided had passed legislation imposing a 988 surcharge, similar to the 911 surcharge that some states use to finance 911 call systems. Respondents rarely reported (12 percent) that there was a 988 surcharge established.

Table 3.2: Budgeting and Financing for 988

Response	Number of Respondents	Percentage
Has your agency established a budget for the transition and long-term support of 988?		
Yes	29	16.11%
No	133	73.89%
I don't know	14	7.78%
Missing	4	2.22%
Does the budget include a sufficient and clear source of funding for:		
One or more local/regional 24/7 crisis call centers or hotlines	21	72.41%
Infrastructure in conjunction with 988 emergency response	14	48.28%
Clinical services in conjunction with 988 emergency response	13	44.83%
Clinical personnel in conjunction with 988 emergency response	12	41.38%
Educational and marketing materials about the introduction of 988	12	41.38%
Service coordination between 988 and 911 emergency response	7	24.14%
Has the state in which your agency resides passed legislation that imposes a 988 surcharge?		
Yes	21	11.67%
No	70	38.89%
I don't know	85	47.22%
Missing	4	2.22%

NOTE: Percentages for the "sufficient and clear source of funding" are limited to the 29 respondents that reported having a budget for the transition and long-term support of 988.

Interview Responses

The qualitative interviews provided an opportunity to learn more about how respondents' jurisdictions funded 988 implementation. We asked about the hotline itself and about mobile emergency and crisis emergency stabilization services. Several funding models were described, with many jurisdictions drawing on multiple sources of funding to support the continuum of emergency mental health care (i.e., the 988 hotline, mobile emergency response, and emergency stabilization and receiving services). For example, multiple jurisdictions received state funding in some capacity (e.g., fully funding services, partially funding services, funding for one additional staff member) to support 988 implementation and the continuum of care. Specific to the hotline, some jurisdictions received local funding or Vibrant Emotional Health planning grants, which have typically have been between $100,000 to $200,000 per state[31]—although SAMHSA recently announced further investments totaling over $100 million.[32]

Regarding emergency mobile response, funding sources described included grant funding, funding from other local agencies (e.g., sheriff's departments, which may have supported co-response models), funding from the American Rescue Plan Act, county taxes, and behavioral health funding allocated at a state level. Finally, in terms of mental health emergency stabilization services, several jurisdictions reported that Medicaid and private insurance were used to fund services. Other sources included funds from the local hospital, tax-levied funds, and funding allocated at a state level for behavioral health services.

Infrastructure

Survey Responses

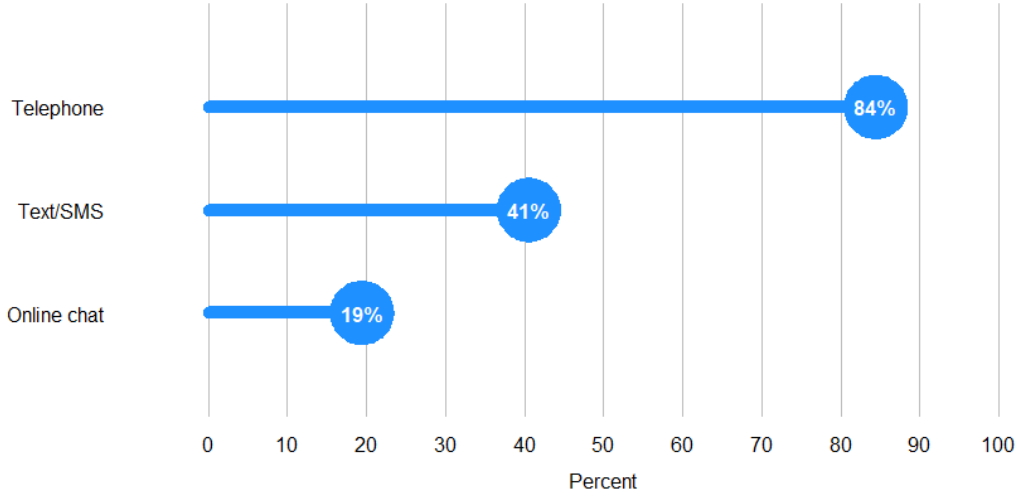
Analysis related to infrastructure to support 988 primarily focused on the presence of local or regional crisis call centers and/or hotlines and their characteristics. The results are reported in Table 3.3. The survey posed questions related to the personnel of the crisis call center or hotline. More than one-half (63 percent) of all survey respondents reported that their hotline was staffed by clinical personnel who are available 24/7. The personnel were mostly paid (49 percent) or a combination of paid staffers and volunteers (27 percent). We also inquired about whether staff was trained in Applied Suicide Intervention Skills Training (ASIST), a two-day training program that teaches how to assist those at risk for suicidal thinking, behavior, or attempts.[33] Responders who have had the ASIST training have been shown to have better caller outcomes.[34] Around 59 percent of respondents reported that staff are trained in ASIST. Only 19 percent of respondents reported that any of the staff was required to speak two or more languages fluently. Almost one-half (48 percent) of respondents reported that at least one of their crisis call centers or hotlines was part of the Lifeline network. Around 20 percent of respondents reported that they did not know whether the number that services their jurisdiction is part of the Lifeline.

Most jurisdictions reported having implemented training for law enforcement officials on crisis intervention (79 percent) and/or collaboration between law enforcement and behavioral health systems (78 percent). Just over one-half (54 percent) of respondents stated that their agency's jurisdiction had engagement of peer staff to support individuals with emergency and urgent mental health needs. Fewer than one-half of respondents reported having a short-term residential crisis stabilization program (48 percent), availability of crisis beds to support community needs (40 percent), and/or urgent care units for mental health (28 percent). Seven percent of survey respondents reported offering each of the eight services. Similarly but at the other end of the spectrum, 8 percent offered none of them. In Figure 3.3, we visually depict the modes of communication that are supported by the crisis call center or hotline. The most common form was telephone (84 percent), followed by text or SMS (41 percent), and finally online chat (19 percent).

Table 3.3. Infrastructure for 988

Response	Number of Respondents	Percentage
Are one or more crisis call centers/hotlines part of the Lifeline network?		
Yes	87	48.33%
No	27	15.00%
I don't know	39	21.67%
Missing	27	15.00%
Does/do the crisis call center(s) or hotline(s) have staffing by clinical personnel 24/7 for 365 days each year?		
Yes	114	63.33%
It varies within my jurisdiction	17	9.44%
No	10	5.56%
I don't know	12	6.67%
Missing	27	15.00%
Are the crisis call center staff paid personnel or volunteers?		
A combination of paid personnel and volunteers	48	26.67%
Paid personnel	89	49.44%
Volunteers	2	1.11%
I don't know	14	7.78%
Missing	27	15.00%
Are crisis call center/hotline staff trained in applied suicide intervention services training (ASIST) or equivalent in order to perform suicide risk screening, assessment and safety planning with callers?		
Yes	106	58.89%
No	3	1.67%
I don't know	44	24.44%
Missing	27	15.00%
Are any crisis call center/hotline staff required to speak two or more languages fluently, such as Spanish?		
Yes	34	18.89%
No	54	30.00%
I don't know	65	36.11%
Missing	27	15.00%
For the most part, does the geographic area covered by your agency's jurisdiction CURRENTLY include:		
Training for law enforcement officials on crisis intervention (CIT) or equivalent	143	79.44%
Collaboration between law enforcement and behavioral health systems	141	78.33%
Trainings for crisis responders on trauma-informed care?	121	67.22%
Engagement of peer staff to support individuals with emergency mental health needs	98	54.44%
Centrally deployed, 24/7 mobile crisis response teams that include licensed clinicians	90	50.00%
Short-term residential crisis stabilization program(s)	87	48.33%
Availability of crisis beds to support community needs	72	40.00%
Urgent care units for mental health	51	28.33%

