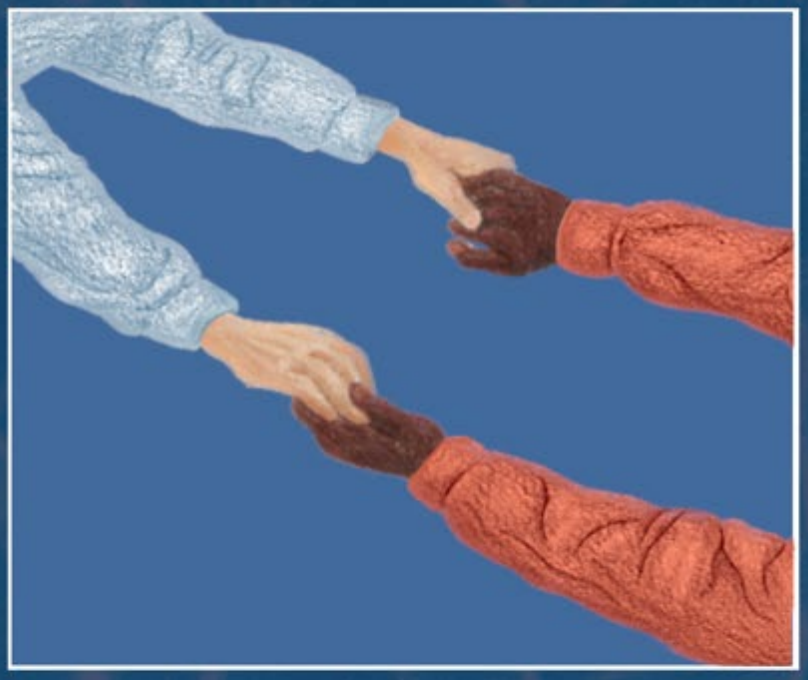
2024

Crisis Systems Coordination and Collaboration: Leveraging Strengths and Opportunity of 988 and 911



Connected and Strong

Sixth in a Series of Ten Technical Assistance Briefs to Foster Unity and Strengthen Continuity Across Crisis Response and Treatment Systems

SAMHSA
Substance Abuse and Mental Health Services Administration

Crisis Systems Coordination and Collaboration:

Leveraging Strengths and Opportunity of 988 and 911

Acknowledgments

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Crisis Systems Coordination and Collaboration: Leveraging Strengths and Opportunity of 988 and 911 was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201700024I/75S20321F42001. Tison Thomas served as contracting officer representative.

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Recommended Citation

Stephenson AH, Naturale A, Miller A, Pinals DA: *Crisis Systems Coordination and Collaboration: Leveraging Strengths and Opportunity of 988 and 911*. Publication No. PEP24-01-023. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024

Originating Office

Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, SAMHSA. Publication No. PEP24-01-023. Released 2024.

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Publication No. PEP24-01-023

Released 2024

Abstract

The transition to the 988 Suicide & Crisis Lifeline in July 2022 was a major step toward creating an effective behavioral health crisis services system that can serve all people in the United States. Critical next steps include ensuring the collaboration between the 988 Suicide & Crisis Lifeline (administered by Vibrant Emotional Health) and 911 Public Safety Answering Points. Across the country, collaboration, organization and partnership is variable and in different stages. Achieving fluidity between systems will ultimately help connect Americans to care when and where they need it, a key priority identified by policymakers and leaders. Decades of reliance upon 911 for behavioral health crises have led to the current need to develop technology, policy, protocols, and staffing to help ensure that anyone calling 988 or 911 will get the right response, at the right time, delivered in a way that eliminates disparities. This work should be continually reassessed through data and outcomes analysis. This technical assistance brief will review many aspects of crisis system collaboration, incorporating stakeholder input gathered during this exciting transition from a default emergency medical and law enforcement response to a more intentional, varied continuum of behavioral health crisis responses.

Highlights

- A behavioral health crisis service system that provides the right response at the right time requires strong collaboration between stakeholders such as state and federal 988 and 911 and 988 Suicide & Crisis Lifeline policymakers; 911 Public Safety Answering Points; emergency medical services; law enforcement; mobile crisis teams; and related national, state, and local associations.
- Coordination and collaboration of these and related systems will require stakeholders to work together to build complete crisis response services that are culturally and linguistically responsive; build and restore the trust of at-risk populations; use data for performance improvement; educate each other; be technologically competent and supportive; include training and response protocols for all parties, including assessments of risk versus safety; maintain confidentiality; and provide compassionate and effective responses.
- Public education is needed regarding what 988 is, when to call 988 versus 911, the collaborative nature of the two systems, and how all the components of the response and any follow-up will transpire.
- Systems changes and long-term maintenance will require the financial sustainability available through multiple funding sources—federal, state, and local government; public and private insurers that abide by parity laws; public and private grants that provide some flexibility; and new sources of funds through appropriations and fees.

Recommendations

1. Begin 988/911 collaboration planning with stakeholders early to set the agenda and address rural and culture change issues that may take more time and energy than expected.
2. Assess existing gaps and identify necessary services, data requirements, liability considerations, and financing needs.
3. Build upon existing resources, rather than starting from scratch, to foster sustainability and interconnectedness of a strong and coordinated 988 and 911 system.
4. Engage members from relevant organizations related to emergency medical and behavioral health services, local affiliates of national associations, and state or local PSAP groups.
5. Help behavioral health leaders and stakeholders become familiar with data and call transfer capabilities offered by organizations such as the National Emergency Services Information System and the National Emergency Number Association, as well as computer-aided dispatch systems.
6. Examine 988/911 collaboration models to determine the most suitable option for the specific region, county, or state, considering input from critical stakeholders.
7. Establish effective procedures and protocols to enhance 988/911 coordination and collaboration that are practical for individuals involved, acceptable to stakeholders, and able to withstand potential legal challenges.
8. With input from all stakeholders and representatives of the community, develop a marketing plan for 988 that includes community input and anticipates questions that may emerge about the 988/911 interface.

Introduction

Since its inception, 911 has, by default, managed behavioral health crisis calls. A 2021 report estimated that 4.2% of EMS calls were related to mental illness alone.[1] Due to a lack of suitable community options, individuals in behavioral health crises have typically been brought to hospital emergency departments (EDs), where crowded conditions and limited access to psychiatric inpatient care create delays that have the potential to cause the individual receiving care to have an exacerbation of symptoms or further decompensation. All too often, and particularly when they have no social support system, such individuals are discharged to jail or the streets with poor aftercare plans. In addition, law enforcement (LE) regularly brings individuals directly to jails without offering them any behavioral health services.[2] Redirection is needed to improve access to proper crisis support, and this requires forging new ground and partnerships. This need was articulated in the 2017 National Association of State Mental Health Program Directors (NASMHPD) report *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care,* and it is no less urgent today.[3] As a key part of the needed continuum of care, states are reimagining a system with the promise of 988 and 911 coordination as the front end of crisis care for everyone, everywhere, at any time.

Key stakeholders

- 988—National Suicide & Crisis Lifeline Centers and local contact centers
- 911—universal emergency number and local Public Service Answering Points
- Law enforcement
- Emergency medical services
- Fire departments
- Mobile Crisis Teams (MCTs)
- State/local behavioral health authorities
- State/local medical authorities
- Related national associations
- Community members

Collaboration between 988 and 911 begins when the leadership of one system recognizes the need and begins a conversation with leaders of the other system. However, the extent to which this is happening has been limited on national, state, and local levels. It is time for robust communications to begin and for collaborations to be built, community by community, with a vision of interoperability at all levels. From the first dispatch decision to the resolution of the crisis, there are countless nuances that will necessitate coordination across key stakeholders.

This paper first takes a step back to review where things stand and put future directions in context. This year's series of Technical Assistance Briefs, produced by NASMHPD on behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA), provides detailed analyses of various aspects of crisis services to help advance the work being done in this expanding field. This paper provides information gathered from stakeholders involved in planning for 988/911 coordination, collaboration and integration, who shared their experiences and insights to assist other state and local leaders facing these decisions. From their perspectives and a review of current practices, this paper makes several policy recommendations.

Facilitating Collaboration to Build Better Behavioral Health Crisis Communication and Coordination: Let the Discussions Begin

The implementation of 988 marks the beginning of a major culture shift, similar to the one that took place with the development of 911. As 988 rolls out, the need for a rapid increase in the interconnectivity between 988 and 911 has become more evident. Even with the marketing of 988, it is likely that 911 will continue to receive calls for behavioral health crises for years to come, until 988 is as familiar a number as 911. Regardless of the number a caller chooses to dial, dispatchers will need to determine how and where to direct calls to ensure the most effective response.

As new 988 and 911 systems strive for effective linkages to behavioral health treatment, caution is necessary to avoid stigmatization. Discussions must take place among 988, 911, and other related systems to plan for collaboration and/or interoperability and allow for a variety of responses, including those that do not involve deployment of on-site responders at all.

This has not been the traditional role of 911 but is typically what 988 offers. Also, when there is the need for an on-site response, responders must be able to triage, to ensure the caller receives the most appropriate and least restrictive approach, as Pinals noted in *Lending Hands: Improving Partnerships*

Timeline of major events at the crisis interface

1966: Publication of *Accidental Death and Disability: The Neglected Disease of Modern Society* (National Academy of Sciences)

1968: First call made to 911

2001: Congress appropriates funds to SAMHSA for National Suicide Prevention Hotline

2005: Establishment of National Suicide Prevention Lifeline

2007: SAMHSA and US Department of Veterans Affairs partner to create Press 1 Veterans Crisis Line

2013: Lifeline adds chat service

2015: Disaster Distress Helpline added to the Lifeline network with different access numbers and funding

2020: National Suicide Hotline Designation Act

2020: Federal Communications Commission adopts 988

2022: 988 established nationwide

The Lifeline's History. Rockville, MD, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/988-timeline.pdf. Accessed Aug 3, 2023

and Coordinated Practices Between Behavioral Health, Police, and Other First Responders.[4] The NASMHPD publication *988 Convening Playbook: Public Safety Answering Points (PSAPs)* includes major discussion points and assessment categories that may be useful in beginning collaborative discussions:[5]

- **Partnerships and performance management.** To what extent does the PSAP have a relationship with local 988 Suicide & Crisis Lifeline Centers and other local crisis centers, engage in cross-system partnerships with a broader set of collaborators, and include behavioral health crisis calls in its quality improvement efforts?
- **Call processes.** How are calls related to behavioral health crises identified and dispatch decisions determined? What is the process for transferring calls to the nearest 988 Suicide & Crisis Lifeline Center or other crisis center, and what are the technical mechanisms for transferring calls? How is information gathered on behavioral health crisis calls?
- **Training.** What training is available for identifying calls related to behavioral health crises, determining dispatch decisions, de-escalating crisis calls, and labeling calls?

"Figure out 'what the win is' for the people you are working with—for example, showing cost savings made a huge difference in our efforts to get recognition and funding from the City of Houston. Knowing the win for them and connecting it to the work is a good way to build consensus."

—Jennifer Battle, MSW, Vice President, Community Access and Engagement, The Harris Center for Mental Health and Intellectual and Developmental Disabilities

Definitions

Coordination: organizing different elements in complex systems to enable them to work together effectively.

Collaboration: working with each other to produce or create something.

Integration: to bring together or incorporate parts into a whole.

Interconnectedness: the state of being connected with each other; mutually joined or related.

Interoperability: the ability of computer systems or software to exchange and make use of data information. A broader definition takes into account social, political, and organizational factors that impact system-to-system performance.

- **Data collection.** How are calls coded or recorded, and to what extent has baseline data been gathered?
- **Sharing incident information and aggregated data.** How is critical incident data such as location shared across first responder and crisis call continuum partners? What is the data-sharing schedule for post hoc, aggregated behavioral health crisis call data? To what extent has baseline data on behavioral health crisis calls (e.g., call volume, call disposition) been shared with collaborators or state and federal agencies for analysis of performance of the system overall?
- **Policy decisions.** These discussions will inform many policy decisions: How should the system be configured—statewide, county-based, urban and rural, by EMS regions, and so on—allowing for use of best-practice models that meet needs and can be applied practically with existing capacity? Should 911 and 988 be maintained as separate access points to the behavioral health system? If not, how or to what extent should they be merged while still maintaining the integrity of their roles? What configuration should be used for the response model? What should oversight and quality monitoring for the system look like, and how is trust built for dialing three-digit emergency numbers?

"One of the ways we have been successful in bringing people together is convening groups via grants that are available for behavioral health training of first responders. We brought EMS and LE to the table for a joint-response training which heightened awareness and working as a team in these responses. With the increase in pediatric crises, other groups to consider including in the discussion are the American Academy of Pediatrics and the Emergency Medical Services for Children program."

