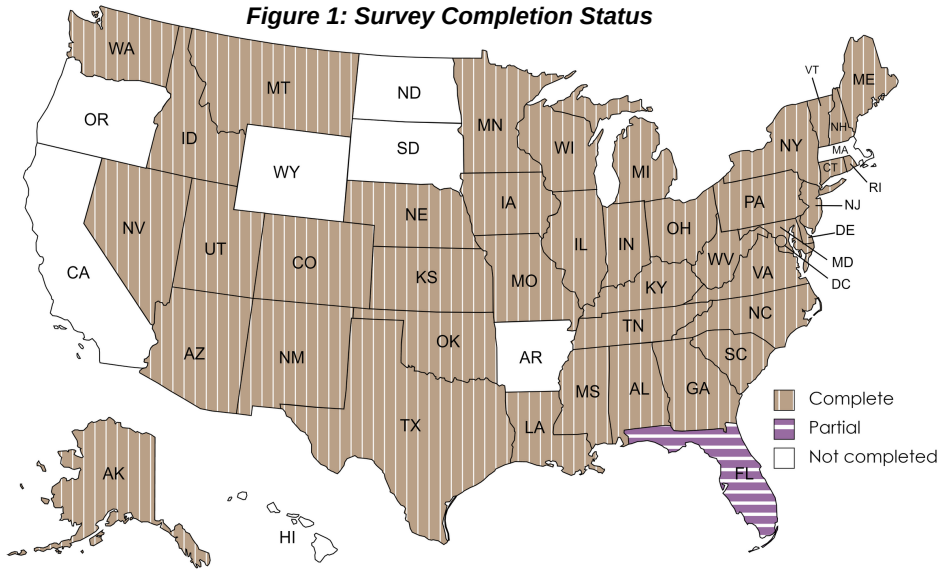
Behavioral Health Call Centers and 988 Implementation

Results from Summer 2021 NRI/NASMHPD Survey

November 2021

In the summer of 2021, the National Association of State Mental Health Program Directors (NASMHPD) Research Institute (NRI) and NASMHPD in collaboration with a group of Transformation Transfer Initiative (TTI) grantee states as well as input from Vibrant Emotional Health, developed an online survey on behavioral health call centers and 988. The purpose of the survey was to help states learn from each other on how they are working to implement 988 within the context of existing and emerging behavioral health crisis continuum. This report summarizes the results of the survey completed either partially or completely by 43 states (see Figure 1).

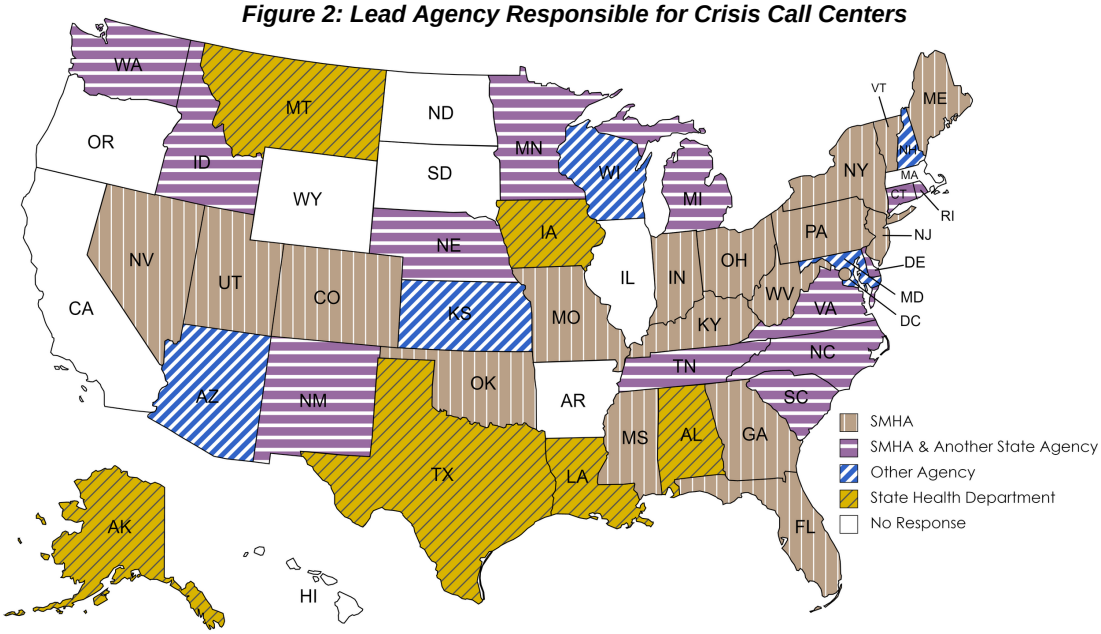
Figure 1: Survey Completion Status



Coordination of Current Crisis Call Centers in States

In 24 states, the State Mental Health Authority (SMHA) has the lead responsibility for crisis call centers, including current coordination of Lifeline Call Centers, whereas, in 11 states, the SMHA shares this responsibility with another state agency, including Division/Department of Public Health. The State Health Department has the lead responsibility in two states, and in five states, an agency other than the SMHA and the State Health Department has the lead responsibility for crisis call centers (see Figure 2).