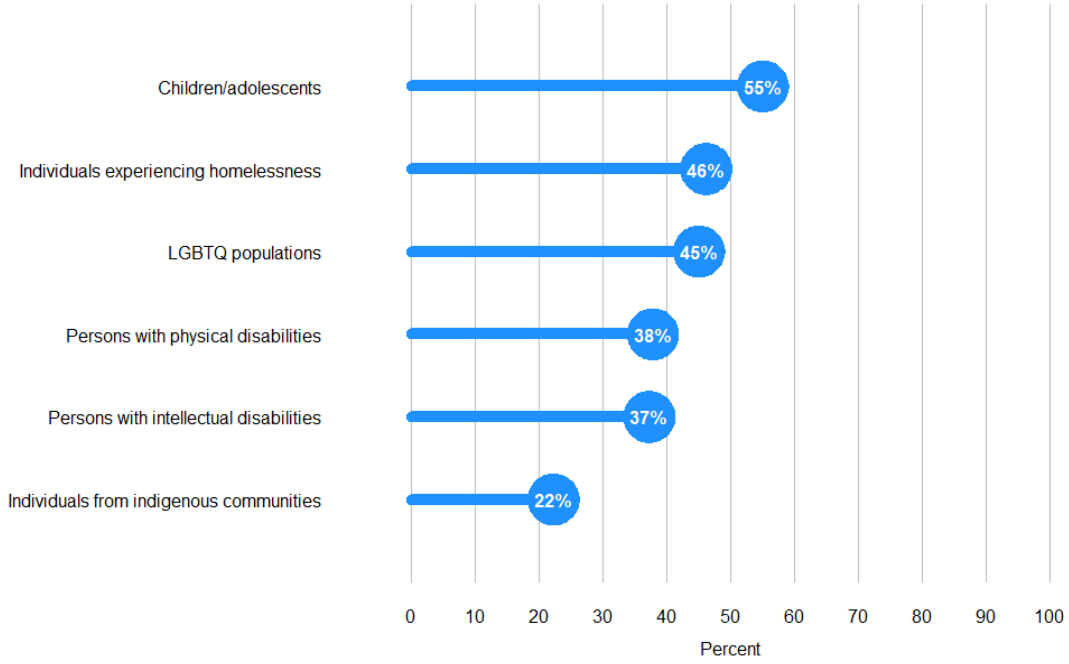
Figure 3.3. Modes of Communication Supported by Crisis Call Center



NOTE: The survey question asked was: "Which modes of communication are supported by this/these crisis call center(s) or hotline(s) (check all that apply)?"

Finally, we inquired about whether the crisis call center or hotline staff were trained to interact with special populations. Less than one-quarter (22 percent) of respondents reported that they did have staff trained to interact with individuals from indigenous communities (Figure 3.4). A little over one-third of survey respondents reported that their staff were not trained to engage effectively with either persons with physical disabilities (38 percent) and/or intellectual disabilities (37 percent). A little less than one-half of survey respondents reported that their staff was trained to engage with the unique needs with LGBTQIA+ populations (45 percent) or individuals experiencing homelessness (46 percent). Finally, more than one-half (55 percent) of survey respondents reported that they did have staff specially trained to interact with children or adolescents.

Figure 3.4: Crisis Call Center Staff Specifically Trained to Interact with Special Populations



NOTE: The survey question asked was: "Are crisis call center/hotline staff specifically trained in how to interact with special populations, including:"

Interview Responses

Local Approach to 988 Calls

We asked interviewees how 988 calls from their jurisdiction would be handled. Some interviewees noted that their county or region has a local Lifeline network call center, whereas others will be relying on a call center in a different county or region or a call center operated at the state level. Administrators in jurisdictions that already possessed a local Lifeline operator noted this as a benefit for 988 preparedness. For example, they felt more confident that Lifeline staff would be aware of local resources, knew that staff were already prepared to handle the types of calls that will be made to 988, and have been able to engage in planning for the interface between 911 and 988.

By contrast, jurisdictions that will rely on a regional or statewide call center expressed concern that Lifeline staff will not be aware of local resources, with one interviewee describing the state-level or regional call centers as "disconnected" from county operations. It was also more challenging for those interviewees to comment on how prepared those regional or statewide call centers are for the transition to 988 because they had less visibility into the planning and preparedness process. However, some did express concern about the preparedness of these state or regional call centers; for example, one interviewee described the transition to 988 as "an extremely large lift" for their centralized call center, and another noted that they were not "100 percent confident" their call center would be prepared because "change is very hard for

people." Some also raised questions about how their local call center would interface with 988 when it goes live.

Considerations for Special Populations

Our interviews provided additional insight into the nature of planning for special populations. All of the interviewees noted that their agencies were aware of the specialized needs of these groups. Some interviewees indicated that they have developed special services for youth, such as mobile emergency response teams specifically focused on youth. A small number said that they will be able to leverage local service providers with expertise in serving subpopulations (e.g., LGBTQIA+ populations, veterans). However, many noted that there are not specific plans in place to serve these groups.

We also asked interviewees whether there were additional communities or populations that they thought might be more challenging to serve via a call center, mobile crisis response team, or crisis stabilization services. Additional populations included those who might be hesitant to call 988 and engage with government-funded services or services outside of their community, such as Amish communities, immigrants and migrant workers, and those with mixed documentation status. Other communities were described as more challenging to serve for logistical reasons; for example, interviewees from large rural areas noted that mobile crisis teams can have a difficult time reaching certain areas of their counties in a timely manner. Another described challenges finding translators to serve those who do not speak English. Although there was a general lack of concrete plans to improve service provision to underserved communities, nearly all interviewees recognized the need to do so. For example, one interviewee remarked,

> [we need to be] building capacity within those [crisis] services, including 988, that are more racially, linguistically, and culturally responsive.

Service Coordination

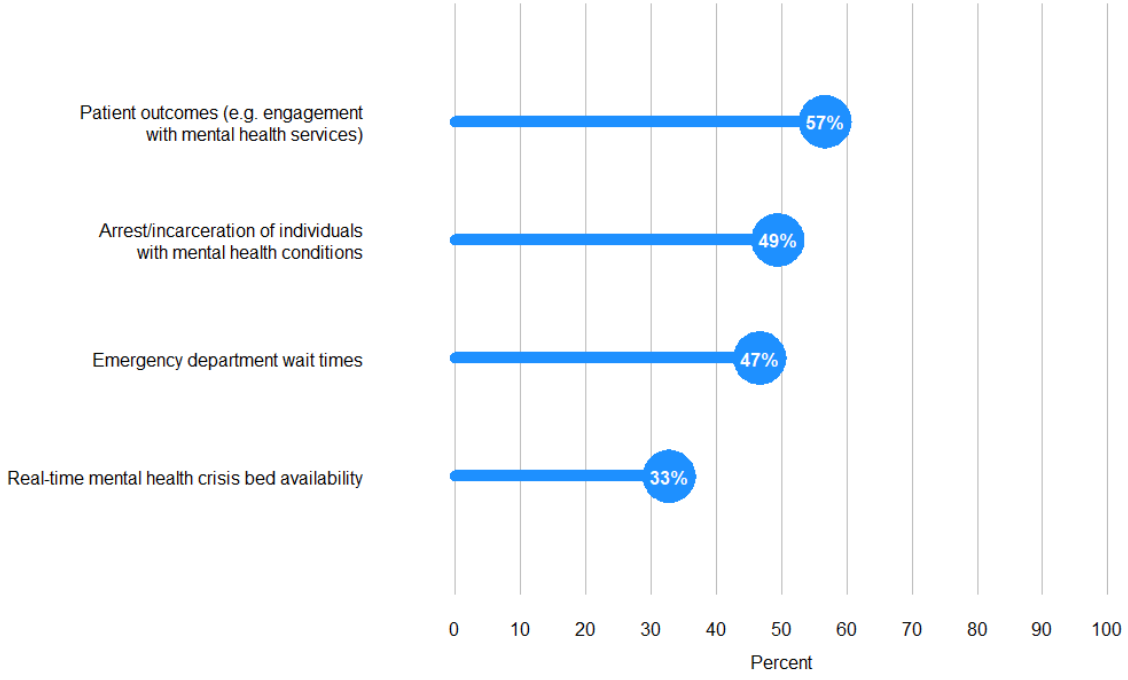
Survey Responses

The final survey domain asked questions related to data collection by respondent agency and/or jurisdiction and related to on service coordination (see Figure 3.5). We found that the most frequently collected data pertained to patient outcomes (57 percent) followed by arrest or incarceration of individuals with mental health conditions (49 percent) and emergency department wait times (47 percent). Only one-third of respondents (33 percent) reported that they collected data on real-time mental health crisis bed availability.