—Debra Perina, MD, Emeritus Professor, former Division Director, Prehospital Care, EMS Fellowship Program Director, and Professor of Emergency Medicine, University of Virginia

A theme that emerged frequently across interviews was the willingness of stakeholders to come together to build diverse advisory, steering, or stakeholder committee roles from the start of 988 planning. Leaders wanted to ensure that the membership of these bodies was broad, including representatives of state and local behavioral health agencies, offices of attorneys general, 988 contact centers, 911, emergency medical services (EMS), EDs, LE, providers, fire departments (FDs), crisis response teams, those with lived experience, and others. Every community throughout the country has specific processes for responding to crises, based on many variables, including federal and state regulations, funding availability, geographic landscapes, and human

capacity/workforce issues. Thus, the need for cross-system collaboration cannot be overstated and is an important first step for communities and leaders looking to implement 988 and 911 coordination and collaboration successfully. An interviewee stated, "One of the biggest lessons learned is regarding collaboration. Although there is collaboration happening with 911 partners, LE is experiencing the biggest change in their operations. Their calls are being diverted to outside agencies, which is not usual. This shift is a culture change for LE, especially in rural communities where PSAP workers know the frequent callers. They are their friends and neighbors—and they care deeply about them."

Because coordination and collaboration requires partnering between the behavioral health crisis system and other entities, it is important for policymakers to consider what partners would be helpful and needed at the table in collaborative discussions. **Table 1** shows some examples of partner organizations at the national level, many of which also have state-level parallel organizations. It is useful for crisis

Table 1: Examples of Partner Organizations for Collaboration with the Behavioral Health Crisis System

- American Academy of Pediatrics (AAP)
- American Association of Poison Control Centers (AAPCC)
- American College of Emergency Physicians (ACEP)
- American Foundation for Suicide Prevention (AFSP)
- American Hospital Association (AHA)
- Association of Public-Safety Communications Officials (APCO)
- Bureau of Justice Assistance (BJA)
- CIT International: Crisis Intervention Team International Association (CIT)
- Council of State Governments (CSG)
- Emergency Medical Services for Children national program (EMSC)
- International Association of Chiefs of Police (IACP)
- International Association of Emergency Medical Services Chiefs (IAEMSC)
- National 911 Program Office, US Department of Transportation
- National Action Alliance for Suicide Prevention (NAASP)
- National Alliance on Mental Illness (NAMI)
- National Association of Black Law Enforcement Officers (NABLEO)
- National Association of Emergency Medical Technicians (NAEMT)
- National Association of Police Organizations (NAPO)
- National Association of State 911 Administrators (NASNA)
- National Association of State EMS Officials (NASEMSO)
- National Association of State Mental Health Program Directors (NASMHPD)
- National Co-Responder Consortium
- National Council for Mental Wellbeing (NCMW)
- National Emergency Medical Services Information System (NEMSIS)
- National Emergency Number Association (NENA)
- National EMS Management Association (NEMSMA)
- National Fire Protection Association (NFPA)
- Vibrant Emotional Health (VEH)

leaders to familiarize themselves with this landscape to consider where potential stakeholders can work together for best coordination and collaboration.

Best Practices and Procedures for 988 and 911 Coordination and Collaboration

Prior to the launch of the 988 Suicide & Crisis Lifeline, most crisis contact centers in the National Suicide Prevention Lifeline (NSPL) network functioned independently of any state oversight, complying primarily with funder requirements and the NSPL's guidelines. With the advent of 988, it is a requirement of SAMHSA's *Cooperative Agreements for States and Territories to Build Local 988 Capacity* that states and territories submit a plan that "includes state oversight of 988 and 911 coordination in collaboration with the state's 911 administrator."[6] SAMHSA does not dictate the specific model to support coordination, collaboration or integration but does describe mobile crisis services as those that are "available 24/7 and that can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call and available to respond. The team may be composed of professionals and paraprofessionals, including peer support providers, who are trained in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis."[7] Mobile crisis teams (MCTs) are envisioned to be specially focused on behavioral health crises, which opens a discussion about how such a team would work with existing on-the-ground responders such as LE, EMS, and others.

Structures for Collaboration

There are many variations in the structures or models of collaborations among 911 services (e.g., EMS, LE, etc.) with the 988 Suicide & Crisis Lifeline and behavioral health crisis response services such as MCTs, co-responder teams, and others. The review of reports and papers, and interviews with state, county, and association representatives that are referenced in this paper provided information about the strikingly broad variety of approaches from locality to locality.

"Warm transfer of non-emergent behavioral health calls from 911 dispatchers to 988 Lifeline Centers is a call diversion model that can be utilized when the 911 dispatch determines law enforcement response is not needed and behavioral health crisis response is more appropriate."

—Valerie Mielke, Deputy Commissioner of Health Services, New Jersey Department of Human Services

As a result, there are numerous promising practices. Of note, too, is that the term *best practices* refers to those that appear to be yielding positive results for the specific users. At this time, they may not be evidence-based or evidence-informed due to the lack of research, but they are deemed best or promising practices via formalized quality standards measurement and monitoring, with applicability to the geographic areas and populations where they are implemented. Though the field of research to determine improved practice is just beginning, this type of quality data is the only data now available for some regions. However, this data is typically program-specific, which may limit the ability to generalize the results to other areas and/or populations, but a close analysis of these practices' evaluation results may assist other localities in deciding which model may be worth trying.

Crisis response systems have been typically classified as (1) LE-based responses (such as deploying officers with Crisis Intervention Team, or CIT, training), (2) LE-based mental health responses (often described as "embedded clinical models," whereby a clinician works for local LE to respond with officers), and (3) mental health–based responses (typically described as separately operated behavioral health responses that can call on LE to jointly respond when needed).[8] These models represent three broad buckets of mobile crisis response work and have been around for years. Today, responses are becoming more nuanced, in line with the interconnectedness related to all three aspects of SAMHSA's envisioned crisis system of "someone to call, someone to respond, and a safe place for help."[9] The following discussion presents examples of how this is taking shape across various designs.

Example: Long-standing coordination between law enforcement and behavioral health in Harris County, Texas

Harris County, Texas, systems have been seen as an experienced leader in response to crisis calls, going back to the late 1990s, when they created a partnership between the police department and behavioral health advocacy organizations. For this County, the use of 988 is an opportunity to get more appropriate services to people in need of immediate care. Houston's Harris Center for Mental Health worked in partnership with the City of Houston's LE and FD/EMS to determine which 911 behavioral health (CIT) call codes can be successfully diverted away from LE/FD/EMS response with telephonic interventions done by qualified behavioral health professionals. They urge states to begin looking at these areas: the data for which 911 call codes do not have a disposition that actually required a 911 response; multiple models to allow for more diverse types of responses to meet community needs; early identification of the partners to have at the table, including those with decision-making authority; asking the communities what they need; talking and having patience with and understanding of each other's perspectives; and helping the partners understand how the development of an interoperable emergency response system can improve things for the community.

"The New Jersey Department of Human Services and Division of Mental Health and Addiction Services (DMHAS) have been collaborating with the Office of Electronic Telecommunications Systems on building protocols for bidirectional warm transfers between the 911 and 988 systems. DMHAS has been working with a committee to update the 911 'guide cards' used in any 911 situation including behavioral health crises. These teams are adding warm transfer protocols for non-emergent behavioral health calls made to 911. Dispatchers from 911 would contact 988 to share the information that had been collected. If it is strictly a behavioral health crisis, then 911 will transfer that call to 988 and may disconnect. "

—Michael Petruzzelli, MPA, Senior Policy Advisor, New Jersey Department of Human Resources

Referral Models: Triaging Who Responds When through Interoperable Systems beyond Call Centers

Model: Interoperability at call centers for diversion from 911 to 988

For areas using a model of interoperability at call centers to allow for diversion from 911 to 988, the existing technology must allow for reliable transfers from local police and PSAPs to 988 to decrease the risk of dropped calls and reliance upon local police if the transfer does not go through. To help avert concerns about liability related to disrupted or misrouted call responses, it is important for call transfers and computer-aided dispatch (CAD) systems to work seamlessly with 988. This requires system-compliant modules, training, and standardization, as well as data collection that can track progress and lead to system improvements.

Model: First responders call for behavioral health clinical support

In this model, after encountering someone in need of behavioral health assistance, responding LE officers or EMS will refer an individual to a behavioral health specialist or navigator.[10] This might occur after the individual is sufficiently stabilized to remain in their home or wherever they are at the time of the 911 call, or it could also happen while the person has been settled into an ED or even in a holding cell or other jail setting. In such cases, the initial call for emergency assistance may not have been directly related to a behavioral health concern, but during the interaction, the first responder has determined there may be a need for a behavioral health evaluation or assessment.

Model: Law enforcement calls for trained citizen support

Rather than dispatching clinicians, LE can request dispatch of behavioral health–trained civilians, including volunteers, crisis workers, peer support specialists, and/or other nonclinical professionals. The nonclinical responders may also serve the community on their own as a mobile crisis response, most likely in areas where there are no other options. Increasingly this may also involve calling in people with lived experience and/or certified peer support specialists with specific crisis training. The key to appropriate support and referrals in this situation is the training of the non-licensed responders. In communities that continue to rely on LE, the role for LE might be to clear the situation through intervention but also to call on trained citizens for support resources and referrals, rather than for assessment or formal mental health interventions, as clinicians would provide. For more information, see the NASMHPD video *Empowering the Roles of Lived Experience: NASMHPD's Voices* on peer support in crisis services. Of course, nonclinical support personnel will need protocols for when to escalate a situation to a trained clinical professional.

Example: Co-locating behavioral health in 911 call centers in Austin, Texas

911 call takers in the city of Austin, Texas, answer emergency calls by asking, "Are you calling for police, fire, EMS, or mental health services?" This question puts behavioral health services on par with other types of common call responses. In addition, Austin has integrated Expanded Mobile Crisis Outreach Team clinicians into the 911 call center to foster partnerships between behavioral health personnel and first responders. This is a co-location model in which all responders work in the same physical space and are working to respond to behavioral health crises from a similar point of view. The Austin staff report this has been transformative by creating faster response times, and by facilitating continued training and seamless feedback loops on calls as well as call codes.

Model: Teleconference and virtual technology

Models for communication and dispatch interconnectedness or integration sometimes rely upon teleconference and virtual technology. The use of these models looks different for rural, suburban, and urban locations, and some of those differences may be largely based on the capacity for a face-to-face response. Rural areas and localities that lack staff or are too remote for deployment of an in-person response in a timely enough manner to address an emergency have long relied on telephone, teleconference, and now, internet-based virtual communications for clinical support.

Such models allow for timely, efficient, and effective responses. Since the COVID-19 pandemic, communities are increasingly using virtual models where necessary and when internet access and appropriate technology allows for a consistent and reliable connection. This model can also provide support for hands-on care to be directed, supervised, and even provided by a distance

clinician. In addition, assessment tools that provide reports (e.g., suicide assessment, depression scale results, etc.) can be sent virtually for analysis and to meet immediate needs. This use of technology can occur in different ways—iPads can be given directly to persons served so they can connect with crisis systems on demand, or the devices can be supplied to ED, LE, or EMS professionals so they can connect with behavioral health specialists in real time for assessments, referrals, and follow-up case management.[11]

Model: Co-location within dispatch centers as a means of triaging and coordination

Embedding behavioral health counselors and other clinicians who can provide crisis intervention and assessment in the same location as 911 dispatchers is a "co-location model." To be effective and efficient, protocols must be in place that identify when and how the staff of each organization makes the determination regarding the most appropriate services to deploy.

Currently, many dispatch agencies use algorithms in the form of electronic "call cards" or "guide cards" for 911 to lead the sequence of actions in any situation including behavioral health. This "early deflection model" can provide even earlier crisis resolution and diversion by redirecting non-life-threatening calls and avoiding sending first responders when unnecessary.

A 911 crisis call diversion program can also place crisis counselors inside an emergency communications center, providing dispatchers the ability to link callers who have nonemergent behavioral health–related issues directly to needed services, rather than dispatching LE units or FD personnel. The behavioral health specialists in this model are embedded in 911 dispatch, again, functioning as a co-location diversion" model (personal conversation with Marsha Ford, Rick Murray, and Debra Perina).

Example: Defining mobile crisis response in Colorado

Colorado is changing its mobile crisis response definition to eliminate confusion regarding the difference between mobile crisis and co-responder models. These services have different sources of funding, and their partnerships can take different forms. Colorado does not have minimum standards for co-responder staffing or policy, so each agency conducts its own oversight. Colorado's 988 teams now follow the US Center for Mental Health Services definition of minimum standards for mobile crisis care. Still, the teams caution against mandates that have potential to harm and have historically caused community partners to become indifferent.