Figure 2: Lead Agency Responsible for Crisis Call Centers



In the majority (40) of responding states, the SMHA is involved (including funding and policy) in crisis call centers. The state substance use authority and the state Medicaid agency are involved in crisis call centers in 22 and 18 states, respectively (see Figure 3).

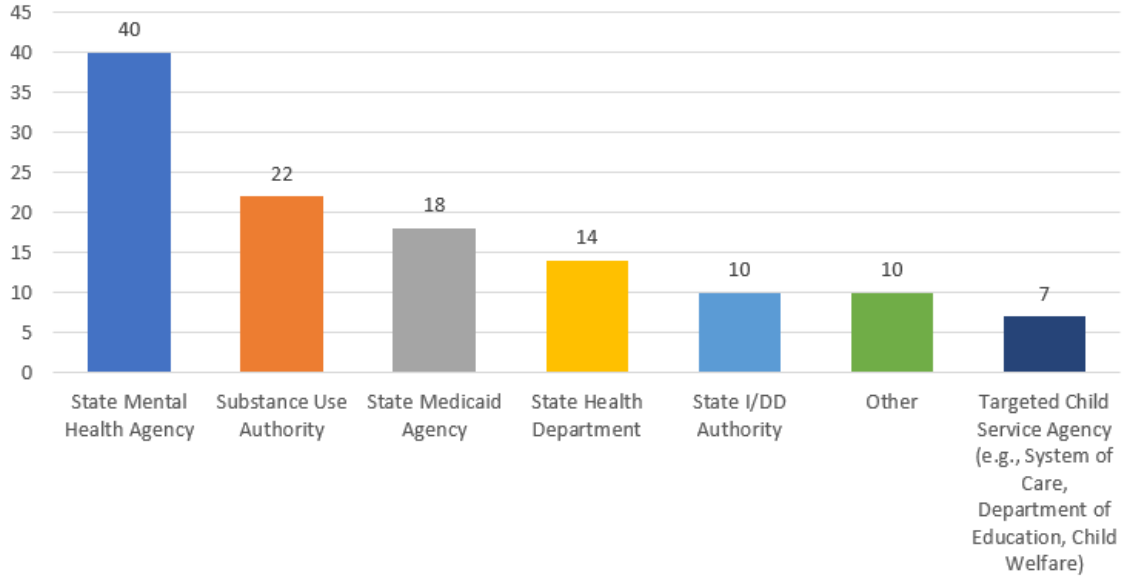
In a continued effort to assist states in transforming their mental health systems of care, the Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services (CMHS) created the Transformation Transfer Initiative (TTI). The TTI provides, on a competitive basis, flexible funding awards to states, the District of Columbia, and the Territories to strengthen innovative programs.

The TTI2022 holds relevance and value for all states and territories as the focus is 988 readiness and improvement and expansions of crisis services. This initiative allows for creativity, flexibility, and collaboration and coalition building opportunities. TTI offers the opportunity for funding, as well as TA, learning opportunities, networking to successes in other states, and enveloping support from NASMHPD staff to help guide your team in achieving successful outcomes transforming your systems on your timeline. The team develops informational exchanges with experts in specific areas of interest and fosters connections between TTI states and territories.

These efforts regarding 988 implementation and crisis services have roots in the National Guidelines for Crisis Care – A Best Practice Toolkit. The toolkit advances national guidelines in crisis care within a toolkit that supports program design, development, implementation and continuous quality improvement efforts. It is intended to help mental health authorities, agency administrators, service providers, state and local leaders think through and develop the structure of crisis systems that meet community needs.