Figure 3.6 illustrates data collection related to crisis call centers or hotlines within respondent jurisdictions. Around 72 percent of respondents reported that they collected data on call volume, and 65 percent of respondents reported that they collected information on the primary reason the client was contacting the crisis call center or hotline. About one-half of respondents (53 percent) collected data on the number of referrals to specialty care or hospitals, time to answer (51

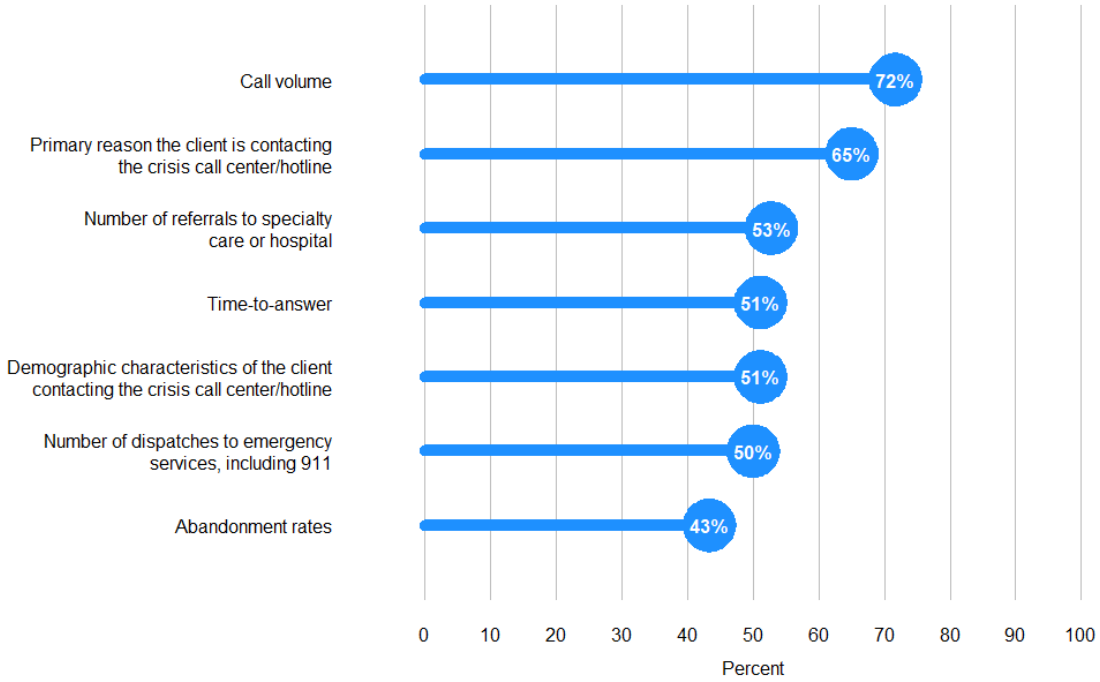
percent), demographic characteristics of the clients contacting the crisis call center or hotline (51 percent), and/or the number of dispatches to emergency services (50 percent). Data collection rates were lowest for abandonment rates (43 percent). Finally, it was rarely reported (22 percent) that crisis call centers or hotline respondents can schedule intake and outpatient appointments on behalf of individuals in need (Figure 3.7), though 26 percent of survey respondents stated that it varied within their jurisdiction.

Figure 3.5: Current Data Collection Within the Agency's Jurisdiction



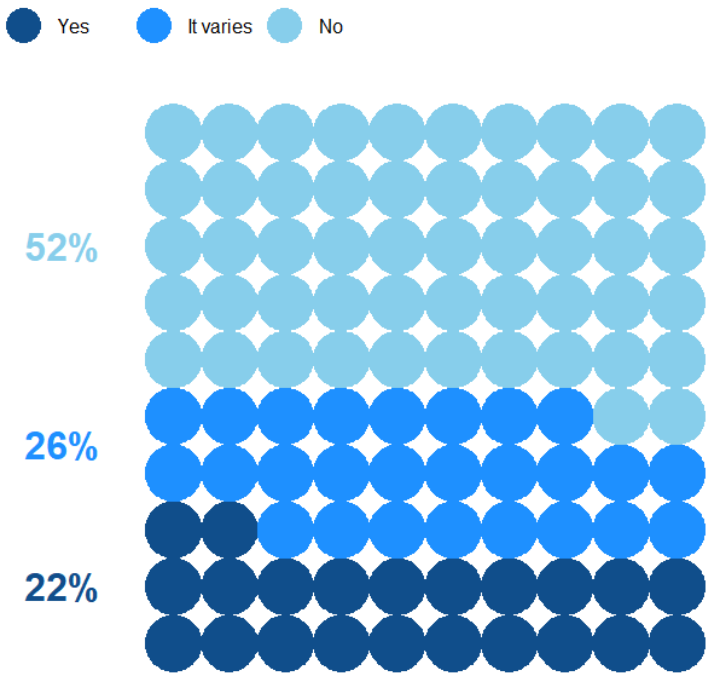
NOTE: The survey question asked was: "Does your agency's jurisdiction CURRENTLY collect data on [TOPIC]?"

Figure 3.6: Current Crisis Call Center or Hotline Data Collection



NOTE: The survey question asked was: “Does/do the crisis call center(s) or hotline(s) within your agency’s jurisdiction collect data on: [topic].”

Figure 3.7. Connection of Crisis Call Center or Hotlines to Emergency Mental Health Services



NOTE: Survey question asked was "Does the geographic area covered by your agency's jurisdiction CURRENTLY have one or more local/regional crisis call centers or hotlines that connects individuals in emergencies with mental health services?"

988 Planning Strengths, Challenges, and Near-Term Priorities

Interview Responses

As a conclusion to our interviews, we asked interviewees to describe what they perceive to be the primary limitation or challenge and primary strength of their jurisdiction's 988 plans. Though we purposely sampled interviewees from more-prepared and less-prepared jurisdictions, we found similar responses emerging across interviewees.

Primary Limitations and Challenges to 988 Implementation Plans

Our question regarding primary limitations was intended to identify the areas that interviewees have found to be most challenging as they prepare for the launch of 988. The most common response was workforce and staffing challenges. Interviewees highlighted workforce shortages and difficulties both hiring and retaining staff. This challenge seemed to be common across different types of jurisdictions; for example, an interviewee in a rural area noted that it can be more difficult to find staff willing to relocate to their area than it is to find people who will

work in larger metropolitan areas. However, an interviewee from a state-level agency also indicated that having sufficient workforce is a barrier throughout their state. As one interviewee stated,

> Community negotiations and partnerships, they're actually easy compared to finding and hiring and keeping staff.

The next most common challenge identified by interviewees was funding or lack of resources. This issue was raised most often by interviewees from less-prepared jurisdictions, though one interviewee from a well-prepared jurisdiction highlighted a lack of financial support for their hotline and mobile crisis services. Funding was often raised in conjunction with staffing issues. For example, as one interviewee stated,

> I think, if we were adequately funded, I believe . . . we would have the skillset to do an excellent job.

A small number of interviewees highlighted other limitations of their 988 plans, including a lack of unified planning and strong sources of guidance and a need to ensure proper handoff and care coordination. For example, one interviewee expressed concern about what might happen if a Lifeline call was routed out of state and whether there would be sufficient knowledge of local resources to make an appropriate referral. A small number of interviewees also highlighted challenges reaching certain areas of their jurisdiction as one of their primary limitations; this was particularly an issue in rural jurisdictions.