Model: Mobile crisis teams using law enforcement as backup

A 2022 survey conducted by NASMHPD's National Research Institute found that 96% of the 46 states responding are operating MCTs. In 24 states, MCTs are available statewide.[12] Some MCTs use LE as backup, and this model may become more common as knowledge of and experience with 988 increases. A behavioral health–led response to 988 calls provides a message to the caller that this will be handled as a behavioral health or suicide crisis and not as a medical or LE

emergency. If safety is a concern, LE can be contacted to provide backup only. This again sends a message that the response is primarily a behavioral health response.

Model: Traditional "co-responders" for mobile responses

The traditional co-responder framework typically features a specially trained team that includes at least one LE officer and one mental health and/or substance use professional, who jointly respond to a behavioral health crisis service call. The mental health professional typically travels in the same vehicle as LE, provides clinical support, conducts screening and assessments, reviews what is known about the individual's history, and navigates and refers the person to community resources on-scene, avoiding unnecessary transport to EDs or LE facilities.[13]

"New Jersey is piloting a new crisis response program called ARRIVE Together. In this model, LE is paired with a behavioral health professional in an unmarked car and assessment is done by a psychiatric screener and transport is provided to a hospital if needed.

With 988, a new response team model—Mobile Crisis Outreach Teams—does not utilize LE and instead includes both a person with lived experience and a mental health professional who can deescalate crisis situations and provide contacts, resources, etc. New Jersey reports that this model has shown great success in other states in engaging individuals with appropriate services and treatment. The State hopes this more person-centered approach will significantly reduce unnecessary contact with LE in the future."

—Valerie Mielke, Deputy Commissioner of Health Services, New Jersey Department of Human Services

Model: Fire department and/or law enforcement join with EMS clinicians

EMS and FDs are increasingly involved in specialized crisis response in a model similar to the one in which trained EMS teams respond to crisis calls with LE. Additionally, some fire/medical co-responder teams may proactively reach out to people with mental illness who regularly call for service.

Model: Peer support workers join law enforcement

In some models, trained or certified peers can be deployed with LE as responders. Peer support services are particularly helpful in easing the potential trauma of the justice system process, encouraging consumers to engage in treatment services, and intervening with individuals at high

risk (e.g., unhoused people and others). Peer services are often free, voluntary, and offer nonclinical support with an end goal of reducing emergency protective orders and involuntary treatment placement. At the same time, the role of professional peers in crisis services is likely growing, and thus this is an area that will likely be further developed. The second brief in this series, *Peer Support Services Across the Crisis Continuum*, provides several examples of models involving peers that can serve as alternatives to co-responder models.

Model: Multiprofessional teams, especially for substance use and other specialized interventions

Teams comprising multiple different professionals are able to respond broadly but also at times are focused on intervening for specific issues, such as substance use, homelessness, and human trafficking. They are composed of specific members that come from different perspectives in the crisis response array.[14] These focused interventions may include both proactive outreach and follow-up, as in the case of an opioid overdose where postcrisis outreach is conducted within 12 to 24 hours of a nonfatal overdose by a team of plainclothes officers, a licensed clinician, and/or a recovery coach. They visit the home of the survivor to provide resources and connections to treatment. Such an approach is also helpful for homeless populations to determine if a person needs to have psychiatric medications refilled or if a new assessment is required. Because victims of human trafficking are often even more wary of LE than other populations, specially trained behavioral health specialists can help identify those who may need assessment, LE, justice, and/or casework advocacy. In other areas, multidisciplinary response teams comprise health care professionals, behavioral health specialists, and LE professionals who bring their skills to bear together to triage and help respond to crises.[15]

Model: Multidisciplinary teams of CCBHCs

SAMHSA's guidance for states' Certified Community Behavioral Health Clinics (CCBHCs) and qualifying "community-based mobile crisis services" both describes and requires a multidisciplinary team model. Under Title XIX, section 1947(b)(2), of the Social Security Act, "qualifying community-based mobile crisis intervention services" must be delivered by a multidisciplinary team that includes "at least one behavioral health care professional who is qualified to provide an assessment within their authorized scope of practice under state law and should also include other professionals or paraprofessionals with expertise in behavioral health or mental health crisis intervention. These additional community-based mobile crisis intervention services team members may include nurses, social workers, trained peer support specialists, and others with relevant experience and expertise as identified by the state in its state plan, waiver, or Section 1115 demonstration.… [S]tates must ensure that all members of

SAMHSA updated the CCBHC Certification Criteria in March 2023, including what is required for crisis behavioral health services:

- Emergency crisis intervention services
- 24-hour mobile crisis teams
- Crisis receiving/stabilization

SAMHSA. CCBHC Certification Criteria. March 2023. https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

the team are trained in trauma-informed care, de-escalation strategies and harm reduction. States should also consider how to meet the needs for language access for people with limited English proficiency or those who are deaf or hard of hearing and comply with any applicable requirements under the Americans with Disabilities Act."[16]

Transitioning to New Models

Although procedures may be put in place to increase 988 and 911 coordination and collaboration, it is important to be mindful that historical practices and culture shifts can take longer than expected. The necessary cultural shift may be more challenging to personnel in geographies where there has been a historical lack of behavioral health professionals. For example, LE and emergency medical technicians (EMTs) may find it difficult to let go of their sense of responsibility to protect and provide safety, in order to partner in an augmented service system. Each community will need to assess or conduct trials of models to determine if they are effective in that geographic area, with the populations served, and with adequate staffing capacity across all the partner agencies to achieve success. It may be most effective for one or more models to be piloted or utilized in distinct parts of a state and even significantly revised based on evaluation results.

The City of Austin TX co-located their Crisis Center clinicians with their 911 Call Center allowing the Expanded Mobile Crisis Outreach Team (EMCOT) to provide upstream services and divert mental health calls, as appropriate, from police response. During the first 8 months 83% of calls were diverted from the police which resulted in savings of $1.6 million in response, transport, and involuntary commitment costs. Through 2021 they had diverted over 5,000 calls with a cost avoidance of over $12.6 million.

Diverse and Sustainable Sources of Funding

Effective coordination relies to some extent on multiple-payer collaborations for universal eligibility and access. In some locations and models, there may be very few options for reimbursement. Available funding and reimbursements for services may directly or indirectly impact the models that states and localities employ. Funding sustainability, while oftentimes a challenge, is critical in achieving equitable access to services. In addition, data will be key in a state's ability to analyze savings realized by reductions in costs for excessive ED utilization, unnecessary utilization of LE, and detention in custody. A reimagined crisis system with responders that can direct people to stabilization services either at home or in appropriate behavioral health settings may be a path to financial sustainability.

Mapping State and Local Practices to Identify Gaps and Resource Needs

One effective way to identify how variables impact the ability of 988 and 911 services to work collaboratively is to map the current practices that localities and states report as working well and then identify gaps and other resource needs.

Example: Utilizing Fairfax County's existing infrastructure for 988 implementation in Virginia

Fairfax County's existing infrastructure for providing behavioral health services facilitated Virginia in becoming the first state to implement 988. The County Mobile Crisis Unit provides on-scene evaluation, treatment, crisis intervention, and a link to 988. With this system the County expects a reduction in calls to the State's Public Safety Dispatch Center, thus reducing the utilization of LE, fire, and rescue resources. Additionally, the Fairfax County Police Department (FCPD) reports 988 will ensure a coordinated response for all behavioral health services in the region. The FCPD spent time building relationships and holding biweekly meetings with several key stakeholders such as the FDs, PDs, college campus police, and behavioral health agencies. The County describes the new situation as a "win-win". Yet, like many communities across the country, it reports behavioral health workforce issues, especially a shortage of clinicians, as their biggest struggle.

Protocols and Procedures within Each Model to Ensure the Right Response at the Right Time

For every model utilized by a state, it will be necessary to have joint protocols that clearly describe how type of care and level of care determination will be made. Procedures and tools for medical triage and behavioral health screening must also be in place for the coordination between 988 and 911 to work safely—the number one priority of the system. Other priorities include time and cost efficiency for medical care, behavioral health agencies, and LE and FDs that will continue to be a part of emergency response services. When individuals in crisis receive the appropriate services from the outset of the response, the level of care needed can be more accurately determined and the quality of care improved.

Accurate screening by the contact center and on-scene responders can help avoid ED visits as well as unnecessary hospital admissions. Avoiding LE responses where LE is not needed, as well as avoiding written criminal complaints and even arrests and jail, may ultimately serve the community and the individual better, changing the course of an individual's life for the long term. Also, behavioral health crisis intervention at the start of an emergency can help avoid the use of force that may escalate the emergency, leading to significant injury or even a fatality.

Coding and Data Collection

Every city and county in the United States has its own set of 911 call classification codes. These are the codes used by emergency responders to communicate with each other during an emergency. Codes can be either over- or under-specific, such as the code "other."[17] The Vera Institute of Justice conducted a multicity 911 analysis evaluating call code inter-rater reliability and found that two call takers were not likely to classify calls the same way—that is, in most cases, the call codes did not match up. Coordination and collaboration will require a common set of codes or a shared framework for cross-comparisons of data from 911, LE, EMS, mobile crisis and other response agencies, 988, and the health and behavioral health care systems.[18]

Example: Enhancing coordination of existing infrastructure in Los Angeles County, California

Los Angeles County, California, has sufficient crisis response resource capacity and even has different types of crisis response teams, but coordination between the behavioral health system and the behavioral health services themselves has historically been limited. In the past, high- and moderate-risk calls would have been transferred to LE dispatch or a co-responder team. The County's current co-responder model is typically a two-person team that comprises a police officer or EMT partnered with a behavioral health professional. Also, the county now has an assessment matrix to help triage behavioral health calls that come in to 911 and are transferred to the 988 Suicide & Crisis Lifeline network center, Didi Hirsch Mental Health Services. Of course, when call transfer or forwarding is involved, the risk of dropped calls or hang-ups increases. This presents the possibility of the loss of life, and it can also be distressing for the caller if it is necessary to repeat their story. Thus, the appropriate technology to link 911 and 988 is essential. First, 911 call takers and dispatchers should be able to bring 988 online so both entities will be able to hear the caller. Similarly, the 988 Suicide & Crisis Lifeline center should be able to link to 911. However, until the technology is in place, linkages between 911 and 988 will not be a seamless process. Bridging these gaps is essential to make this a reality. Technology should not be a limiting factor to any crisis continuum plan.

Sherin JE: Consolidated Report Response to the Motions "Crisis Response Coordination" (Item 3, Agenda of March 4, 2020) and "Alternatives to Law Enforcement Crisis Response" (Item 40-H, Agenda of June 23, 2023). Los Angeles, CA, County of Los Angeles Department of Mental Health, August 17, 2020

Differing classification codes are not the only challenge. Agencies and services also have different terminology, jargon, and data collection rules and tools. Local and state agencies are now recognizing the need for shared language and understanding in their dialogue—a "data dictionary." Common definitions and application of coding must be an integral part of integration or interoperability. Working on a set of common definitions can build trust and buy-in among the staff at different agencies. To this end, all states, the District of Columbia, and two US territories have adopted a national standard data dictionary, the National Emergency Medical Services Information System (NEMSIS) data dictionary for patient care reporting.[19] Data is collected by state EMS offices and submitted to the University of Utah for this data set. It includes data from 50 million 911 responses from across the country from 2022 alone, including behavioral health emergencies. NEMSIS sets a national standard for how patient care information resulting from prehospital EMS activations is documented. With NEMSIS data, EMS stakeholders can more accurately assess EMS needs and performance, as well as support better strategic planning for the future of EMS systems. Data is also used to help benchmark performance, determine the effectiveness of clinical interventions, and facilitate cost-benefit analyses. It also shows whether people called 988 or 911 previously, for what reason, and the service they expressed that they needed. Over the course of developing 988, it will be helpful for policymakers to consider whether it would be possible to adapt the NEMSIS dictionary to include more specific definitions for behavioral health emergencies, thus creating a joint 988/911 data dictionary and data set. As analysts look more closely into the reasons a call was made, there will be more to learn about how a crisis is experienced, defined, and managed, which may inform how to avoid some crises in the future.[20] The states interviewed stressed the importance not only of data collection but also of making certain everyone involved agrees on the definition of the constructs before you begin measuring them.

Example: Diversion of PSAP Calls to 988 in Colorado

Colorado has launched pilot programs in which PSAPs transfer calls to the 988 Suicide & Crisis Lifeline system. The routing process related to geo-location is being evaluated currently for accountability regarding the transfer. Global Positioning System (GPS)–enabled geo-location technology (e.g., smartphones or tablets equipped with GPS) can help the closest MCT locate someone in need in real time, providing accurate directions to the emergency site quickly and efficiently. It can also allow the dispatching agency to monitor the MCT in the field to track its progress during the response. Client tracking software is another technological option to serve special populations such as homeless individuals or those who have limited access to traditional communication methods. To date, the State has not developed minimum staffing standards nor a policy to ensure seamless transferring of calls. However, the pilot is in place to help determine which protocols are working optimally.