For more information about TTI2022, please contact David Miller (david.miller@nasmhpd.org) or Leah Holmes-Bonilla (leah.holmes-bonilla@nasmhpd.org)

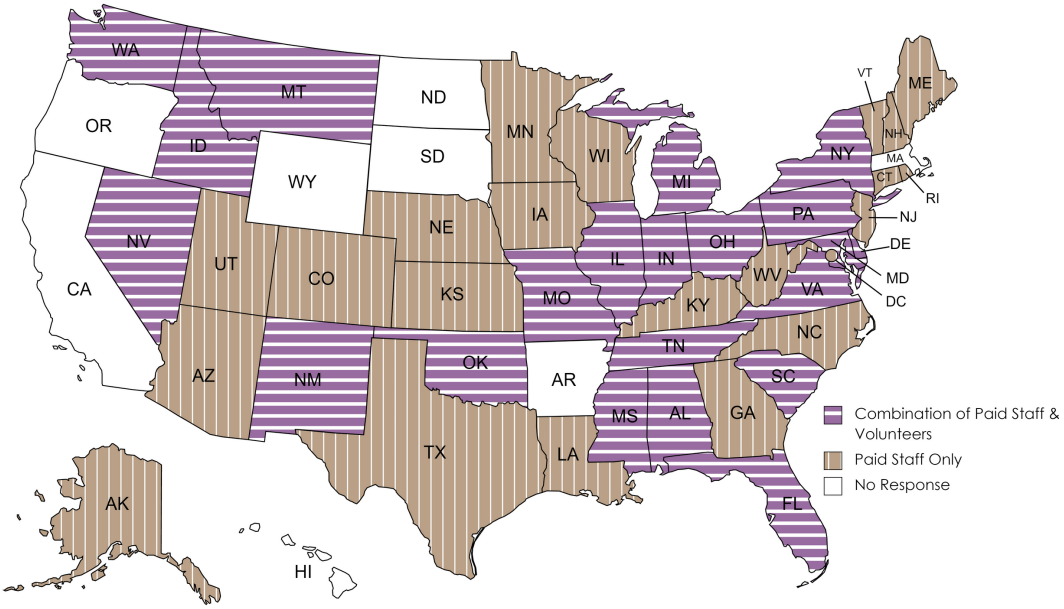
Figure 3: State Agencies Involved in Crisis Call Centers (number of states)



Lifeline Call Centers

In 24 states, Lifeline Call Centers are operated by a combination of paid staff and volunteers, whereas, in 19 states, these call centers are operated by paid staff only (see Figure 4).

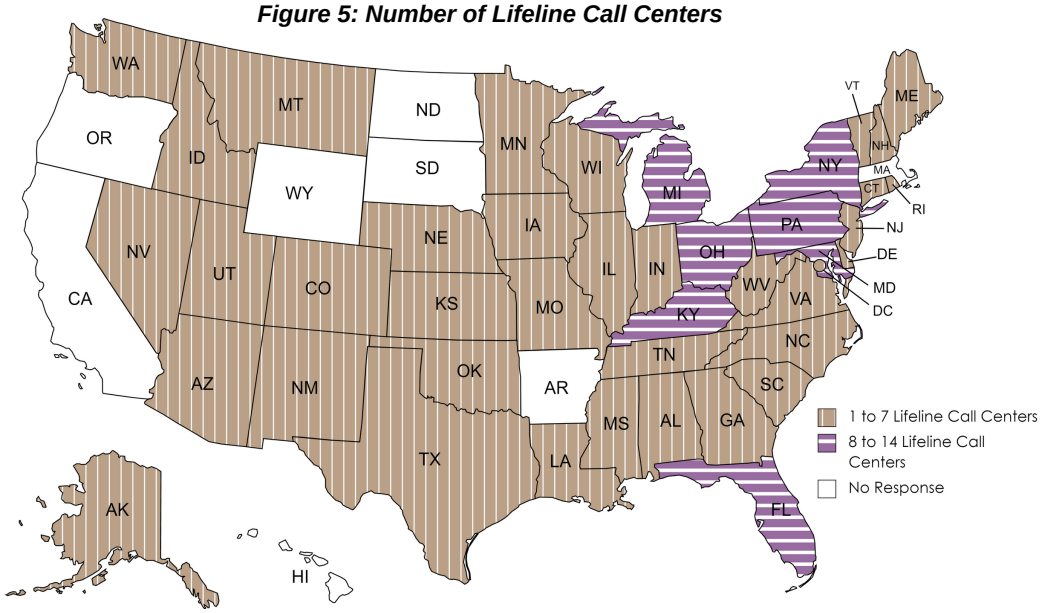
Figure 4: Lifeline Call Centers Operated by Paid Staff and Volunteers or Paid Staff Only



Majority of responding states (37), indicated that not all Lifeline Call Center operators are licensed mental health professionals. In Florida, Maine, and Utah, all Lifeline Call Center operators are licensed mental health professionals. In only nine states, Lifeline Call Center staff work fulltime on Lifeline, whereas in 34 states, Call Center staff also have other responsibilities including answering in-state crisis call centers and texts, additional areas of focus including sexual assault support services and domestic violence.