Primary Strengths of 988 Implementation Planning

We also asked respondents to describe the primary strength of their jurisdictions' 988 plans. This question was not intended to capture all aspects of a "successful" planning process; rather, it was to understand what interviewees perceived as one or two key strengths of their jurisdictions' plans. The most common response was collaboration and partnerships. Both more-prepared and less- prepared counties noted that their interagency collaborations have been a critical aspect of their planning, including partnerships with behavioral health providers, other county agencies (e.g., child welfare, law enforcement, criminal justice agencies), hospitals, and local leadership. An interviewee from a less-prepared jurisdiction noted,

> I am confident that we can build, you know, a good system and that we'll have the support and engagement of our partners.

Some interviewees also described the capabilities and expertise of their current behavioral health providers as a key strength. For example, one interviewee noted that having a local provider as the 988 hotline provider will ensure that they are familiar with local resources, which will benefit callers. Similarly, another interviewee described their 988 and mobile crisis provider as "well-experienced," noting,

> [it] really has the structure, stability, resources to be able to provide the service . . . . That's one of the reasons we selected this provider. They have their fingers in pretty much all we do.

Another praised the skill of their long-standing mental health emergency staff:

> We have people who have worked in crisis intervention for decades who clearly know the law around working with people under the [State Mental Health Legislation]. They also are very gifted in knowing what resources exist in the community and how to access those resources. They're good at doing follow-up after a call if the person has been released. So I feel like we have a good pool of people who know their jobs and do them well.

A small number of interviewees also indicated that they have data to support planning and decisionmaking, which they perceive as a strength.

Priorities Before the Launch of 988

Finally, we asked interviewees to reflect on the most important goal for their jurisdiction prior to July 16, 2022, when 988 launches. Nearly one-half of the respondents noted that there needs to be more education of the public to ensure that they are aware of 988. Some interviewees described local efforts that they plan to initiate from within their agency (e.g., promoting 988 on their agency's website and through social media), but one interviewee also noted that they wished there were more formal federal guidance to states on how to raise awareness of 988 at the local level. A small number of respondents indicated that their jurisdictions are focused on formalizing policies and procedures related to 988 and the continuum of care—for example, establishing clear protocols, established lines of communication, and memoranda of understanding between agencies. This also included developing plans for the interface between 988 and 911 or local crisis lines. A small number of respondents also expressed a desire for their agency to have greater involvement in state or regional planning efforts, such as the following observation:

> So far, I'm not at that table, so I'm not sure what's happened. I don't even know who should be at that table, and whose responsibility it is to convene the table.[35]

Other responses included the need to formalize additional funding sources and ensure there is an adequate workforce.

A summary of challenges, strengths, and near-term priorities is summarized in Table 3.4.

Table 3.4. Summary of Challenges, Strengths, and Near-Term Priorities for 988 Planning

Theme	Summary of Responses
Limitations and challenges to 988 implementation plans	• Workforce shortages • Difficulty retaining staff • Lack of funding • Lack of coordinated planning efforts • Need for concrete guidance • Concerns about care coordination
Strengths of 988 implementation planning	• Collaborations and partnerships with local agencies and providers • Capable behavioral health providers with needed expertise • Data to support decisionmaking
Priorities before the launch of 988	• Raising public awareness of 988 • Formalizing policies and procedures related to 988 and the continuum of emergency mental health care • Participating in regional or state planning efforts • Formalizing funding • Improving staffing levels

Chapter 4. Conclusions and Recommendations

In this project, we conducted a survey of behavioral health program directors throughout the United States, receiving responses from 180 individuals who represented jurisdictional coverage of more than one-third of the U.S. population and 23 states, as well as semistructured interviews with a subset of 15 interviewees from jurisdictions that were identified, based on their survey responses, as more or less prepared for 988 implementation. The launch of 988 has the potential to be an important milestone in the nation's approach to mental health emergency response. Calls to the Lifeline networks are expected to increase substantially, even in the first year after the launch of 988,[36] and guidance from organizations such as SAMHSA and NASMHPD has encouraged jurisdictions to use the launch of 988 as an opportunity to evaluate their current continuum of emergency care and consider how the increased volume of calls may necessitate improvements to existing emergency care options.[37]

Recommendations

Our survey suggests that local and state behavioral health leadership appreciates the importance of preparing for the launch of 988; however, they did not report that their jurisdictions had taken the steps to be prepared in terms of strategic planning and financing, and jurisdictions lack sufficient infrastructure and service coordination. Here, we offer four major recommendations for behavioral health program directors to prepare for 988 and to support successful mental health emergency response systems.

Coordinate with Local Institutions to Develop a Strategic Plan That Enhances Mental Health Emergency Response—and Includes Stable Sources of Revenue

Just over one-half of respondents reported that their agency had not been involved in the development of a strategic plan. On the one hand, this finding is somewhat surprising: Strategic planning is a routine process in most public organizations, particularly in anticipation of large structural changes.[38] On the other hand, the Federal Communications Commission approved 988 in July 2020 during the height of the COVID-19 pandemic,[39] and government agencies have been largely preoccupied with their response to that crisis. This isn't to say that jurisdictions haven't been engaged in 988 planning efforts; during interviews, multiple respondents reported receiving guidance from state-level agencies, participating in planning committees or task forces, and collaborating with leaders from other counties. Interviewees also described their collaborations with other local stakeholders, such as law enforcement and medical centers. However, many interviewees still described their agency as unprepared with respect to staffing,

financing, infrastructure, and coordination of services based on the survey, and this may point to a need to formalize a strategic plan.

Moreover, in practical terms, the launch of 988 simply means that an additional phone number (988) can be used to reach the NSPL. If local jurisdictions fail to expand their mental health emergency response infrastructure despite the potential for an increased volume of calls, it is essentially continuing the status quo. This status quo may be problematic from the perspective of health care delivery, and overstretched systems may lack the resources to alter their current trajectory, which could have negative effects on the availability of mental health services and outcomes. Moreover, if calls go unanswered or hotline staff are unable to connect callers to needed local resources, people may stop trusting 988 as a credible resource.

This implies that behavioral health agencies should develop strategic plans that have buy-in from institutions that are engaged in emergency response—from law enforcement to nonprofit social service agencies. Agencies may lack the ability to innovate prior to the launch of 988, but a three-to-five-year plan with interim benchmarks could serve as a valuable compass that orients institutions toward common goals. Our interviews suggested that, at least in part, needed resources might include more-concrete guidance on how to plan for and support an expanded continuum of care, especially for jurisdictions facing geographic challenges such as counties that have extremely rural and remote areas. However, it also means having sufficient funds to support such services.

Critical in this equation would be the development of a budget that has stable sources of revenue. Fewer than one in six respondents (16 percent) reported that their agency had a budget to support 988 operations; among those with an earmarked budget for 988, fewer than one-half reported a clear source of funding for clinical personnel or services.

In anticipation of the rollout of 988, the federal government has allocated approximately $282 million for strengthening network operations and strengthening local crisis call center capacity.[40] Numerous grants have also been awarded through Vibrant Emotional Health, which will serve as the nonprofit administrator of 988.[41] However, these sources of funding are not sustainable in the long run. This finding was supported by our interviews: Several jurisdictions have received grants to support 988 implementation, but interviewees also described efforts to pool a variety of funding sources to sufficiently support 988 and their continuum of emergency mental health care—including local tax levies, Medicaid, and private insurance. Some raised concerns about the sufficiency and sustainability of these fundings models. Looking to 911 as a corollary, most states have embedded a surcharge for 911 callers, the proceeds of which are directed to support 911 and emergency service operations.[42] Fewer than one in eight individuals (12 percent) identified an equivalent financing mechanism in their jurisdiction for supporting 988. This mechanism offers at least one avenue for continuous support of 988 services, if legislatures can enable it.