Immediately upon the launch of 988, several states mandated that their crisis centers collect and share their data with state behavioral health authorities (SBHAs), including information that could be personally identifying (e.g., county codes in low-population areas). Previously, data collection across 988 centers had excluded any external data reporting and distribution other than in the aggregate. Even internal data use had been limited to protect the confidentiality of users. With the transition to 988 and establishment of the state's involvement in funding and oversight of crisis center performance, data access and privacy have become a primary focus of discussion. The 988 Suicide & Crisis Lifeline's policy on confidentiality was based on users' expressed fears that calling 988 would automatically result in a 911 response, or that callers would be taken to a psychiatric facility or jail. If the states decide that personally identifying data will be accessible to them, confidentiality may factor into a person's decision to use 988. Therefore, in communities where marginalization and negative outcomes of police responses have already engendered greater distrust, significant efforts must be made to ensure and communicate protections regarding data access and usage.

NENA Suicide/Crisis Line Interoperability Standard

The National Emergency Number Association (NENA) is another stakeholder in coordination and collaboration and has begun to partner with crisis lines. NENA has a mission of fostering the technological advancement, availability, and implementation of a universal emergency telephone number system. It has developed a guidance document, *The NENA Suicide/Crisis Line Interoperability Standard*,[21] to help ensure that persons at imminent risk of suicide receive the emergency assistance they need. NENA's minimum standard in this regard requires that PSAPs and Emergency Communications Centers "maintain operational procedures for managing suicide emergencies," including guidelines to identify and locate the individual at risk as well as contact the receiving facility regarding the caller's risk status.[22] The guidelines are clear that crisis line answerers should not contact a PSAP until after an extensive assessment of risk and safety, and after all other options have been exhausted to secure a person's safety unless the caller has already taken some action to end their life and immediate rescue is necessary. The crisis lines are required to provide PSAPs with all information available to them to assist in locating the individual, although it is uncommon that they need to do so. For crisis lines, calling a PSAP is typically a last resort. Fortunately, PSAPs have approximately a 90% success rate in locating individuals in need of services. PSAPs are legally permitted to obtain or request that a mobile carrier obtain the geo-location of a subscriber at imminent risk of death. There is no reasonably foreseeable legal risk (including risk under the privacy rules of the Health Insurance Portability and Accountability Act of 1996, or HIPAA) to a PSAP for requesting that a carrier send the location of a user at imminent risk, nor for the PSAP to provide the crisis line with disposition information relating to the attempted rescue of such a user.[23]

Proactive Follow-Up in the Aftermath of the Immediate Crisis

SAMHSA has provided grant funding for follow-up services through the 988 Suicide & Crisis Lifeline centers to ensure follow-up for suicidal persons who contact 988, provide enhanced coordination of crisis services, and coordinate with mobile on-site crisis response. The goal of this funding is to ensure continuity of care to safeguard the well-being of individuals who are at risk of suicide. As with adults, crisis stabilization at home is also a key part of children's behavioral health crisis services.[24,25] Although follow-up care is often overlooked in the crisis services field, "crisis centers are uniquely positioned to be a crucial resource for people in need of follow-up care and are a vital resource for linking patients to services and providing emotional support," and most 988 centers provide "some form of follow-up service with programs ranging from follow-up services for familiar callers, monthly check-ins for high-risk callers, ED/inpatient discharges, and third-party calls."[26] In the advanced interconnectedness framework, proactive follow-up may be a service that could stem from 988 or 911 responses, such that regardless of the number contacted or the source of response, necessary ongoing care would be available in the aftermath of the crisis.[27,28]

Reducing Risk of Potential Liability Concerns Related to 988 and 911 Collaboration, 911 Diversion, and Law Enforcement Engagement

Liability concerns are best addressed with clear language and understanding. A wise place to begin is by building a data dictionary because the same word may mean different things to personnel in behavioral health or LE or 911/EMS. Another source for clarification is reviews of case law and issue scenarios. 911 staff indicate that they do not want to be sued, and reviewing case law will make them less liable because ignorance of the law is not a defense. Laws must be written clearly and express that not doing anything also involves risks. To make the decision-making process easier, it is important to include state attorneys general early and learn from actions taken by other states.

Diverting calls from a traditional 911 LE or LE/EMS response or determining the need for a joint response constitutes "911 diversion" from traditional responses. Liability concerns associated with 911 diversion are very state-specific, because each state has its own civil/tort laws, qualified immunity laws, and so on. Approaches to address these liabilities can also vary. Introducing a state law or internal policy process written into a memorandum of understanding (MOU) among all entities can assist with managing the risk of potential liability. The Assistant Attorneys General assigned to agencies are familiar with state law and individual agency regulations. They would be very helpful explaining what is covered and where gaps exist. They will also help with negotiating language for memorandums of understanding (MOUs) or legislative language if

necessary. As Pinals noted in *Lending Hands,* collectively, partners including LE and EMS need to be included in the system design and standard operating procedures development.[29]

Example: 988/911 liability legislation in Washington state

A 988/911 **liability law** signed by the governor of the State of Washington, House Bill 1134, has the intention to reduce liability concerns of the crisis dispatch systems and those who would be providing the services. A provision of the bill states, "(1) No act or omission of any certified public safety telecommunicator or crisis call center staff or designated 988 contact hub staff related to the transfer of calls from the 911 line to the 988 crisis hotline or from the 988 crisis hotline to the 911 line, done or omitted in good faith, within the scope of the certified public safety telecommunicator's employment responsibilities with the public safety answering point and the crisis call center or designated 988 contract hub and in accordance with call system transfer protocols adopted by both the department of health and the emergency management division, shall impose liability upon: (a) the certified public safety telecommunicator or the certified public safety telecommunicator's supervisor; (b) the public safety answering point or its officers, staff, or employees; (c) the clinical staff of the crisis call center or designated 988 contact hub or their clinical supervisors; (d) the crisis call center or designated 988 contact hub or its officers, staff, or employees; or (e) any member of a mobile rapid response crisis team or community-based crisis team endorsed under section 8 of this act. (2) This section shall not apply to any act or omission which constitutes either gross negligence or willful or wanton misconduct."

In terms of examining liability considerations, current issues pertaining to disparate practices and negative impacts of LE responses toward individuals with mental illness and of racial and ethnic minorities continue to catalyze the need to shift responses to LE as a last resort unless safety warrants their participation. *The Washington Post* reported data for the first six months of 2015 from its police shooting database revealing that 22% of the people killed by a police officer in the line of duty were Black, 15% were Hispanic, and 22% were identified as having a mental illness.[30] This is not just a recent problem, as the *Los Angeles Times* database reported that from 2001 to early 2022, almost 80% of all people killed by LE in Los Angeles County were Black or Latino.[31] In addition to addressing issues of race in emergency response, alternatives to justice system involvement for people experiencing behavioral health issues are critical. To that end, the US Department of Justice has recently issued findings in several communities of discriminatory patterns and practices, as well as violations of the Americans with Disabilities Act (ADA), by police when dealing with people with behavioral health conditions.[32,33] Given this important scrutiny of practices, collaboration and improvements are imperative. From this perspective, 988 and 911 will need to share core goals as they plan how to work together moving forward. It will be important to examine existing liabilities, discriminatory practices, and overarching patterns of use of force and working with people with disabilities within the current system, and at the same

time, to develop mechanisms for understanding the link between liability and negative outcomes in emerging systems. When practices and protocols are delivered appropriately, liability can be mitigated.

"Many states enjoy language in their laws for EMS personnel such as immunity from liability clauses. 'Standardized, and evidence-based, when possible' governs how decisions should be made. There are model EMS clinical guidelines that communicate expectations for care and that include behavioral emergencies."

—Dia Gainor, MPA, QAS, Executive Director, National Association of State EMS Officials

Concepts of qualified immunity that have been in place for emergency responders and LE are important elements related to liability. It remains uncertain whether qualified immunity will apply to future personnel in emerging response models with new types of responders and triage systems. *Qualified immunity* is defined as a statutorily created doctrine that shields certain officials from being held personally liable for violations of law or policy. In the context of LE responses, for example, individuals who interact with police have the right to be free from the use of excessive force by police, but police also have some qualified immunity from personal liability when acting in their official capacity and engaging in actions within the scope of LE policies, training, and protocols, and within the law.[34] The US Supreme Court has observed that qualified immunity balances two important interests—"the need to hold public officials accountable when they exercise power irresponsibly and the need to shield officials from harassment, distraction, and liability when they perform their duties reasonably."[35] Some state laws have abolished certain types of qualified immunity. For example, Colorado determined that due to qualified immunity, countless victims were deprived of the ability to vindicate their civil rights in federal court.[36]

Liability for EMS has nuances that are different from those of LE, as EMS is a health care entity and so the use of force is generally not the same issue as it is for LE. Protocols that delineate to whom EMS can transfer cases will be needed to help ensure that the staff have a framework to follow. This is the case in Orange County, North Carolina, where EMS can hand off to an MCT.[37] In addition to civil laws, informed consent is a critical component when treating EMS patients. In an emergency that is life-threatening, there may be exceptions to formal informed consent, but otherwise, consent should be obtained verbally or in writing because, without the valid exceptions, it can be unlawful for EMS to touch anyone. In certain cases, verbal and

definitive consent cannot be obtained prior to treatment.[38] These issues are and will be just as relevant to mobile behavioral health crisis responders as they are to other first responders. What that means for responses involving children or adults under guardianship is also critical to understand, as are the implications for working with individuals who lack capacity in the moment but are engaged in conduct that puts themselves or others in harm's way. State civil commitment laws permit physical holds if proper protocols are followed and if authorities have executed necessary documentation in support of this action. Therefore, responders must consider when to involve legally authorized decision makers for people in crisis who may not be legally able to make their own decisions about care, and they must have knowledge of rights and protocols to know how to proceed in managing a situation with someone who is not consenting.

Interviewees for this review collectively noted that many jurisdictions currently operate under or are pursuing MOUs to help enhance the coordination and limit liability across responders. For example, The Harris Center in Houston, Texas, has implemented an MOU with its local FD and police department (PD). An MOU operates as a document that allows all parties to collectively agree on the mutual responsibilities and to the performance and accomplishment of the agreed-upon scope of work. Increased collaboration between 988 and 911 can provide more options for those in crisis, such as dispatching MCTs to individuals in a behavioral health crisis in lieu of police or EMS. The 988 Suicide & Crisis Lifeline's *Policy for Helping Callers at Imminent Risk of Suicide* handbook[39] provides examples of emergency services providers that have established and maintained formal or informal relationships, as well as relationships for collaboration and for meeting 988 Suicide & Crisis Lifeline center requirements.

Lessons Learned from the History of 911 That Can Inform 988

As early as 1966, the National Academy of Sciences published a report that recommended a single nationwide telephone number that would summon an ambulance.[40] This was a result of the impacts of traffic accidents, crimes, and medical emergencies.[41] Only two years later, 911 was operational. The service grew quickly with call centers around the country operating independently but lacking consistent protocols and training. Additionally, the capacity to provide the service, especially in rural and frontier areas, was, and remains, a challenge.

By the early 2000s, significant enhancements were made to 911, such as the wireless National 911 Profile Database; the transition to digital communications to allow for voice, data, and video transmissions from various types of devices; and the ability to share this information with 911 call centers and emergency responders. Under the Enhance 911 Act of 2004 (known as "e-911"), the US Department of Commerce was charged with leading the effort to coordinate, support, and promote optimal 911 services.[42]

Over the next 15 years, 911 became more structured, and 911 services across the country more coordinated and organized. The National 911 Program Office was established within the

National Highway Traffic Safety Administration (NHTSA). PSAPs generally must demonstrate a wide array of capabilities, such as the ability to receive and transfer data to each other successfully; to locate people calling from wireless and internet; and to access the National 911 Profile Database, allowing for sharing of data such as funding sources and types of calls. The Program Office compiles standards for distribution to help the PSAPs achieve interoperability and recommends 911 minimum training guidelines. The National 911 Program launched a forum to share best practices, lessons learned, case studies, and tools in the 911 community, and it has created a long-term plan and strategic goals for a nationally uniform 911 data system.[43]

"It's changing the view. Each agency should implement a protocol that outlines to whom EMS can 'hand off,' whether on-scene or via transport. Many departments have successfully incorporated telehealth and alternate destinations into their protocols through collaboration with their medical director."