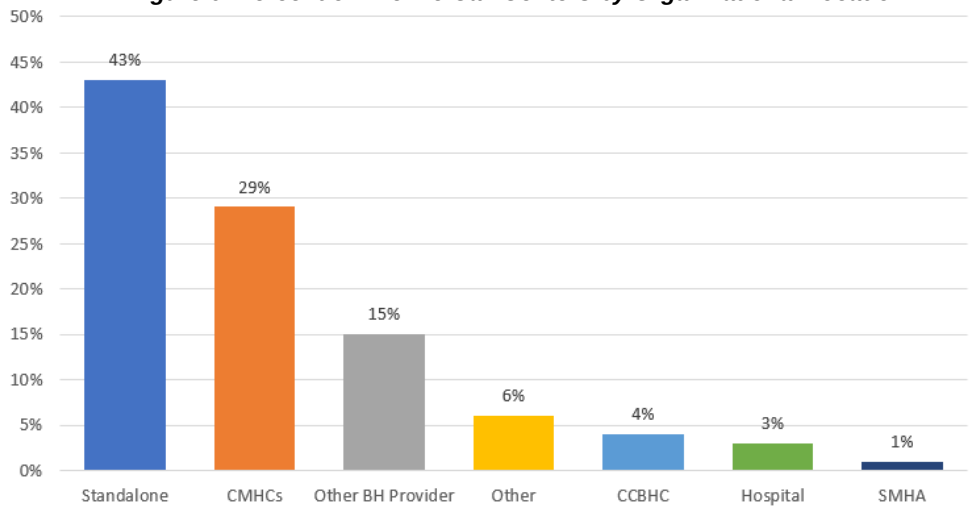
In 36 states, there are a total of 167 Lifeline Call Centers currently operating, an average of four Lifeline Call Centers in each state (median of two), ranging from a low one in 13 states to a high of 14 in one state (see Figure 5).

Figure 5: Number of Lifeline Call Centers



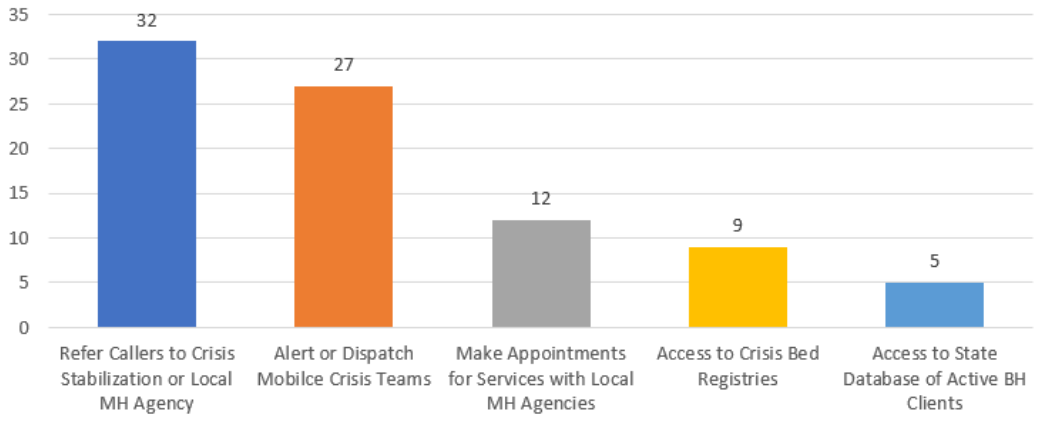
Majority (43%) of the Lifeline Call Centers that are currently operating are standalone call centers and 29% the Lifeline Call Centers are operated as part of a Community Mental Health Center (see Figure 6).

Figure 6: Percent of Lifeline Call Centers by Organizational Location



In 11 states, Lifeline Call Centers are not integrated with the state's behavioral health crisis system. However, in most of the responding states, the Lifeline Call Centers are integrated with the state's behavioral health crisis continuum. In 32 states, Lifeline Call Centers can refer callers to crisis stabilization programs or the local mental health agency; in 27 states, Lifeline Call centers can alert or dispatch mobile crisis teams; and in 12 states, Lifeline Call Centers can make appointments for callers with the local mental health agency (see Figure 7).

Figure 7: How Lifeline Call Centers are Integrated with the State's Behavioral Health Crisis System (number of states)