Conduct a Needs Assessment for Mental Health Infrastructure and Personnel and Examine Whether Recently Passed Federal Legislation Could Support Investments in It

Prior research has emphasized the importance of a mental health care continuum in which emergency response is one component.[43] From this vantage point, dialing 988 constitutes the first step in linking prospective clients to appropriate services. Yet we observed that fewer than one-half (48 percent) of respondents' jurisdictions contained short-term crisis stabilization programs, and roughly one-quarter (28 percent) possessed urgent care units for mental health. Sixty percent reported having a shortage of crisis beds. Our interviews also indicated that insufficient mental health personnel may continue to be an obstacle—a concern that is reflective of a nationwide mental health workforce shortage.[44]

If jurisdictions are already struggling to meet the demand for mental health crisis services, it raises important concerns about how they will address any increases in demand that might result from the launch of 988. It also highlights the importance of investing in capacity along the full continuum of care to ensure that patients are able to receive longitudinal care. A longer-term strategy would be to conduct a comprehensive needs assessment for local mental health infrastructure—ranging from school-based services for children and adolescents to community residential facilities for individuals with long-term needs. Although the development of new infrastructure is costly, the American Rescue Plan Act and the Infrastructure Investment and Jobs Act,[45] both signed in 2021, contain tens of billions of dollars for states to expand their mental health infrastructure.

Although adequate funding may be one way to boost the mental health workforce, our interviewees suggested that this alone is unlikely to solve the problem. One option for increasing the workforce, which is also supported by 988 guidance documents,[46] is to increase integration of peer support staff into the mental health emergency response.

Ensure That Local Mental Health Emergency Hotlines Follow Best Practices, Collect Information on Performance and Are Part of the Lifeline Network

A large majority—85 percent—of respondents stated that their jurisdiction currently operates a mental health emergency response hotline or call center. However, fewer than one-half (48 percent) of respondents were confident that the hotline was part of the Lifeline network, and few incorporated online chat and text/SMS features that are preferred modes of communication among adolescents and young adults. In interviews, respondents whose jurisdiction possessed a local Lifeline call center were more confident that there was sufficient capacity to handle local calls, in terms of both making local connections to care and having the ability to manage an increased volume of calls once 988 is implemented. Those without a local call center expressed concerns about the ability of a regional or statewide call center to be aware of local resources;

moreover, places with an existing local hotline highlighted uncertainty regarding its interface with 988.

Of those jurisdictions with hotlines that are either not part of the network (15 percent) or whose respondents were unsure about the hotline's relationship to the Lifeline network (22 percent), an important next step would be to research the requirements to create this link. This is important because call centers that are part of the Lifeline network perform better, as measured by reducing the caller's distress, than those that were not.[47]

Of those jurisdictions with mental health emergency hotlines, over three-quarters (78 percent) reported ongoing collaborations with law enforcement as well as CIT or equivalent training for law enforcement officials. However, without institutional change, training alone is unlikely to have a major impact. Public health officials have repeatedly stressed the importance of bidirectional communication between 911 and 988 operators and response staff:[48] Many individuals dialing 911 may be unfamiliar with 988 as an alternative that more appropriately meets their needs; and callers of 988 may also require responses from law enforcement officials, depending on the circumstances.

When inquiring about data collection to monitor and aid hotline performance, we identified several shortcomings. Most notably, a minority of jurisdictions track availability of mental health services that could aid callers, such as crisis bed availability, and roughly one-half of hotlines did not capture data on time to answer, dispatches to 911, or call abandonment rates. Although some aspects of information may be challenging to gather (e.g., time to answer), others appear more straightforward (e.g., call abandonment)—requiring only that hotline respondents complete a brief form after each call. Such actions would appear to be low-hanging fruit that, if tracked, could allow jurisdictions to know whether and to what extent hotlines are successfully meeting the needs of callers.

Attend to Equity Considerations, Including Identifying Populations That May Have Unique Intervention Needs or May Have Barriers to Accessing Emergency Mental Health Services

A key issue that emerged from the surveys and interviews pertains to the ability of jurisdictions to serve populations that might have special needs. About one-half (55 percent) of survey respondents noted that their call center staff were trained to interact with children or adolescents; fewer than half were trained to interact with other groups, such as LGBTQIA+ populations or people from indigenous communities. Interviewees highlighted other subpopulations with potentially unique needs, such as veterans and immigrant populations. Importantly, many of these groups may be especially at-risk for mental health emergencies,[49] highlighting the importance of ensuring that providers are well trained to serve these groups and that culturally competent providers are available in the local community. Interviewees also noted that some of these groups are already difficult to engage in mental health services—for example, because they feel more comfortable relying on their community to handle mental health concerns

rather than calling a hotline, experience higher levels of stigma for seeking mental health treatment, or are mistrustful of government-funded services. Trained call staff are important, but so are inroads that increase individuals' willingness to use mental health emergency services in the first place. Collaborating with credible messengers and members of these difficult-to-reach communities may be one way to address this concern.

Study Limitations

We note several study limitations. First, our survey response rate was 26 percent. Although this figure is in line with other online surveys,[50] it nevertheless represents a self-selected sample that may differ from a random cross-section of jurisdictions throughout the United States. However, our observations provide a glimpse into the status of jurisdictions representing a large cross section of the United States, and therefore may be valuable in its own right. Moreover, although nonrespondents may differ from respondents, it is possible that respondents were more aware of the 988 policy and therefore more prepared than nonrespondents. Therefore, our results may be an overestimate of preparedness for each of the four domains.

Second, we were unable to validate respondents' expertise beyond targeting government officials likely to be involved in 988 implementation and other behavioral health services policies. We limited distribution of the survey to lead administrators of public sector behavioral health agencies, partly to ensure that respondents were well positioned to answer survey questions. However, for a few specific questions—e.g., "Has the state in which your agency resides passed legislation that imposes a 988 surcharge?"—a plurality of respondents reported "I don't know." Wherever relevant, we have sought to make this information transparent, and we see this as informative of the types of knowledge that program directors have (or do not have) at their fingertips.

Third, our survey assumes that jurisdictions either own or coordinate with crisis call centers or hotlines. But that may not be the case, given that there are various types of models for financing and management of crisis call centers and hotlines.[51] We must also acknowledge that this survey was conducted in February and March 2022. Survey responses would likely evolve as the launch of 988 approaches.

Finally, regarding the interviews, we intentionally selected interviewees from more- and less-prepared jurisdictions. Therefore, these findings are not necessarily generalizable to jurisdictions that fall somewhere between those two extremes. In addition, only 13 percent of survey respondents expressed willingness to participate in an interview, and those individuals represented only ten states.

Conclusion

Through this survey study, we received responses from 180 behavioral health program directors of states and counties around the United States. Although many reported a lack of

preparedness for 988, these findings underscore specific areas for greater investment, such as infrastructure that would allow callers to connect with local services in a timely manner. The findings also highlight strengths that could be built on, such as existing mental health emergency hotlines that could be integrated as part of the Lifeline network. We hope that this information will be consumed by administrators who wish to examine their preparedness relative to their peers and by legislators who could pass legislation that would channel more support to 988 in the coming months—both in advance of 988 going live in July 2022 and in the months that follow.

Appendix A. Survey Instrument

Pulse Survey on Preparedness for 988: Mental Health Emergency Response

Introduction

WHAT: A 5-minute, confidential survey on preparedness for 988, the mental health hotline that will launch later this year. This survey is being completed by behavioral health leaders around the country to "take a temperature" on preparedness and gauge the need for more support.

WHO: This evaluation is being led by the RAND Corporation, a non-profit, non-partisan research institution based in Santa Monica, CA, and is sponsored by the Sozosei Foundation, which is focused on the decriminalization of mental illness.

HOW LONG: The survey will take about 5 minutes to complete.

CONFIDENTIALITY: We plan to present aggregate survey responses in the spring of this year, including sharing results through a report and interactive website. Neither your name nor your agency will be listed to preserve confidentiality of all respondents. Participation is voluntary.

COMPENSATION: You will be provided with a $10 gift card code to Amazon for completing the survey.

- Yes, I would like to continue.
- No, thank you. I prefer not to continue.

_____

I. Preparedness

Background

The Federal Communications Commission (FCC) recently adopted rules to establish 988 as the new, nationwide 3-digit phone number for Americans in mental health emergencies to connect with suicide prevention and mental health support specialists. 988 will go live on July 16, 2022. Communities throughout the U.S. are preparing for this in different ways, including:
(i) developing and/or enhancing local and/or regional 988 call centers that provide emergency

intervention and possibly dispatch trained, mobile crisis response teams rather than or in tandem with police or EMS, and (ii) establishing service coordination between 988 and 911 and/or local treatment facilities.