—Kate Elkins, EMS/911 Specialist, National 911 Program, Office of Emergency Medical Services, National Highway Traffic Safety Administration, US Department of Transportation

Initially, 911 emergency services such as ambulance/EMTs did not suffer from the stigma associated with mobile crisis and other psychiatric emergency services. EMS that include LE, however, continue to be under pressure to improve practices, specifically around equitable treatment of everyone they serve, including those facing behavioral health crises. With the ongoing growth of 911, EMS, and now 988 responses, there will continue to be extensive efforts to rebuild trust with all communities by proving that responders are committed to equitable practices. This will be discussed further in the section below.

Building Relationships and Trust among Specific At-Risk Populations by Fostering Collaborations and Services between 988 and 911

State behavioral health authorities and local health departments are beginning to collaborate with community partners to assist them in communicating about 988, particularly to explain to communities the distinction between 988 and 911. New messaging about 988 services is critical, and therefore determining both the key partners and the key messages should be part of the planning. A Pew Charitable Trusts article revealed that only 13% of adults in the United States have heard of 988, nine months after its launch.[44] This is likely because widespread marketing campaigns had not yet been rolled out early while the 988 Suicide & Crisis Lifeline infrastructure was being established. Even after being provided with language that described 988

and its purpose, 40% had concerns about LE as responders, being forced to go to the hospital, being charged for services they could not afford, and privacy related to the call. In addition, one in four were concerned about ending up in jail. As the systems evolve, it is important to keep in mind that "a robust continuum of crisis services must be ready to serve all people *equitably*, and as such the lessons learned at the 911 interface are important to carry forward in the 988/911 interoperability planning."[45]

Mistrust of Emergency Response and a Path Forward

Increasing access to and quality of crisis services alone will not reduce disparities in the use of behavioral health services by historically underserved and high-risk groups, nor build their trust in calling a three-digit number for help. The Pew Charitable Trusts study mentioned above indicated that individuals with mental health issues and LGBT+ individuals were the most concerned, with 56% of those with mental illness and 46% of LGBT+ individuals concerned about an LE response.[46] Concerns related to behavioral health services are rooted both in individuals' cultures and in prior negative or unsatisfactory experiences with the health care system.[47] Culture may also play a significant role in how and when individuals seek care, as it can influence their comfort with seeking care, shape their understanding of behavioral health conditions, and define their expectations regarding interactions with service providers.[48]

Mistrust is one factor that impacts the rates of use of behavioral health services among minority and LGBTQI+ populations. Rates provide a picture of vast disparities. Although racial and ethnic minority populations have rates of mental disorders similar to Whites, for minorities these disorders are more likely to last longer and result in more significant disability. In 2020, 52% of Whites with any mental illness received mental health services, compared to 37% of Black people, 35% of Hispanics, and 21% of Asian Americans.[49] LGBTQI+ populations of all ages disproportionately experience more instances of mental health and substance use disorders, suicidality, and poorer well-being outcomes than do their heterosexual and cisgender peers.[50] Tribal members, veterans, children and adolescents, older adults, the chronically ill and disabled, people with lower incomes, people with language needs (e.g., American Sign Language, Spanish); and people living in rural areas also experience disparities.[51,52,53]

"Too often, policies and programs are developed and implemented without thoughtful consideration of racial equity. When racial equity is not explicitly brought into operations and decision-making, racial inequities are likely to be perpetuated."

—Government Alliance on Race and Equity (GARE)

Nelson J, Brooks L: Racial Equity Toolkit: An Opportunity to Operationalize Equity. Local and Regional Government Alliance on Race & Equity (GARE), September 2015. https://www.racialequityalliance.org/viewdocument/racial-equity-toolkit-an-opportuni-2

Trust in using 988 may be impacted by acculturation, culture, religious beliefs, language barriers, lack of knowledge of services and where to obtain them, lack of recognition of signs and symptoms of behavioral health conditions, shame, desire to keep behavioral health issues private and within the family, and prior negative experiences with these services.[54] Additionally, achieving a reduction or an elimination of behavioral health disparities will require clinicians to look at their own attitudes about race. An increase in their cultural competence and social awareness will assist in eliminating bias against ethnic and racial minorities.[55] Interoperable systems will need to consider uniformly how these issues factor into who calls what number and how responders best respond.

"Failure on the part of practitioners to go beyond clinical history gathering to recognize and acknowledge the larger historical perspectives from which they and their patients of color draw conclusions and make decisions contributes to the mistrust of the medical and mental health communities and to perpetuation of the current climate of health care disparities."

Suite DH, La Bril R, Primm A, et al: Beyond misdiagnosis, misunderstanding and mistrust: Relevance of the historical perspective in the medical and mental health treatment of people of color. J Natl Med Assoc. 2007; 99:879–885

Lack of trust by minorities and LGBTQI+ groups in the behavioral health system and the relationship between 911 and LE are factors that may drive the use of 988.[56] Many studies cite the Tuskegee Syphilis Study as a major cause of African Americans' distrust in the health care system; however, there are other factors that reduce trust: other examples of racism and discrimination; substandard care, especially for populations with negative social determinants of

health; concerns about privacy; and a general mistrust of large societal institutions. LGBTQI+ people also experience discrimination and even abuse in health care settings that discourage them from seeking care, and they have difficulty finding alternative services if they are turned away. In a 2018 study, 8% of LGBTQ individuals were refused care due to actual or perceived sexual orientation, and 14% of those who had experienced discrimination in the past year avoided or postponed needed medical care due to disrespect or discrimination by health care staff.[57]

"There is representation from the Latinx and the Black community on the 988 Key Stakeholder Coalition. We are discussing how to get the message into the communities. Three listening sessions were dedicated to discussions with stakeholders on things that are critical to consider. Then marketing in the community can begin so they are aware of and understand 988."

—Valerie Mielke, Assistant Commissioner, Division of Mental Health and Addiction Services, New Jersey Department of Human Services

Mistrust in one institution, such as LE, carries over to another institution, such as health care;[58,59] that is, excessive use of force by police decreases trust in medical institutions. Concerns have been raised that a call to 911 (and possibly 988) for a behavioral health emergency may not only result in an LE response but also provide enough data to warrant "reasonable suspicion"[60] of a crime, resulting in an individual being detained or arrested.

As the coordination and collaboration between 988 and 911 evolves, it is important to triage the right calls to the right responders. The Center for American Progress and the Law Enforcement Action Partnership examined data from 911 police calls for service from 8 cities and found that 23% to 39% of calls were low priority or nonurgent, while only 18% to 34% of calls were life-threatening emergencies.[61] Thus, it could be argued that lower-priority, nonurgent calls could be a beginning for examining the types of calls that could be routed to MCTs, but also that this data should be examined across communities to ensure triaging is done fairly.

Commonalities among Factors Impacting Trust by US Minority Populations

There are commonalities among the factors that may lead to distrust by minorities and the LGBTQI+ population in the use of 988. There are similarities between and among Hispanics/Latinos', Blacks', and Asians' barriers to seeking behavioral health care—acculturation, culture, religious beliefs, language barriers, and lack of knowledge of services and where to obtain them.[62,63] Hispanic/Latinx individuals may prefer not to discuss mental health or

may not recognize the signs and symptoms of mental health conditions; they may also be concerned that the stigma associated with a behavioral health condition would cause shame or unwanted attention for their families.[64] Asian attitudes and values may create a sense of honor within the family that limits willingness to speak with outsiders about mental health issues.[65] Research indicates that Black, Indigenous, and People of Color (BIPOC) oftentimes believe that even mild depression or anxiety would be considered negatively, as a serious mental disturbance, in their social circles.[66] Research also finds BIPOC men are particularly susceptible to the perception of stigma.[67] Hispanics/Latinos may deny the presence of a mental health condition unless they are unable to cope or the symptoms of the condition are life-threatening. Hispanic/Latino family members may also discourage seeking treatment or taking medications due to a lack of knowledge or spiritual or cultural beliefs.[68] One such belief is in *fatalismo* ("fatalism"), a concept that individuals cannot change their fate but must trust in a higher power because mental illness is a punishment or form of divine justice.[69] Some Latinos seek help from healers (practitioners of *curanderismo*,[70] a type of traditional healing) and home remedies. These practices could be incorporated by a mental health professional into a treatment plan. Limited English proficiency is a limiting factor for accessing behavioral health services for 30.8% of Asian Americans. This level is a similar to that of Hispanic adults (32.9%) but 10 times higher than the rate among non-Hispanic Black adults (3.1%).[71]

"For communities to shift away from police-led responses to people experiencing behavioral health crises, they must engage and fund new partners who can plan and implement different approaches."

—Vera Institute of Justice

Beck J, Reuland M, Pope L: Behavioral Health Crisis Alternatives: Shifting from Police to Community Responses. Vera Institute of Justice, November 2020. https://www.vera.org/behavioral-health-crisis-alternatives

Understanding and addressing the underpinnings of these at-risk groups' mistrust related to culture is as important as understanding mistrust of somatic and behavioral health services, and fears of LE. Collectively, these three areas may provide the opportunity to address mistrust in its entirety.

Restoring, Building, and Maintaining Trust for the Crisis Response System to Succeed as an Interoperable Network

Trust in health care begins with the physician-patient relationship and can extend to other types of care providers. When people are particularly vulnerable, such as during a behavioral health crisis, they must trust that their support person or caretaker has their best interests at heart.

BuildingTrust.org has identified five dimensions of trust in care: competency, caring, communication, comfort, and cost. Following are some examples of these dimensions that apply to 988 and 911 collaborations:

- **Competency:** incorporating community members in governance of the system in question through a community advisory or oversight committee
- **Caring:** telehealth or in-person follow-up visits with the providers who initially cared for the individual
- **Communication:** mandatory training for staff on listening and collaboration to help individuals feel safe
- **Comfort:** the use of lay language, culturally affirming care, and linguistic competency, as well as responders who reflect the diversity of the community
- **Cost:** affordability pathways to make services financially accessible

Another method for building the trust of the community is by building basic goals and skills for responders and 988 Suicide & Crisis Lifeline Centers' staff, including first responders (EMS or MCTs) trained regarding de-escalation and diversion from the criminal and juvenile justice systems.[72]

> **"If we don't have data, we can't address the disparity. That is what changed my mind about data. We ask callers who are willing to provide data on race, ethnicity, gender, and sexual orientation so that we can understand more about who we are serving."**
>
> ***—Tanya Barrett, MS, LPC, NCC, Senior Vice President, 2-1-1 Connecticut's Health and Human Services, a division of the United Way of Connecticut***

The goals and skills that can be incorporated for all responders across the 988 and 911 systems include knowledge, skill, and attitudes gained from training in de-escalation; best practices in response used for only the most high-risk situations as defined in advance; behavioral health professionals and peers in mobile response as the default first responders; diversion to a nearby crisis intervention service provider, using GPS and "bed registry" information; guidelines for

safe and nonstigmatizing transport, and basic or introductory training in CIT Core Elements for Public Safety for *all* first responders and 911 call dispatchers.

For specific populations, directed approaches can be helpful. For example, incorporating cultural and linguistic differences and acknowledging gender and sexuality into a person's care significantly improves outcomes and improves trust, which is critical for a therapeutic relationship to be effective and for obtaining knowledge of the person's condition, thus changing their beliefs about it and breaking down acculturation barriers. For example, SAMHSA's Center of Excellence on LGBTQ+ Behavioral Health Equity was established to provide behavioral health practitioners with vital information on supporting the LGBTQI+ population. An additional factor for equitable response programs is procedural justice training, which encourages LE officers to explain their actions to civilians and treat them respectfully, fairly, and with dignity.[73,74]

Communities that engage in public discussions on issues that affect them gain an increased sense of self-efficacy, social capacity, and control, all of which are critical for community and individual well-being and for fostering trust in and support for the final decisions. Community voices support governmental decisions by providing accurate and complete information, a process that can lead to more equitable outcomes.[75]

"Overall, there is now a more mainstream national discussion about mental health and structural racism, which is helping destigmatize mental illness, especially in communities of color."

—Sosunmolu Shoyinka, MD, Chief Medical Officer, Philadelphia Department of Behavioral Healthcare and Intellectual Disability Services

Health regulatory boards have authority to require cultural competence training. SBHAs might consider a requirement for providers to engage in ongoing cultural competence and diversity training for recertification.

Racism and anti-LGBTQI+ sentiments affect the mental well-being of all people in lasting ways. Therefore, individuals will be more likely to seek help from 988, will be better served, and their mental well-being will be improved when the roots of their distrust (including LE and cultural perspectives) and any weaknesses in care they receive are recognized and improved. This will require significant changes in strategies for reaching out and providing care when people are experiencing a behavioral health crisis.