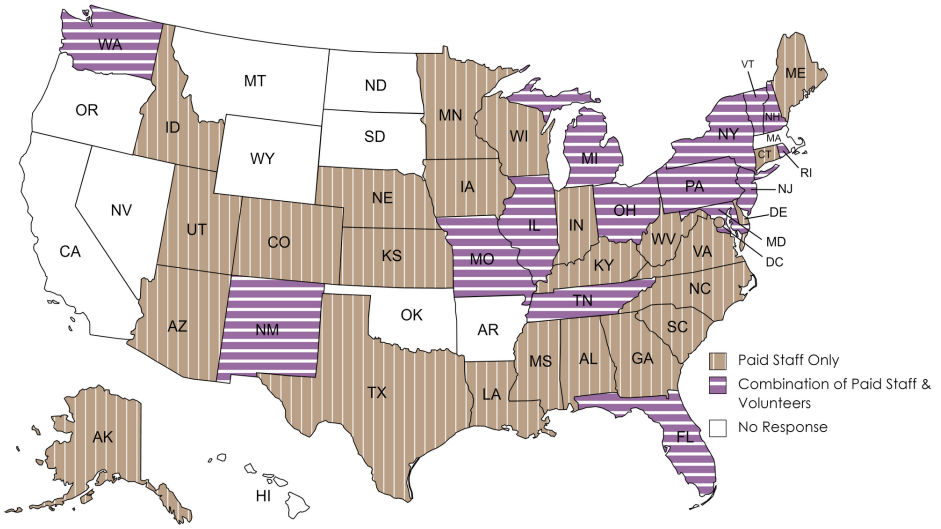
In some states, Lifeline Call Centers have historically operated separately from the SMHA's behavioral health crisis continuum. In 26 states, there are plans to bring these systems together and improve coordination with Lifeline Call Centers. For example:

- In Alaska, the SMHA is working on building connections with the rest of the crisis system. The 988-implementation work has supported statewide coordination and the SMHA is exploring coordination in all areas and will be adding this to the state's implementation plan.
- In Alabama, current efforts are underway to establish a comprehensive crisis system to meet the needs of Alabamians to ensure there is someone to talk to, someone to respond, and somewhere to go.
- In Arizona, the SMHA is exploring the consolidation of in-state crisis call center services into a single statewide network, inclusive of Lifeline calls.
- In Connecticut, the SMHA is looking to further integrate behavioral health appointment scheduling, direct bed admission, and GPS tracking and dispatch of mobile crisis clinicians.
- In Iowa, as part of the 988-planning process, the state is considering all aspects of the crisis continuum and how Lifeline Call Centers will integrate with the crisis system.
- In Idaho, the Divisions of Behavioral Health, Public Health, and Medicaid are all working in collaboration with Idaho's Lifeline Call Center to enhance Idaho's Crisis Care Continuum.
- In Indiana, the SMHA is exploring the implementation of the Crisis Now and CCBHC models which will closely coordinate crisis care across the continuum, including the Lifeline Call Centers.
- In Michigan, the new centralized state crisis and access line—the Michigan Crisis and Access Line (MiCAL)—will operate a full crisis continuum and serve as the state's National Suicide Prevention Lifeline (NSPL) provider.
- In West Virginia, the Lifeline Call Center works closely with the SMHA and state behavioral health providers to connect callers with services, either through warm transfer or referral. Proposed 988 legislation, if passed, will help fund further integration with crisis and related behavioral health services.

Behavioral Health Crisis Call Centers that are Not Part of the Lifeline Network

Thirty-six states have behavioral health call centers that are not part of the Lifeline network. Unlike the Lifeline Call Centers, the behavioral health crisis call centers are operated by paid staff only in majority of the reporting states (25) and a combination of paid staff and volunteers in 15 states (see Figure 8).

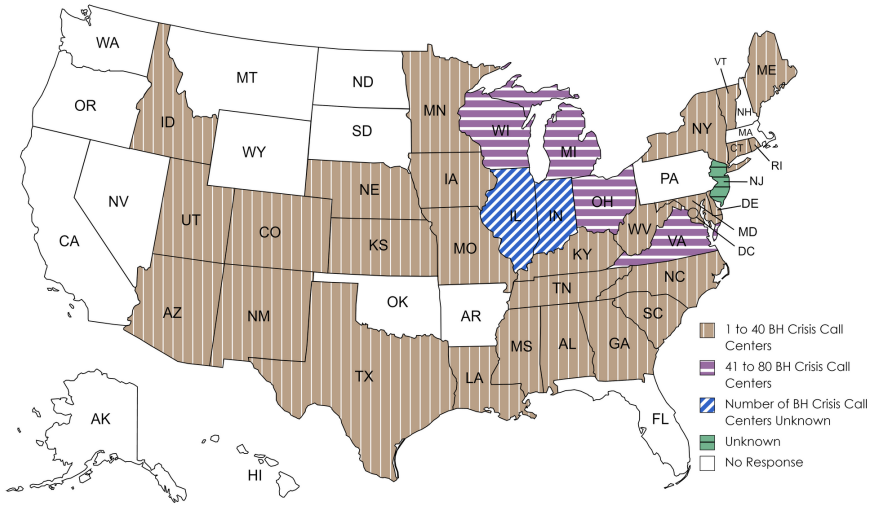
Figure 8: Behavioral Health Call Centers Operated by Paid Staff Only or Paid Staff and Volunteers



Like Lifeline Call Centers, in the majority of responding states (25), not all behavioral crises call operators are licensed mental health professionals. Some states require call center staff to be behavioral health professionals to facilitate triage of individuals with behavioral health crisis. For example, in Delaware, Mississippi, and South Carolina all behavioral health crisis call operators are licensed mental health professionals. Training and credentialing requirements for behavioral health crisis call operators are set by the state (24 states), providers (21 states), and by counties (5 states). In 12 states, behavioral health crisis operators only work on crisis calls, whereas in 27 states, operators have additional behavioral health responsibilities, including processing behavioral health authorizations, services enrollments and disenrollment, working on emergency room enhancement programs, and mobile crisis teams.