Introduction

*To start, let's first cover 4 questions on **preparedness**. Please answer to the best of your ability.*

1. How important do you think it is that your agency be prepared for the transition to 988?

- Not at all important
- A little bit important
- Somewhat important
- Very important

2. On the follow categories, how prepared do you think the geographic area covered by your agency's jurisdiction is for the transition to 988?

	Not At All Prepared	A Little Bit Prepared	Somewhat Prepared	Very Prepared
Staffing				
Financing				
Infrastructure				
Coordination of services				

3. Currently, what is the status of crisis stabilization psychiatric bed capacity in your agencies' jurisdiction?

- We generally have sufficient crisis stabilization psychiatric bed capacity
- We generally DO NOT have sufficient crisis stabilization psychiatric bed capacity
- I don't know

4. Currently, what are the major entry points for someone receiving care for a mental health emergency in your agencies' jurisdiction (check all that apply)?

- Emergency department at general hospital
- Psychiatric emergency department
- Outpatient mental health clinic or community mental health center
- Crisis residential treatment program
- Deployment of a mobile crisis response team
- Dialing 911
- Other:_____

II. Strategic Planning & Financing

Introduction

*Next, let's cover a couple questions about **strategic planning**.*

5. Has your agency been involved in the development of a strategic plan for the transition to 988?

- Yes →***Proceed to Q6***
- No → ***Skip to Q7***
- I don't know → ***Skip to Q7***

→ If yes:

6. Does the strategic plan include: (check all that apply)

- A plan for starting (or maintaining operations at) one or more local/regional 24/7 crisis call centers or hotlines
- A plan to engage diverse stakeholders (e.g., first responders, hospitals, health plans) in conjunction with 988 emergency response
- A plan for educational and marketing materials about the introduction of 988
- A plan for clinical services in conjunction with 988 emergency response
- A plan for clinical personnel in conjunction with 988 emergency response
- A plan for infrastructure in conjunction with 988 emergency response
- A plan for service coordination between 988 and 911 emergency response

7. Has your agency established a budget for the transition and long-term support of 988?

- Yes →***Proceed to Q8***
- No → ***Skip to Q9***
- I don't know → ***Skip to Q9***

→ ***If yes:***

8. Does the budget include: (check all that apply)

- A sufficient and clear source of funding for one or more local/regional 24/7 crisis call centers or hotlines
- A sufficient and clear source of funding for educational and marketing materials about the introduction of 988
- A sufficient and clear source of funding for clinical services in conjunction with 988 emergency response
- A sufficient and clear source of funding for clinical personnel in conjunction with 988 emergency response
- A sufficient and clear source of funding for infrastructure in conjunction with 988 emergency response
- A sufficient and clear source of funding for service coordination between 988 and 911 emergency response

9. Has the state in which your agency resides passed legislation that imposes a 988 surcharge (often used to help finance services)?

- Yes
- No
- I don't know

III. Range of Services

Introduction

Lastly, let's cover a few questions on the range of services available for supporting a robust mental health emergency response system.

10. Does the geographic area covered by your agency's jurisdiction CURRENTLY have one or more local/regional crisis call centers or hotlines that connects individuals in emergencies with mental health services?

- Yes → ***Proceed to Q11***
- No → Do you have a concrete plan to include this in the future? ***Skip to Q18***
- I don't know → ***Skip to Q18***

11. Are one or more crisis call centers/hotlines part of the Lifeline network?

- Yes
- No → Do you have a concrete plan to include this in the future?
- I don't know

12. Which modes of communication are supported by this/these crisis call center(s) or hotline(s) (check all that apply)?

- Telephone
- Text/SMS
- Online chat
- Other_____

13. Does/do the crisis call center(s) or hotline(s) have staffing by clinical personnel 24/7 for 365 days each year?

- Yes
- It varies within my jurisdiction
- No → Do you have a concrete plan to include this in the future?
- I don't know

14. Are the crisis call center staff paid personnel or volunteers?

- Paid personnel
- Volunteers
- A combination of paid personnel and volunteers
- I don't know

15. Are crisis call center/hotline staff trained in applied suicide intervention services training (ASIST) or equivalent in order to perform suicide risk screening, assessment and safety planning with callers?

- Yes
- No → Do you have a concrete plan to include this in the future?
- I don't know

16. Are crisis call center/hotline staff specifically trained in how to interact with special populations, including:

	Yes	No	I Don't Know
Children/adolescents			
Individuals experiencing homelessness			
Persons with physical disabilities			
Persons with intellectual disabilities			
LGBTQ populations			
Individuals from indigenous communities			

17. Are any crisis call center/hotline staff required to speak two or more languages fluently, such as Spanish?

- Yes
- No → Do you have a concrete plan to include this in the future?
- I don't know

18. *For the most part*, does the geographic area covered by your agency's jurisdiction CURRENTLY include:

- Centrally deployed, 24/7 mobile crisis response teams that include licensed/credentialled clinicians?
  - → If no: Do you have a concrete plan to include this in the future?
- Short-term residential crisis stabilization program(s)
  - Yes/It varies within my jurisdiction/no
  - → If no: Do you have a concrete plan to include this in the future?
- Urgent care units for mental health
  - → If no: Do you have a concrete plan to include this in the future?
- Availability of crisis beds to support community needs?
  - → If no: Do you have a concrete plan to include this in the future?
- Engagement of peer staff to support individuals with emergency and urgent mental health needs
  - → If no: Do you have a concrete plan to include this in the future?
- Collaboration between law enforcement and behavioral health systems
  - → If no: Do you have a concrete plan to include this in the future?
- Training for law enforcement officials on crisis intervention (CIT) or equivalent?
  - → If no: Do you have a concrete plan to include this in the future?
- Trainings for crisis responders on trauma-informed care?
  - → If no: Do you have a concrete plan to include this in the future?

19. Does the geographic area covered by your agency's jurisdiction CURRENTLY collect data on:

- Emergency department wait times
  - → If no: Do you have a concrete plan to include this in the future?
- Real-time mental health crisis bed availability
  - → If no: Do you have a concrete plan to include this in the future?
- Arrest/incarceration of individuals with mental health conditions
  - → If no: Do you have a concrete plan to include this in the future?
- Patient outcomes (e.g., engagement with mental health services)
  - → If no: Do you have a concrete plan to include this in the future?

If Q10 = Yes, display Q20 and Q21. Otherwise, skip to Q22

20. Does/do the crisis call center(s) or hotline(s) within your agency's jurisdiction collect data on:

- Call volume
  - Yes/It varies within my jurisdiction/no
  - → If no: Do you have a concrete plan to include this in the future?
- Number of referrals to specialty care or hospital
  - Yes/It varies within my jurisdiction/no
  - → If no: Do you have a concrete plan to include this in the future?
- Number of dispatches to emergency services, including 911
  - Yes/It varies within my jurisdiction/no
  - → If no: Do you have a concrete plan to include this in the future?
- Time-to-answer
  - Yes/It varies within my jurisdiction/no
  - → If no: Do you have a concrete plan to include this in the future?
- Abandonment rates
  - Yes/It varies within my jurisdiction/no
  - → If no: Do you have a concrete plan to include this in the future?
- Primary reason the client is contacting the crisis call center/hotline
  - Yes/It varies within my jurisdiction/no
  - → If no: Do you have a concrete plan to include this in the future?

- Demographic characteristics of the client contacting the crisis call center/hotline
  - Yes/It varies within my jurisdiction/no
  - → If no: Do you have a concrete plan to include this in the future?

21. Does your agency's jurisdiction CURRENTLY allow crisis call center/hotline responders to schedule intake and outpatient appointments on behalf of individuals in need?

- Yes
- It varies within my jurisdiction
- No → Do you have a concrete plan to include this in the future?
- I don't know

V. Conclusions

22. If you would like to receive a $10 Amazon gift card for completing this survey, please provide your email address:_____

23. If you are open to participating in a brief follow-up interview to discuss your experiences with 988, please enter your first and last name:_____

THANK YOU FOR YOUR TIME!