Relationships between Mobile Crisis and Law Enforcement

For many years LE has operated as the default responder in many communities for behavioral health–related 911 calls. According to NENA, 911 receives more than 240 million calls (including those concerning behavioral health) every year.[76] The majority of 911 calls involve nonviolent, noncriminal incidents such as wellness checks and mental health crises. Police and policing reform advocates often assert that specialized providers such as social workers and peer support counselors are better equipped to handle these situations than LE. Except for locations that receive CIT training, most LE receives minimal training on appropriate behavioral health responses. However, with the current changes to crisis services systems, LE trainings have begun to increase. Encounters between police and civilians experiencing mental health challenges may turn violent and, in some cases, deadly. Development of adequate resources in the community in lieu of police can help avert the potential harms of unnecessary police response—stigmatization, escalation, incarceration, and increased trauma—and offers more effective and less costly access to care.[77] Crisis counselors responding to 988 calls are guided to utilize the least intrusive course of action, when possible, by providing options like MCTs.[78]

Collaboration between 988 and 911 is integral to the system of care because people will continue, by habit, to call 911 when they can call 988. Communities need to ensure coordination between and among 988 Suicide & Crisis Lifeline centers, the 911 system, and community behavioral health crisis services including mobile crisis response teams. Communities should begin collaborations by coordinating training guidelines and response protocols for all disciplines—988 Suicide & Crisis Lifeline center staff, 911 operators, EMS, LE, FDs, and MCTs. Systems used by CAHOOTS in Eugene, Oregon,[79] and Harris County in Houston, Texas,[80] are well-established examples of community-based responses that have been well coordinated for years. These and others are described further below.

According to SAMHSA, “Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment that is likely to produce more effective results than inpatient hospitalization or ED utilization. When collaboration exists among hospitals, medical and behavioral health providers, LE, and other social services, community-based mobile crisis services are an effective and efficient way of resolving current and preventing future behavioral health crisis situations.”[81] SAMHSA outlines minimum expectations and best practices to operate an MCT. Examples of successful MCTs and LE collaborative models exist around the country. Four are outlined below.

Eugene, Oregon

CAHOOTS (Crisis Assistance Helping Out on The Streets) provides mobile crisis intervention 24/7 in the Eugene-Springfield Metro Area. CAHOOTS dispatches teams of medical professionals and crisis workers. CAHOOTS responders are dispatched through the Eugene police-fire-ambulance communication center.[82] Research shows that CAHOOTS diverts 3% to 8% of calls from the police and very rarely relies upon a police officer as backup.[83]

Denver, Colorado

STAR (Support Team Assisted Response) provides mobile crisis intervention between 6 a.m. and 10 p.m. in the Denver area. STAR deploys emergency response teams that include a medical professional and a crisis worker. STAR responds to low-risk calls—trespass calls, welfare checks, intoxicated parties, and mental health distress—where individuals are not at imminent risk. STAR is dispatched through Denver 911 communications.[84] During the program's tenure, about 13% of the 911 calls for service have been diverted to the STAR program.[85]

"Frequent communication within the 911 call center has shattered the wall between mobile crisis services and all other first responder divisions."

—Stephanie Hepburn, Editor-in-Chief, #CrisisTalk

Hepburn S: Austin's 911 Call Center Integrates Mental Health Call Crisis Diversion. Alexandria, VA, #CrisisTalk, June 1, 2021. https://talk.crisisnow.com/austins-911-call-center-integrates-mental-health-call-crisis-diversion/

San Francisco, California

SCRT (Street Crisis Response Team) provides rapid, trauma-informed response 24/7 across San Francisco. SCRT dispatches teams that include a medical professional, a clinician, and a peer specialist, dispatched through the San Francisco Department of Emergency Management.[86] Research shows that SCRT is diverting over half (58%) of calls monthly for individuals experiencing a behavioral health crisis.[87]

Austin, Texas

Austin created a first-in-class mental health call crisis diversion program in which telecommunicators ask callers whether they need services from the traditional list of police, fire, or EMS, but now have added mental health services to the list. Austin has partnered with its local mental health authority, Integral Care, for this diversion program, in which crisis center clinicians (C3s) are co-located at Austin's 911 call center. This transformative approach has allowed C3s and the Expanded Mobile Crisis Outreach Team to work from the same platform as LE to eliminate dropped calls, decrease response time, facilitate partnership, continue training, and provide seamless feedback loops. This model demonstrates bridging the gap and focusing on a common goal of trust and strengthened relationships.

Call Center Coordination and Best Practices

Collectively, states, counties, and localities need a "no wrong door" approach for callers, whether they dial 988 or 911. In this way, call takers can be the first responders to engage with an individual experiencing a behavioral health crisis. Developing a call tree or call assessment matrix and amending 911 call-taking procedures is a giant step in diversion. The call assessment matrix used by Didi Hirsch Mental Health Services in Los Angeles County helped inform a countywide crisis system redesign.[88] Virginia has utilized another example of a statewide 911 call matrix to divert individuals experiencing a crisis.[89]

Specialized Training for Law Enforcement and Other Crisis Responders

Many groups, from local jurisdictions to national organizations, are developing specialized trainings in crisis intervention and cultural competency to improve responders' knowledge of and skills in responding to behavioral health crises. Some academic centers are beginning to offer credentialing for behavioral health responders operating in crisis services. The Wayne State University School of Social Work in Michigan, through its Center for Behavioral Health and Justice, recently launched an initiative to develop such a certification process.[90]

State of California

The State of California is building a vigorous training component with cultural competency embedded in its crisis response system. The four major elements of developing cultural competency are (1) awareness—of your own view on the cultural world; (2) attitude—toward differences among cultures; (3) knowledge—of diverse cultural beliefs, views, and practices; and (4) skills—in dealing both with the difference between and among diverse cultures and with their interrelationships. Cultural competence creates an awareness of the value of collaborating with individuals of diverse cultures, races, genders, ethnicities, beliefs, experience, and ideas. This awareness will better prepare LE personnel for their duty to serve.[91]

National Council for Mental Wellbeing

The National Council for Mental Wellbeing (NCMW) developed a public safety training titled Mental Health First Aid® (MHFA) for Public Safety. MHFA had been broadly applied to the general population to promote mental health literacy, especially in relation to crisis situations, but NCMW adapted a version specifically for LE, 911 dispatchers, and EMS. This training provides options for de-escalating incidents as well as a basic understanding of mental illnesses, so learners are better equipped to respond to behavioral health–related situations without compromising safety.[92]

Bureau of Justice Assistance

The Bureau of Justice Assistance has established a Police–Mental Health Collaboration[93] model training tool kit that provides a curriculum, videos, and other tools with a focus on persons with mental illness as well as people with intellectual and developmental disabilities, another important group that is at risk of negative encounters with LE.

"A method of building trust is ensuring the centers are accredited. We are accredited by the American Association of Suicidology. As part of these accreditations, we are required to have an MOU in place with 911. Being part of a body that is on the cutting edge is important. Accreditation forces a space where you prioritize thinking about documenting and planning for how to meet and exceed the established standards of excellence. It is more about professional oversight than funders' contractual relationships."

—Tanya Barrett, MS, LPC, NCC, Senior Vice President, 2-1-1 Connecticut's Health and Human Services, a division of the United Way of Connecticut

Guiding Principles and Practices for 988 and 911 Coordination and Collaboration

The following are best practice actions that have been taken and found fruitful by organizations that are in the early stages of 988/911 collaborations. They are not evidence-based best practices that have undergone scientific evaluation but are based on field experience and collective reviews.

Best Practice—Building Trust

Trust is built through **quality** by pursuing accreditation for contact centers.

Knowing the individuals served facilitates a person-centered approach to crisis services, whereby systems will be required to build what works for the individuals, not just what works for the system.

Another way to build trust is through **being present and sharing.** Building relationships is a tried-and-true method of enhancing collaboration and eventually achieving greater coordination and collaboration. Because 988 and 911 cultures are different, it is important for each to be present for the other, and to be transparent with system development, data, and quality measures. State mental health personnel interviewed for this chapter shared that because LE works face-to-face, virtual relationships may not be fruitful. In-person meetings, showing your face, and caring about all the other huge transformations partners are dealing with are very important. Also, **being attentive** by attending meetings in person, being engaged in the discussions, and being open to tough questions all build confidence and comradery. Informants also stressed the importance of being able to admit where you have mis-stepped. They said listening to issues, concerns, and complaints; listening in on 911 calls; and doing a ride-along with police and understanding and respecting the work they do have also been extremely useful. The LE and behavioral health systems are different and are often at odds with each other, so **building trust** is hard and time consuming. The racial equity component can be controversial, but with everyone working toward the same goal of keeping people out of jail, it becomes easier.

"We are making an effort to collect very strong data on race and ethnicity so that we are able to understand more about who we are serving and how to serve better. We have a very robust public-facing dashboard which includes annual, monthly, and quarterly reports. This data helps us figure out how to train our workers…. [W]ho is calling and what they are calling for is important."

—Tim Marshall, LCSW, Senior Advisor and Private Consultant; former Director of Community Mental Health, Connecticut Department of Children and Families

Best Practice—Facilitating Cultures and Culture Change

The state personnel interviewed for this paper all agreed that 988 and 911 coordination and collaboration will involve a **workforce culture change** and that it may be more difficult for some than others. However, all agreed that when the stakeholders understand the benefit of the change for the public, they begin to think differently, more creatively about how they can adapt their operation to make the system better.

Best Practice—Collaboration

As mentioned above, **collaboration** includes competency, caring, communication, comfort, and cost. A system that is brought together by multiple parties of interest with the knowledge, expertise, and desire to make the 988/911 interface work will be the best that it can be for those served and for those who serve. In some cases that can be strengthened through MOUs and other formalized cooperative agreements, shared policies and protocols, and review of data.

An MOU includes, but is not limited to, a description of the collaborative integration, staffing, roles, and responsibilities of all parties; performance standards and quality monitoring; and indemnity. A memorandum does not replace statute nor adopted policies and procedures. NASMHPD's *988 Convening Playbook: Public Safety Answering Points (PSAPs)*[94] includes sample MOUs between a blended crisis center and a PSAP.

"I would be really conscious of the branding of 988 and how it applies to the diverse cultures in the country. I would pay special attention to making sure ads are diverse and that an effort to collect data around race and ethnicity is made for the purpose of analysis. We need to be able to understand more about who we are serving so they can be better served. Not requesting this type of data for analytic purposes would be a disservice."

—Tanya Barrett, MS, LPC, NCC, Senior Vice President, 2-1-1 Connecticut's Health and Human Services, a Division of the United Way of Connecticut

Summaries of Interviews with Representatives of States, Counties, and National Associations

National/State/County–Specific Crisis Planning and Operations Information Gleaned from Interviews

California

California started planning for the implementation of 988 with a clean slate and the intent to develop an ideal crisis system, and this was then catalyzed by the adoption of California Assembly Bill 988.[95] The first step was creating a strategic crisis care continuum plan that includes strategies for preventing crises. The plan begins in 2023 and will be implemented through 2029. Agencies are charged with developing a five-year plan over the next two years.

Each agency is responsible for coordinating work with its own stakeholders. The legislature has oversight, but the state agency will be developing metrics and providing implementation updates to the legislature. The agencies are also supporting the contact centers both programmatically and financially and are planning for a new MediCal mobile crisis benefit, modeled on federal guidance. Agencies will not be required to implement mobile response until the benefit is in place but will be required to include a comprehensive response for mental health and substance use disorders. Mobile teams will include a minimum of two members, both of whom can be peer supporters who are required to have a connection with a licensed professional, via telehealth if necessary. To work within the constraints imposed by the current workforce shortage, the team may include a broad array of types of professionals, including EMTs.

> **"Be careful not to build up walls before you even talk to the people on the other side."**
>
> ***—Rick Murray, Director, Department of EMS and Disaster Preparedness, American College of Emergency Physicians***

In guidance to counties, there is a clear expectation of coordination between 988 and 911. LE members are not precluded from responding with the team but do not count toward the two team members. The plan considers it a best practice not to include LE with the team unless necessary. The counties have been instructed to inform the State of how they will make that determination. There is a rigorous training component under development that includes cultural competency as planners look to address risk. Since there is a county-based model for the specialty behavioral health delivery system, authority is delegated from the State to the counties, thereby sharing risk. The 988 Technical Advisory Board has formed a working group to specifically develop policies related to how 911 and 988 will interact from a technological perspective. It is important to the board to have a "no wrong door" approach supported by messaging that is clear about which number to call. When public service announcements are completed, 988 will be advertised as a suicide and crisis hotline, and federal guidance in this area is anticipated for the planning in California.

Colorado

Colorado's statewide crisis response system is starting with strong collaboration between 988 and 911, conversations with LE and EMS, and some direction from legislative language.[96] A few years ago, the Colorado Department of Public Safety received federal funding to establish a work group to develop pilot programs in which PSAPs transfer behavioral health calls. One pilot, Rocky Mountain Crisis Services, is already in operation. This was an important first step as routing ability is critical, particularly as it relates to geo-location. Public Safety is also launching a rural pilot using a similar protocol.