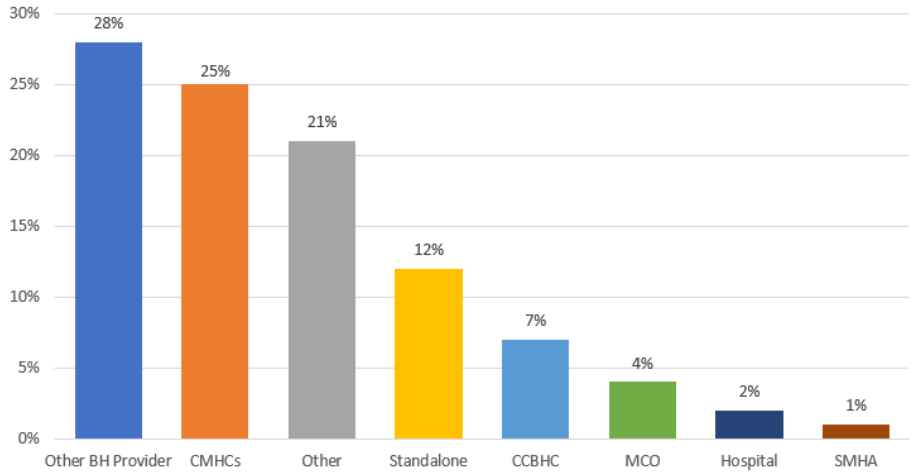
In 32 states, there are a total of 510 behavioral health crisis call centers currently operating, an average of 16 call centers in each state (median of eight), ranging from a low of one in eight states to a high of 80 in two states (see Figure9).

Figure 9: Number of Behavioral Health Crisis Call Centers



Twenty-five percent of the behavioral health crisis call centers are currently operating as part of a Community Mental Health Center and 12% are standalone call centers (see Figure 10).

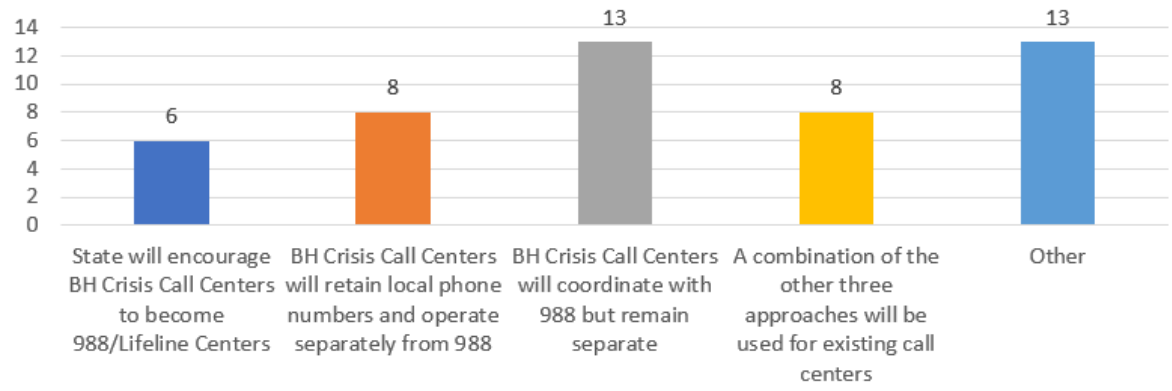
Figure 10: Percent of Behavioral Health Crisis Call Centers by Organizational Location



States were asked how they are planning for behavioral health crisis call centers that are not part of the Lifeline network to work with 988. Six states will encourage behavioral health crisis call centers to become 988/Lifeline Call Centers and in 13 states, behavioral health crisis call centers will coordinate with 988 but will remain separate (see Figure 11). In eight states, a combination of these approaches will be used for existing behavioral health call centers. For example:

- In New Jersey, all behavioral health crisis call centers will be encouraged to become familiar with 988 and provide information to the 988 Resource and Referral Database. It is expected that some will retain local numbers and operate separately while some may coordinate with 988 but remain separate.
- In New York, the state is working with local government units to identify all crisis lines and coordinate and/or replace these lines with 988 contact centers.