If you have questions or concerns about your rights as a participant in this survey you may contact RAND's Human Subjects Protection Committee toll-free at (866) 697-5620 or by emailing hspcinfo@rand.org.

Appendix B: Interview Instrument

Background on Interviewee and Agency

I thought we could start with just a few background questions.

1. Can you start by telling me about your role within your agency?

2. How big is the geographic area covered by your agency – for example, how many people are in your county? What is the composition like, in terms of urban, rural, or suburban?

3. Can you tell me a bit about how your agency has been involved with respect to 988 preparation? What do you still need to do before 988 goes live in July?

4. What type of guidance have your drawn on to prepare for 988 implementation? From what sources?

5. What types of agencies have you been collaborating with as you prepare for the transition to 988, if any? Who are the other primary stakeholders in your [county/state]?
    a. Potential probes: Have collaborations been with agencies within your [county/state] or outside your [county/state]?

Crisis Call Hotline ("Someone To Talk To")

I would like to ask a bit about the way that mental health emergency calls are handled in your [county/state].

On the survey, you indicated that your jurisdiction [does/does not] currently have a regional crisis call center that is part of the Lifeline network.

If agency does have a crisis call center

6. Do you think the crisis call center is prepared for the transition to 988? Why or why not?
    a. (Potential probes: Sufficient staff, right mix of staff (clinical vs. non-clinical), open enough hours)
7. How do you think 988 implementation is going to affect the volume of calls to your crisis call center? How do you estimate that?
8. How is your [state/county] ensuring that your call center(s) is prepared for the transition to 988?
    a. What challenges have you encountered in preparing your call center(s)?
9. Will you expand the capacity/have you expanded capacity?

a. (Potential probes if already expanded) How did you go about doing so? What challenges did you overcome?
b. (Potential probes if going to expand) How will you go about doing so? What challenges do you foresee?
c. (If no and it seems like they are not prepared for 988 with their current capacity) How will your county supplement its existing crisis call capacity? (Potential probes: Calls will be transferred to another regional center)

10. Do you anticipate that the type of call you receive to your call center is going to change, and how so? For example, do you think the proportion of cases that get resolved on the phone will change?

If agency does NOT have a crisis call center

11. Does your county currently provide access to a crisis call center? If so, how?
12. What approach will you use for the transition to 988?
    a. (If yes) Do you foresee any challenges or limitations to continuing to use this approach?
    b. (If no) What is your plan for the 988 transition?

Mobile Crisis Teams ("Someone to Respond")

A key aspect of 988 implementation is assisting individuals whose needs cannot be met via the crisis line alone, such as deploying a mobile crisis response team or finding a bed in a short-term crisis stabilization unit.

13. How prepared is your [state/county] to provide a mobile response to 988 callers who need an intervention?
14. What approach will be used for 988 callers? What are the strengths or limitations of this approach?
    a. How different is this from your county's current approach to handling mental health emergencies?
15. Are there areas of your [county/state] that are not currently covered by mobile crisis teams? If yes, what are your plans to address this?
16. What will the role of law enforcement be in crisis responses? Has your agency discussed with law enforcement about 988?

Crisis Receiving and Stabilization Services ("A Place to Go")

17. What type of crisis care options are available in your [county]? How do you anticipate these will be utilized for 988 callers?
    a. Is the existing capacity sufficient? (If no) How is your county addressing this, if at all?

18. Are there areas of your [county/state] that don't have easy access to emergency mental health care or stabilization services? How do you plan address this, if at all?

Resources, Staffing Needs, and Equity Considerations

19. Can you tell me how your [state/county] is funding 988 implementation? (Potential probes: State funding, federal funding, fee for service/insurance payments, private support)
    a. Potential probes: How are you funding the hotline? Crisis response teams? Crisis services?
    b. How long is funding guaranteed? [If using one-time funding] What will you do once those funds have been spent?
20. What will the role of peer support staff be across each aspect of the response (hotline, crisis response, crisis services)? By "peers," we mean staff with lived experience of mental health conditions.
21. How has your [county/state] planned to serve groups of people who might have unique needs, such as military veterans, LGBTQ+ individuals, or youth?
22. Are there any communities or populations that you think will be more challenging to serve through 988 and the associated crisis services? Who are those groups? (Potential probes: Socioeconomically disadvantaged neighborhoods, rural areas, youth, individuals with physical disabilities or limitations)
    a. What are the biggest challenges in those areas? How are those challenges being addressed?

Strengths/Challenges

23. What would you say is the primary strength of your [state/county]'s 988 plans?
24. What is the primary limitation/challenges of your [state/county's] 988 plans?
25. What is the most important thing your [state/county] needs to address before July 16, when 988 goes live?

Conclusion

26. Is there anything else you would like to discuss or tell me about before we conclude this call?

Appendix C. Strategic Planning Questions Broken Down by Director Type

We report the number of respondents and percentage of respondents based on their responses to questions related to strategic planning for 988. We inquired about preparedness, bed capacity, entry points for mental health emergencies, and strategic plans. We report the number of respondents and percentages based on whether the respondent was a state or county/region behavioral health director.

Response	County or Region		State	
	Number of Respondents	Percentage	Number of Respondents	Percentage
How important do you think it is that your agency be prepared for the transition to 988?				
A little bit important	4	3.01%	0	0.00%
Not at all important	1	0.75%	0	0.00%
Somewhat important	24	18.05%	0	0.00%
Very important	104	78.20%	16	100.00%
Currently, what is the status of crisis stabilization psychiatric bed capacity in your agencies' jurisdiction?				
We generally have sufficient crisis stabilization psychiatric bed capacity	21	15.79%	4	25.00%
We generally DO NOT have sufficient crisis stabilization psychiatric bed capacity	107	80.45%	12	75.00%
I don't know	5	3.76%	0	0.00%
Currently, what are the major entry points for someone receiving care for a mental health emergency in your agencies' jurisdiction?				
Emergency department at general hospital	123	92.48%	16	100.00%
Psychiatric emergency department	22	16.54%	8	50.00%
Outpatient mental health clinic or community mental health center	92	69.17%	14	87.50%
Crisis residential treatment program	33	24.81%	4	25.00%
Deployment of a mobile crisis response team	78	58.65%	9	56.25%
Dialing 911	101	75.94%	13	81.25%
Has your agency been involved in the development of a strategic plan for the transition to 988?				
Yes	41	30.83%	16	100.00%
No	82	61.65%	0	0.00%
I don't know	9	6.77%	0	0.00%
Missing	1	0.75%	0	0.00%
Does the strategic plan include:				
A plan for starting (or maintaining operations at) one or more local/regional 24/7 crisis call centers or hotlines	30	22.56%	16	100.00%
A plan to engage diverse stakeholders in conjunction with 988 emergency response	27	20.30%	15	93.75%
A plan for educational and marketing materials about the introduction of 988	17	12.78%	12	75.00%
A plan for clinical services in conjunction with 988 emergency response	18	13.53%	13	81.25%
A plan for clinical personnel in conjunction with 988 emergency response	15	11.28%	10	62.50%
A plan for infrastructure in conjunction with 988 emergency response	20	15.04%	12	75.00%
A plan for service coordination between 988 and 911 emergency response	23	17.29%	12	75.00%

NOTE: Sample is restricted to behavioral health directors who we were able to identify as either a state or county director. Frequency percentages are reported based on the denominator for the full set of respondents that were identified as a state or county director respectively.

Appendix D: Financing Questions Broken Down by Director Type

We report the number of respondents and percentage of respondents based on their responses to questions related to financing for 988. We inquired about the budget for 988 and whether a surcharge exists to finance 988. We report the number of respondents and percentages based on whether the respondent was a state or county/region behavioral health director.