Colorado is one of few states that has no state-established minimum standards for staffing MCTs. Therefore, the State has made it a priority to build trust across its 86 PSAPs, which are

currently doing their own oversight. Because oversight is strongly related to liability, the State is working with its attorney general to develop an MOU that outlines standard operating procedures including consistency when transferring calls. The State is also assessing service availability, including the scope of services to incorporate into MOUs. It has been determined that 988 teams will follow the mobile crisis definition that uses the CMHS minimum standards for staffing and operations as well as a standardized data dictionary. Planners will be working on reviewing case law to help centers understand liability issues. In addition, they are learning about data and the different record systems of PSAPs, LE, and EMS, as well as the joint issues of privacy in and funding for shared records.

The State agency is clear that it does not have all the answers and is happy to invite community partners to the table and go sit at theirs. It shares updates with its Peer Council to solicit feedback with a response loop to demonstrate how feedback impacts the system. The plan is to incorporate transparency and accountability and ensure everything has been community-led and -endorsed. Planners hear fear and confusion, but everyone is sharing their truth, so planners are convinced that collaborations will be successful. The process has included some difficult conversations with LE to help build trust and foster mutual belief that the gains will be worth the effort. This effort includes looking for partners that want to be involved in piloting changes. For example, planners believe that for the purpose of mobile crisis response, they need CIT to be statewide. Colorado is looking forward to developing pilots and creating options. Interviewees expressed the importance of harmonization and consistency to obtain the buy-in they wish to see from the stakeholders and the community.

> **"A lesson learned is sharing information about *joint issues of concern*. Many agencies didn't know that liability was an issue. It is important to think about it and how 911/LE/PSAPs/EMS interface with the call centers while resources are being developed during a pilot project."**
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> ***—Valerie Mielke, Assistant Commissioner, Division of Mental Health and Addiction Services, New Jersey Department of Human Services***

Connecticut

In Connecticut, 988 is operated by the 211 system ("211 CT"), which has been in place since 1976. In addition to information and referral and crisis intervention, 211 also provides services for disasters and emergency preparedness, response, and recovery. According to 211 CT interviewees, 40% of the call volume is behavioral health crisis–based and, following the implementation of 988, such calls have continued to increase. However, the number of calls being escalated to first responders has not increased and remains under 1%. System planners

"Although 911 does not report to 211, the Department of Mental Health and Addiction Services and the Department of Children and Families ensured collaboration through their statewide Suicide Advisory Board with more than 900 active members. During the development and planning of Vibrant grants, they were used as the 'go-to' coalition."

—Tim Marshall, LCSW, Senior Advisor and Private Consultant; former Director of Community Mental Health, Connecticut Department of Children and Families

credit this success to collaboration versus integration. They intend to transfer calls as infrequently as possible, and instead respond to callers' immediate needs.

Being a 988 Suicide & Crisis Lifeline provider has resulted in creating relationships with the first responder community. Staff from 211 CT have been involved in coordination with the 911 system and worked with State police and other entities for training. Outreach and coordination conversations with LE happen regularly. The 211 CT system manages information referral and crisis intervention as the single, statewide blended 211 and 988 center. Collaborating is perceived as desirable because it still leaves room for some independence regarding how a crisis worker responds.

The 211 CT system established protocols that allowed it to dispatch MCTs for youth, and this has set a standard, as the child crisis system is working very well. The adult system has moved to a similar model, providing residents a way to access mobile crisis services through a statewide front door. The system also established a public-facing dashboard with annual, monthly, and quarterly reports. Data on the characteristics of the callers has also proved to be valuable, as it assists in determining appropriate training for workers.

Connecticut's behavioral health system has very strong data on race and ethnicity, revealing that Black, Brown, and other minority children utilize mobile crisis services at higher levels than they represent in the general population. This is important: since these children are overrepresented in the child welfare and juvenile justice systems, planners do not want them to be underrepresented in the treatment data. This information has helped in targeting messaging to minority communities regarding which number to call when. The state Department of Mental Health and Addiction Services (DMHAS) and Department of Children and Families (DCF) provide oversight for the system and bring together all partners. The work is supported by two public acts—one focused on police transparency and accountability and the other on ensuring collaboration between DMHAS and DCF to incorporate behavioral health, mental health, and PSAP procedures. The initial goal had been to consider how 911 calls could be diverted to 211, but the focus has changed because all partners were concerned about honoring the caller's wishes and needs.

LE is very proud of its responses to behavioral health situations. From the beginning everyone focused solely on how to connect callers as quickly as possible without rerouting calls. Connecticut is dedicated to avoiding the use of LE for responses to children. If LE must be involved in a response, their job is to secure public safety, and then mobile crisis responders go in for response and stabilization. LE recognized that the family's trust is key to continued use of the service.

Connecticut identified several areas for guidance: when branding 988, ensure it applies to diverse cultures and ensure ads are diverse; callers' wishes should be respected—that is, LE and the FD should not respond when the caller has dialed 988 for help; and most calls can be resolved on the phone—do not escalate the situation unnecessarily.

Harris County, Texas

Harris County's 911 Crisis Call Diversion (CCD) project is eight years old, predating 988 legislation at the federal level. The integration has roots in a long-standing partnership in the County between LE and the local mental health authority. The program began as the result of an informal conversation about how to continue to expand programming designed to help people who are experiencing non-imminent-risk behavioral health crises avoid interacting with LE. There are other ongoing partnerships between these groups going back more than 25 years, including being early adopters of CIT training for both city and County LE, establishing a 24-hour walk-in behavioral health crisis emergency center, and integrating co-response teams into city and County LE. They also started the Clinician and Officer Remote Evaluation (CORE) program, which allows clinicians to assess a situation remotely using electronic tablets, assisting police in keeping persons in crisis out of hospitals and out of jails. The County explained that co-locating its LE field-based behavioral health unit within the PD keeps conversations alive.

Leaders in Harris County moved ahead by developing their own approach to 911 and crisis line integration by funding it through two philanthropic organizations and, later, with help from the US Bureau of Justice Assistance. At that point, they created a formal agreement- called a Memorandum of Understanding or MOU, with the City of Houston and the Houston PD. The behavioral health authority and LE MOU requires the arrangement of behavioral health dispatch by qualified behavioral health professionals with a specified amount of training. These professionals are also required to undergo training in PD-specific rules and regulations, and follow the guidelines from both the FD and the PD.

Prior to the MOU, triage for services included only ambulance, FD, or PD. For behavioral health–related calls, the FD would not go to the scene until a police dispatch arrived and "cleared the scene" to make it safe for the FD to come on-scene. After reviewing the "clear the scene" data, leaders found that there was very little need, if any, for an LE intervention in these situations. This initiated a conversation that brought the EMS and the FD into the project, allowing diversion of behavioral health calls from these agencies to the behavioral health responders as well.

For the first eight years of the project, it used a data system called "iCarol" to collect call data. This data system was separate from 911 systems and facilitated follow-ups or redirects if needed. Through this system, the CCD team can determine the number of calls that are fully diverted, meaning no police/fire/EMS response is needed, and those that do require an LE/FD/EMS response. Data from LE response times and 911 call clips allow the tracking of response times and how long an officer was on the scene of a call that was not completely diverted but had a CCD intervention. The project was able to demonstrate shorter response times for officers on these calls, thus resulting in an additional cost deferment for the City of Houston. The significant cost deferment led the City to agree to fund the project in partnership with the Texas Health and Human Services Commission and initiated the creation of a guideline manual developed in partnership with the PD.

There is considerable excitement in Harris County regarding the addition of dedicated mobile crisis outreach teams and rapid response teams to the CCD project, and the spectrum of ways they can intervene either by showing up on the scene with EMT and/or officers, or arriving after an officer has assessed a situation. Harris County's advice for other counties and states is to bring in a range of partners early, aiming not to miss anyone from joining the discussion, and assess early what the "win" is for each of them. Officials noted that this type of inclusiveness makes collaboration easier and makes it happen faster.

New Jersey

New Jersey's 988 Key Stakeholder Coalition has a breadth of representation including police chiefs, call center personnel, leaders from the Department of Children and Families, and individuals with lived experience. The coalition has been very active in considering the perspective of minority communities and has included Black and Latinx community members. Three listening sessions have been dedicated to hearing about 988 services from communities.

"The coalition has been asked to reach out to communities with which they are connected. They have identified 20 different communities that are historically underserved and are asking them to suggest resources that can be used by 988. In addition, there are three tribal communities that are state-recognized with whom New Jersey plans to collaborate. Special populations are being invited into the discussions, including people with intellectual and developmental disabilities as well as children, youth, families. They are working with the Children's System of Care regarding warm hand-offs for children and youth to make the system integrated and seamless."

—Mary Jean Weston, State Lead for 988, Division of Mental Health and Addiction Services, New Jersey Department of Human Services

The governor has provided funding to expand contact centers and a third party has been consulted to help leverage federal financial participation funding for the mobile crisis response outreach teams.

The 988 model that is envisioned looks very different from the existing system. Currently there is some capacity to go on-site if the person meets commitment criteria, and then the individual is transported by police to a psychiatrist for an assessment. Almost all mobile responses involve CIT-trained LE. The new system will have services in every county and there will be a triage process to determine acute need. MCTs will include someone with a bachelor's degree who can provide contacts and resources, as well as a person with lived experience. Mobile crisis outreach teams will be a mobile response that involves very few LE contacts.

A subset of the EMS council has been meeting to develop modified "guide cards" that include 988 and can be used by 911 dispatchers. Because not all PSAPs use guide cards, leaders will be working with the state police to develop universal warm-transfer policies. LE has expressed enthusiasm for 988 and interest in having it roll out successfully. New Jersey's leadership is also working on a new initiative, called the ARRIVE Together model (for Alternative Responses to Reduce Instances of Violence & Escalation). This is a co-responder model with an unmarked car. The yearlong pilot has been successful, and the State intends to take it statewide.

Virginia

In Virginia, the impetus for 988 was November 2020 legislation, the Marcus-David Peters Act,[97] which required development of a crisis continuum as identified in the Crisis Now model.[98] This included 911 diversion, a 988 system, and emergency backup for specialized mobile crises. LE must provide emergency backup services for mobile crises, and LE must use specially trained officers when needed to respond to a higher-acuity behavioral health instance.

The action steps began with the appointment of a stakeholder group including representatives from 911 and LE, disability advocates, and others. They were given about 6 months (until July 1, 2021) to develop a statewide plan, and five pilots (one per region) were to be implemented by December 1, 2021. In addition, the group was to implement additional pilots at a rate of one geographic catchment area per region per year through 2026, and remaining sites by 2028. There is a general State framework, which varies across regions, that can be adjusted based on regional assets and needs. Some regions have co-responder models that are locally funded or are working with other funding or initiatives for diversion. The local behavioral health agencies have assumed oversight for planning and implementation. Data collection will be through the Marcus Alert Program, which collects data from 911 centers across four levels. Demographic data will be collected through 988. The sole focus of one of the equity projects (Equity at Intercept Zero) is analysis of disparities using the crisis platform data.

Due to the reduction of burden that LE has experienced in recent years, they are optimistic about 988. Historically LE had always dispatched unless there was a related medical issue. Now there is an option to connect with 988 for a transfer or, if in doubt, LE can dispatch CIT officers or a

co-response team without any repercussions when that area does not have the experience to make those choices or the resources for sending LE if needed. Co-responder teams are not a regulated service, but rather utilize agreements. The clinicians are generally employees of the local public behavioral health system, which has an agreement with the local PD for co-training on how to respond. Each locality develops its own training and procedures.

A larger public awareness campaign will begin in summer of 2023. In anticipation of an increase in calls, six projects are in place to expand service delivery through recovery community organizations. One project will be a referral source from 988 as an alternative to the traditional public behavioral health system. Another project is working with historically Black colleges and universities in Virginia to increase diversity in the field. The programs are also tackling public awareness of 988, particularly in peer communities and communities of color.

Virginia staff report that the major lessons learned are the impact of collaboration, the culture shift for LE, and the essential nature of relationships and constant communications. Virginia interviewees expressed that in hindsight it would have been best to involve the Association of Public-Safety Communications Officials' (APCO) local chapters earlier in the process to facilitate spreading information more quickly and effectively than communicating to localities one by one. The LE and behavioral health systems have been at odds for a long time, and building trust is hard and time-consuming, but it is also a good opportunity to be in front of the issues and partnering with LE. Everyone is working toward the same vision, and the behavioral health leadership wants to help LE reduce its burden and get officers back to the work they signed up to do.

National Associations and Agencies' Specific Concerns and Insights

National Association of State EMS Officials (NASEMSO)

NASEMSO defines *interoperability* today as "cautious handoffs." Respondents emphasized the importance of the caller knowing who to reach out to, the 911 center having the immediate capability to transfer information between 988 and 911, and the importance of differentiating between the technology and operations aspects of interoperable responses.