Figure 11: Behavioral Health Crisis Call Centers Coordination with 988 (number of states)



In 16 states, the behavioral health crisis call centers serve additional callers who will not be the focus of 988, such as callers with intellectual/developmental disabilities (ID/DD) with crisis. For example:

- In Alabama, as some community providers provide comprehensive services, there may be instances where crises may extend beyond the population of focus of 988.
- In Connecticut, individuals with ID/DD are served in all crises call centers.
- In Iowa, Your Life Iowa provides crisis line services for SUD and problem gambling concerns.
- In Kentucky, the behavioral health crisis call centers serve clients with ID/DD, gambling, victims of sexual assault, domestic violence, and child abuse and neglect, as well as SAMHSA Treatment Locator Line.
- In New Jersey, the behavioral health crisis call centers focus on situations or populations that are not the focus of 988 or mental health crisis, including, family guidance, Alzheimer's caregiver support, health screening, peer recovery warmlines, etc.

Warmlines

Behavioral health warmlines provide early intervention with emotional support that can prevent a crisis, 911 calls, and/or hospital emergency department visits. In the majority of responding states (32), the SMHA supports behavioral health warmlines. These warmlines are operated by behavioral health crisis call centers in 17 states, by a different entity such as NAMI in 16 states, and by peers in 15 states.

Warmlines coordinate with behavioral health crisis call centers and other crisis services in a variety of ways. For example, warmlines:

- Provide referrals to Community Mental Health Centers.
- Coordinate with behavioral health crisis lines for additional services.
- Provide a warm transfer to peer lines including peer respite and outpatient peer services..
- Contact mobile crisis teams and connect callers to services.

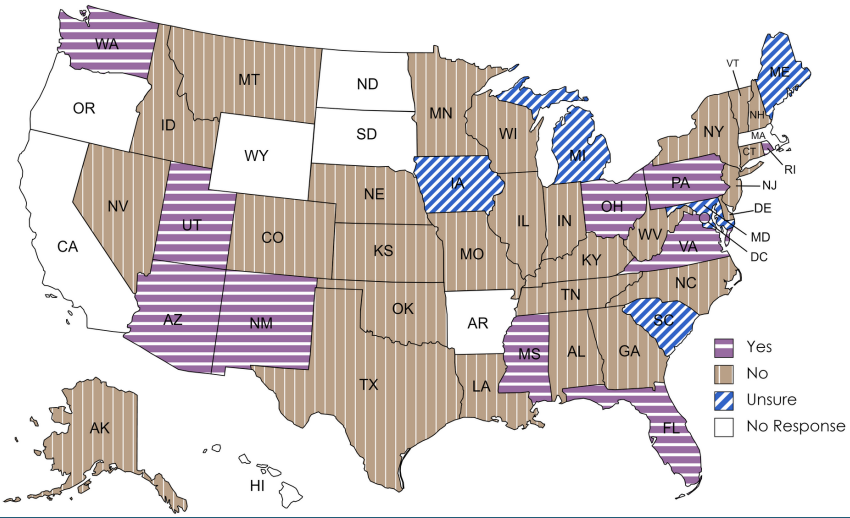
States are still working on determining how warmlines will communicate and coordinate with 988. Some of the responses states provided include:

- Planning for integration and coordination of existing warmlines and crisis lines is ongoing (Iowa).
- Currently all warmlines are operated by the behavioral health crisis call centers, the SMHA intends to coordinate with 988 (Idaho).
- The administrator of the warmlines is serving on the Key Stakeholder Planning Coalition and coordination is currently being addressed as part of the plan development (Illinois).
- To be determined by the 988 Planning Coalition. There are still questions that need to be answered about transferring calls, protocols, messaging, technology, etc. (Maine).
- Warmlines will act as a support to 988 and refer to and from as needed (Mississippi).
- Plans are for 988 and warmlines to make referrals to each other as appropriate. Warm transfers will be explored as best practice for transferring of calls in both directions. Also, warmlines will be included in the 988 Resource and Referral Database (New Jersey).