Response	County or Region		State	
	Number of Respondents	Percentage	Number of Respondents	Percentage
Has your agency established a budget for the transition and long-term support of 988?				
Yes	8	6.02%	8	50.00%
No	114	85.71%	7	43.75%
I don't know	10	7.52%	1	6.25%
Missing	1	0.75%	0	0.00%
Does the budget include: (check all that apply)				
One or more local/regional 24/7 crisis call centers or hotlines	6	4.51%	6	37.50%
Infrastructure in conjunction with 988 emergency response	3	2.26%	5	31.25%
Clinical services in conjunction with 988 emergency response	3	2.26%	5	31.25%
Clinical personnel in conjunction with 988 emergency response	2	1.50%	5	31.25%
Educational and marketing materials about the introduction of 988	2	1.50%	5	31.25%
Service coordination between 988 and 911 emergency response	1	0.75%	3	18.75%
Has the state in which your agency resides passed legislation that imposes a 988 surcharge (often used to help finance services)?				
Yes	16	12.03%	2	12.50%
No	38	28.57%	14	87.50%
I don't know	77	57.89%	0	0.00%
Missing	2	1.50%	0	0.00%

Appendix E: Infrastructure Questions Broken Down by Director Type

We report the number of respondents and percentage of respondents based on their responses to questions related to infrastructure for 988. Specifically, questions related to crisis call centers, the Lifeline network, staffing, training for special populations, and language services. We report the number of respondents and percentages based on whether the respondent was a state or county/region behavioral health director.

Responses	County or Region		State	
	Number of Respondents	Percentage	Number of Respondents	Percentage
Does the geographic area covered by your agency's jurisdiction CURRENTLY have one or more local/regional crisis call centers or hotlines that connects individuals in emergencies with mental health services?				
Yes	113	84.96%	14	87.50%
No	14	10.53%	2	12.50%
I don't know	4	3.01%	0	0.00%
Missing	2	1.50%	0	0.00%
Are one or more crisis call centers/hotlines part of the Lifeline network?				
Yes	57	42.86%	13	81.25%
No	23	17.29%	0	0.00%
I don't know	33	24.81%	1	6.25%
Missing	20	15.04%	2	12.50%
Which modes of communication are supported by this/these crisis call center(s) or hotline(s) (check all that apply)?				
Telephone	112	84.21%	14	87.50%
Text/SMS	49	36.84%	10	62.50%
Online chat	20	15.04%	6	37.50%
Does/do the crisis call center(s) or hotline(s) have staffing by clinical personnel 24/7 for 365 days each year?				
Yes	88	66.17%	10	62.50%
No	8	6.02%	0	0.00%
It varies within my jurisdiction	7	5.26%	4	25.00%
I don't know	10	7.52%	0	0.00%
Missing	20	15.04%	2	12.50%
Are the crisis call center staff paid personnel or volunteers?				
A combination of paid personnel and volunteers	25	18.80%	8	50.00%
I don't know	12	9.02%	1	6.25%
Paid personnel	75	56.39%	5	31.25%
Volunteers	1	0.75%	0	0.00%
Missing	20	15.04%	2	12.50%
Are crisis call center/hotline staff trained in applied suicide intervention services training (ASIST) or equivalent in order to perform suicide risk screening, assessment and safety planning with callers?				
Yes	77	57.89%	11	68.75%
No	3	2.26%	0	0.00%
I don't know	33	24.81%	3	18.75%
Missing	20	15.04%	2	12.50%
Are crisis call center/hotline staff specifically trained in how to interact with special populations, including:				
Children/adolescents	73	54.89%	11	68.75%
Individuals experiencing homelessness	60	45.11%	8	50.00%

Responses	County or Region		State	
	Number of Respondents	Percentage	Number of Respondents	Percentage
Persons with physical disabilities	53	39.85%	7	43.75%
Persons with intellectual disabilities	52	39.10%	8	50.00%
LGBTQ populations	60	45.11%	8	50.00%
Individuals from indigenous communities	28	21.05%	4	25.00%
Are any crisis call center/hotline staff required to speak two or more languages fluently, such as Spanish?				
Yes	24	18.05%	5	31.25%
No	38	28.57%	6	37.50%
I don't know	51	38.35%	3	18.75%
Missing	20	15.04%	2	12.50%
For the most part, does the geographic area covered by your agency's jurisdiction CURRENTLY include:				
Centrally deployed, 24/7 mobile crisis response teams that include licensed/credentialled clinicians?	72	54.14%	5	31.25%
Short-term residential crisis stabilization program(s)	63	47.37%	6	37.50%
Urgent care units for mental health	35	26.32%	4	25.00%
Availability of crisis beds to support community needs	51	38.35%	8	50.00%
Engagement of peer staff to support individuals with emergency and urgent mental health needs	67	50.38%	11	68.75%
Collaboration between law enforcement and behavioral health systems	105	78.95%	11	68.75%
Training for law enforcement officials on crisis intervention (CIT) or equivalent?	105	78.95%	14	87.50%
Trainings for crisis responders on trauma-informed care?	90	67.67%	11	68.75%

NOTE: Sample is restricted to behavioral health directors who we were able to identify as either a state or county director. Frequency percentages are reported based on the denominator for the full set of respondents that were identified as a state or county director respectively.

Appendix F: Service Coordination Questions Broken Down by Director Type

We report the number of respondents and percentage of respondents based on their responses to questions related to service coordination for 988. We inquired about data collection, and the ability to schedule intake and outpatient appointments. We report the number of respondents and percentages based on whether the respondent was a state or county/region behavioral health director.

Response	County or Region		State	
	Number of Respondents	Percentage	Number of Respondents	Percentage
Does the geographic area covered by your agency's jurisdiction CURRENTLY collect data on:				
Emergency department wait times	65	48.87%	4	25.00%
Real-time mental health crisis bed availability	47	35.34%	3	18.75%
Arrest/incarceration of individuals with mental health conditions	71	53.38%	4	25.00%
Patient outcomes (e.g., engagement with mental health services)	77	57.89%	6	37.50%
Does/do the crisis call center(s) or hotline(s) within your agency's jurisdiction collect data on:				
Call volume	97	72.93%	13	81.25%
Number of referrals to specialty care or hospital	74	55.64%	9	56.25%
Number of dispatches to emergency services, including 911	70	52.63%	8	50.00%
Time-to-answer	65	48.87%	12	75.00%
Abandonment rates	51	38.35%	12	75.00%
Primary reason the client is contacting the crisis call center/hotline	88	66.16%	13	81.25%
Demographic characteristics of the client contacting the crisis call center/hotline	71	53.38%	9	56.25%
Does your agency's jurisdiction CURRENTLY allow crisis call center/hotline responders to schedule intake and outpatient appointments on behalf of individuals in need?				
Yes	25	18.80%	0	0.00%
No	44	33.08%	8	50.00%
It varies within my jurisdiction	23	17.29%	4	25.00%
I don't know	21	15.79%	2	12.50%
Missing	20	15.04%	2	12.50%

NOTE: Sample is restricted to behavioral health directors who we were able to identify as either a state or county director. Frequency percentages are reported based on the denominator for the full set of respondents that were identified as a state or county director respectively.

Abbreviations

24/7	24 hours a day, seven days a week
988	three-digit national hotline for mental health emergencies
ASIST	Applied Suicide Intervention Skills Training
EMS	emergency medical services
LGBTQIA+	lesbian, gay, bisexual, transgender, queer, intersex, asexual, and others
NASMHPD	National Association of State Mental Health Program Directors
NSPL	National Suicide Prevention Lifeline
RQA	rapid qualitative analysis
SAMHSA	Substance Abuse and Mental Health Services Administration

Endnotes

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[7] NSPL, undated.
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[32] Vibrant Emotional Health, 2021b.
[33] SAMHSA, undated-a.
[34] Gould et al., 2013.
[35] Note that this quote was paraphrased due to poor recording quality during this interview.
[36] Vibrant Emotional Health, 2020.
[37] SAMHSA, 2021b; Pinals, 2020.
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[39] Federal Communications Commission, 2022.
[40] SAMHSA, 2021a.
[41] SAMHSA, 2021a.
[42] Hartsig, 2017.
[43] SAMHSA, 2020.
[44] Satiani et al., 2018; IHS Markit, 2018.
[45] Pub. L. 117–2; Pub. L. 117–58.
[46] SAMHSA, 2020; National Alliance on Mental Illness, 2021.
[47] Ramchand et al., 2017.

[48] Hepburn, 2022; Rizzo, 2022.
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