The association's perspective is that state EMS directors and medical directors are attempting to catch up—to understand what is happening and how interoperability is being addressed. For example, if the caller has dialed 988 but needs 911, how much information can be transferred to the ambulance crew? The state directors question how they can best prepare and orient every ambulance service in their respective states to understand a new source from whom they will be receiving information. NASEMSO leadership expressed concern that the EMS directors in the states are suffering from a lack of information shared about the 988 system evolution. They are concerned that there is insufficient and at times no interagency communication (e.g., between the SBHA director or 988 crisis services lead and the state EMS director, or at the local level of ambulance services and mobile crisis). During the interview, it was noted that they often saw 988

discussed in news coverage but thought it was important to have these conversations, which had often not been occurring, in their day-to-day work. Collaboration and communication are critically important, and fortunately, in most states the EMS director is housed in the health department, where work on 988 is taking place. They concluded with advice that it is imperative for connections between the behavioral health director and EMS director to be made.

NASEMSO would define system "enhancement" as complete on-the-ground integration. When what SAMHSA calls the "second horizon" arrives—that is, when MCTs are universally available—NASEMSO leadership wondered how these teams would interface with EMS, how they would collaborate on the scene together, and how crew configuration might change if an MCT determines the person needs an ambulance. They noted that there are still many unanswered questions. They believe that rural areas will continue to present challenges for responses, and even more so for 988 teams that may be minimally available in hard-to-reach areas, where PSAPs may therefore default to ambulance teams to respond to 988 calls.

NASEMSO wants states to know about the National Emergency Medical Services Information System (NEMSIS.org), a universal data collection system that incorporates a national standard data dictionary for patient reporting. As noted in the body of this paper, all states, the District of Columbia, and two territories have adopted this system, which makes data transmissible automatically. It provides a wealth of information about the behavioral health emergencies handled by 911. A weekly report contains a section on behavioral health emergencies.[99]

NASEMSO leaders also want states to know that many states enjoy exception language in their laws for EMS personnel, such as immunity-from-liability clauses. "Standardized, and evidence-based when possible" governs how decisions should be made. There are model EMS clinical guidelines that communicate expectations for care (including behavioral emergencies). For PSAP centers, there is a protocol-driven series of questions that dispatch asks to determine urgency. The answers help explain how the dispatcher decided which, if any, team was dispatched. NASEMSO interviewees pointed out that standard practices are the best vehicle for addressing liability.

NASEMSO members are concerned about the hyper-focus on police because most of the time, an ambulance is dispatched at the same time as LE. There could be a conversation on vehicle placement—once LE assesses the scene and clears it for safety, the paramedic is often in front. NASEMSO leadership thought the ambulance services would welcome the opportunity to have an MCT as an alternative, and more aptly, as a dispatch option.

NASEMSO leadership described a view that interoperability should be driven not just by policy and practices, but by technology. How is the connection made logistically? Is it truly interoperable? Operation could involve deploying responses of mobile crisis by itself, EMS by itself, or a combination. There is a need for evidence-driven/-based protocols to follow patient care and destination. Decisions should be made about documentation so that it will be clear where information can be entered and how it can be retrieved. NASEMSO leadership also

recognized that 988 services cannot be insular. There will be two-way handoffs, and questions remain as to how these warm transfers might happen.

NASEMSO suggests that states consult with them and also include the National Association of State 911 Administrators (NASNA) as a stakeholder in these discussions.

American College of Emergency Physicians (ACEP)

Representatives of ACEP and a former president of AAPCC shared the following lists of concerns, how things really work, and suggestions for 988/911 interoperability.

Concerns

1. Under the current system, it is not easy to identify a person's location and route the call to the appropriate PSAP nearby.
2. As currently structured, 988 does not seamlessly interact with many computer-aided dispatch (CAD) systems.
3. In rural areas, dispatch systems are frequently based in LE agencies run by sheriffs' departments. Sheriffs and EMS do not always agree on how to approach a call for a mental health patient, which can further confuse a response and integration of 988.
4. Issues related to liability risks include lack of compliance modules in dispatch protocols, CAD systems not interfacing seamlessly with 988 and potentially dropping calls when transferring, training and standardization, adequate data collection, good data to prevent hospitalizations, and not thinking through decisions.

How things work

1. Historically the integration has been local, not a statewide system.
2. In some ways what 988 is facing is what poison control centers have faced, not being part of the 911 system.
3. The answers to collaboration and integration will not come easily as they are a mix of state and local decisions involving EMS and many others.
4. Guide cards provide 911 with uniform narratives to get responses from callers.
5. Dispatch centers are upgrading their systems to comply with US Department of Homeland Security requirements and available grants.

Suggestions

1. Start a conversation with a clear idea of desired initial achievements, which may be plans for how handoffs should happen, and at the same time look at the bigger opportunities with telecom, enhanced 988, standardized training, and guidelines.

2. Access problems are greater in rural areas where capacity for crisis teams does not exist yet and dispatch is largely controlled by LE—which begs the question of what happens when a dispatch is decided by the sheriff.
3. The executive directors of the National Co-Responder Consortium and NASEMSO should be at the table, as well as leaders from the American Academy of Pediatrics and the federal EMS for Children program, due to an increase in pediatric crises.
4. To make inroads, interoperability is best achieved on a statewide basis with coordination between the SBHAs and the state entity that handles EMS and dispatch.
5. Guide card narratives could be customized to enhance questions regarding behavioral health. There are a couple of private companies that create cards with prearrival instructions so any agency could customize them to work for behavioral health.
6. There are so many variables from state to state that a possible place to start is the state's EMS office, because every state has one.

National 911 Program

The National 911 Program is housed in the Office of Emergency Medical Services, NHTSA, US Department of Transportation. The 988/911 interoperability challenges from the national program's perspective begin with a sense that there has been insufficient information sharing, which limits the understanding of 988, and vice-versa. Concerns were expressed about times when incorrect information about 911 has been released. The 911 industry generally uses similar technology across sites, but it is very different from the 988 technology and currently in most settings not interoperable with the technology used by Vibrant Emotional Health (VEH).

> **"It is very important to have data to analyze before making substantive changes."**
>
> ***—Marsha Ford, MD, FACEP, FACMT, former President, American Association of Poison Control Centers***

A major concern is that there are many misconceptions about CAD. It cannot be used to transfer calls to Lifeline centers. All of 911 is locally controlled and not regulated. There are 250+ CAD vendors, and some departments use multiple systems. CAD systems provide for the automation of call-taking questions, and then dispatch responses. They also can provide updated information from a 911 center to the receiving technology device (if one exists) in the emergency vehicle as more information is gathered. The operational limitation for a handoff to 911 is that the VEH systems do not currently have the ability to transfer the caller technologically, if appropriate, to 911, and if calling on behalf of the caller it can take time to identify the right 911 center and provide information to locate the caller.

The operational limitations for a handoff to 988 involve different technology and concern about continuity of care for the caller. Local 911 centers are responsible for the continuity of care, usually based on state law. Centers that perform emergency medical dispatch could be subject to charges of abandonment for the transfer of calls unless it is determined through protocol and medical direction that 988 constitutes the same or a higher level of care, compared with 911.

Operators of 911 centers have concerns that they could be held liable for the outcome of a caller that is transferred to 988. The major concerns are that a call may be dropped in transfer or that the 988 Suicide & Crisis Lifeline counselor will not handle the situation as well as they would have. There needs to be trust in the counselors to do their jobs well, the ability to reach 988 in a timely fashion, assurance the call has connected, and the ability to transfer the call back if necessary.

Another challenge is the move to next-generation 911. California could be a good model, but its service is unique to the state and may not be generalizable to other regions. Since every state is different, this technology and operational enhancement will need to vary state by state. About 60% of call centers have only two positions staffed per shift; when asked to transfer to a crisis line it could take several minutes, taking one call taker out of play. Also, not all 911 call takers have been trained in handling suicidal callers. As the systems grow, there will be better opportunities to facilitate interoperability—but as this happens collaboration and communication will be critical. When looking at interoperability, NASNA will be able to provide guidance for state-by-state issues. The association should be engaged early and often.

"NHTSA is collaborating with SAMHSA to bringing together the 911, EMS, and crisis communities to help facilitate education and understanding, and to develop interoperability among all three developing systems. … We will help the EMS and 911 communities to understand SAMHSA's priorities as we work to educate federal partners and the crisis community about EMS and 911 systems and their priorities. We are trying to stay engaged with the federal players and educate our communities as best we can while encouraging them to get involved now. The 911 community wants to understand the 988 technologies. 911 sees themselves as the first, first responders and strong partners with police, EMS, and fire."

—Kate Elkins, EMS/911 Specialist, National 911 Program, Office of Emergency Medical Services, National Highway Traffic Safety Administration, US Department of Transportation

Conclusion

Coordination and collaboration of 988 and 911 is the next frontier in the development of emergency services, since the transition to 988 as a number to call for suicide prevention and crisis response is now in effect. Most 988 contacts will be handled by counselors who are able to de-escalate a crisis through conversation and refer people to other needed behavioral health services without mobilizing a response on-scene. Yet some 988 contacts will require a transfer to 911, and the myriad of calls to 911 that involve behavioral health crises seem to be appropriate to be warm-transferred to 988, unless there is some information in the call that necessitates a different response, such as one involving a medical or safety concern.

Coordination and collaboration, therefore, involves technical aspects that minimize or eliminate call drops and ensure that the call is picked up promptly and able to be transferred quickly, as well as an infrastructure that ensures call centers are available to receive the calls through dispatch and authorized to transfer bidirectionally. Additionally, collaboration involves the operational aspects beyond technology such as training, coordination, data collection and sharing, and ongoing system quality improvement.

The most critical step needed now is to foster dialogue about these issues, and to begin to develop the necessary policies, protocols, and funding streams to create and sustain functional response services that achieve the best outcomes for all people anywhere, anytime a crisis arises.

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Appendix

List of Acronyms	
211 CT	Connecticut 211 system
911	universal emergency number
988	988 Suicide & Crisis Lifeline
AAP	American Academy of Pediatrics
AAPCC	American Association of Poison Control Centers
ACEP	American College of Emergency Physicians
ADA	Americans with Disabilities Act
AFSP	American Foundation for Suicide Prevention
AHA	American Hospital Association
APCO	Association of Public-Safety Communications Officials
ARRIVE Together	Alternative Responses to Reduce Instances of Violence & Escalation model (New Jersey)
BJA	Bureau of Justice Assistance
C3	crisis center clinician
CAD	computer-aided dispatch
CAHOOTS	Crisis Assistance Helping Out on the Streets (Eugene, Oregon)
CCBHC	Certified Community Behavioral Health Clinic
CCD	Crisis Call Diversion program (Harris County, Texas)
CIT	Crisis Intervention Team
CIT International	Crisis Intervention Team International Association
CMHS	US Center for Mental Health Services (of SAMHSA)
Consortium	National Co-Responder Consortium
CORE	Clinician and Officer Remote Evaluation program (Harris County, Texas)
CSG	Council of State Governments
DCF	Department of Children and Families (Connecticut)
DMHAS	Department of Mental Health and Addiction Services (Connecticut)
e-911	Enhance 911 Act of 2004
ED	emergency department
EMS	emergency medical services
EMSC	Emergency Medical Services for Children national program
EMT	emergency medical technician

FCPD	Fairfax County (Virginia) Police Department
FD	fire department
GPS	Global Positioning System
HIPAA	Health Insurance Portability and Accountability Act of 1996
IACP	International Association of Chiefs of Police
IAEMSC	International Association of EMS Chiefs
LE	law enforcement
LGBTQI+	lesbian, gay, bisexual, transgender, queer or questioning, intersex, and more
MCT	mobile crisis team
MHFA	Mental Health First Aid (program of NCMW)
MOU	memorandum of understanding
NAASP	National Action Alliance for Suicide Prevention
NABLEO	National Association of Black Law Enforcement Officers
NAEMT	National Association of Emergency Medical Technicians
NAMI	National Alliance for Mental Illness
NASEMSO	National Association of State EMS Officials
NASMHPD	National Association of State Mental Health Program Directors
NASNA	National Association of State 911 Administrators
NCMW	National Council for Mental Wellbeing
NEMSIS	National Emergency Medical Services Information System
NEMSMA	National EMS Management Association
NENA	National Emergency Number Association
NFPA	National Fire Protection Association
NHTSA	National Highway Traffic Safety Administration
NSPL	National Suicide Prevention Lifeline
PD	police department
PSAP	Public Safety Answering Point
SAMHSA	Substance Abuse and Mental Health Services Administration
SBHA	state behavioral health authority
SCRT	Street Crisis Response Team (San Francisco)
STAR	Support Team Assisted Response (Denver)
VEH	Vibrant Emotional Health