Working with 911

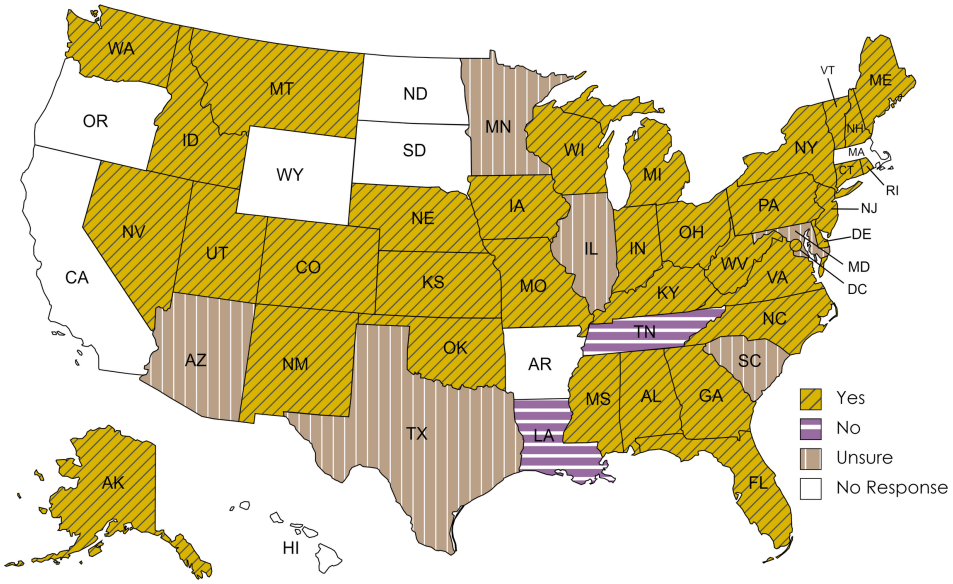
In 11 states, local behavioral health agencies have developed standardized workflows or decision trees for how 911 behavioral health crisis calls are referred to existing behavioral health crisis call centers (see Figure 12). For example, in Arizona, SMHA contracts with Regional Behavioral Health Authorities (RBHAs) require coordination and collaboration with 911. RBHAs have both formal and informal relationships established with 911, public safety, and first responders.

Figure 12: State has Standardized Workflows on how 911 Behavioral Health Crisis Calls are Referred to Behavioral Health Crisis Call Centers



Most states (35) are developing operational workflows or decision trees for how 988 and 911 call centers will interact to refer behavioral health and/or public safety calls (see Figure 13). For example, in Alaska, as part of the coordination workgroup, the SMHA is organizing this work and engaging dispatchers across the state. One dispatch center has developed a good relationship with the call center and the SMHA is basing some of the work from lessons learned from this relationship. There have been workgroups and presentations on how to do this across Alaska. One of the planning items is engaging staff from all Public Safety Answering Points (PSAPs) in the state. In Kansas, 911 PSAP representatives have met with existing 988 call centers as part of the coordination planning. In Montana, the Department of Public Health and Human Services (DPHHS) is in the process of developing crisis resource maps and flow charts for mental health crisis dispatch and referral.

Figure 13: State is Developing Operational Workflows for 988 and 911



Sixteen states are working on providing training to 911 call center operators to recognize and divert calls to 988 from individuals experiencing a behavioral health crisis. For example, Alaska is discussing the provision of trainings to 911 call center operators in workgroups to support the implementation of this practice. In Georgia, the SMHA plans to train both 911 and Georgia Crisis Access Line (GCAL) at the same time. The plan is in the early stages and the SMHA is working with the Georgia Emergency Communications Authority (GECA). Idaho has started initial partnership with 911 operators; however, 911 operators have not started diverting calls.

State Experiences Working on Implementing 988

In 34 states, the state behavioral health leadership have described a vision for integrating state operated behavioral health crisis services, including call centers, local mental health agencies, mobile crisis teams, coordination with law enforcement and other first responders, crisis stabilization units, detox center, and inpatient settings into the referral process provided by 988/Lifeline crisis contact centers. For example:

- "The national implementation of 988 provides Alabama with the unique opportunity to fully integrate and intentionally align the state's crisis system design and service delivery. Alabama will coordinate longstanding efforts to expand access to robust and timely crisis behavioral health service, including 24-hour mobile crisis teams, emergency crisis intervention service, and crisis stabilization developed using evidence-based best practices in SAMHSA's *National Guidelines for Behavioral Health Crisis Care*. Alabama's leadership is remodeling the state's crisis system of care to meet the goal of building up to statewide Certified Community Behavioral Health Clinic (CCBHC) implementation in five years, continuing to build upon the state's existing framework/redesign of the creation, integration, and delivery of crisis services."
- "Missouri is looking closely at all pieces of the State's crisis system to ensure integration and avoid a patchwork system. The Department of Mental Health, the Missouri Behavioral Health Council, and stakeholders work closely to discuss how the different components of crisis care connect and how they can further integrate. The vision of Missouri's crisis system is that all pieces of care—call centers, local mental health agencies, mobile crisis steams, coordination with law enforcement and other first responders, crisis stabilization units, detox centers, and inpatient settings—can be connected so that individuals in crisis are supported at whatever level or crisis system they enter."

As states are working on plans for the implementation of 988, they have found several groups or entities as being most helpful including, mental health boards, statewide suicide prevention councils, Vibrant Emotional Health, 911 administrators, advocacy groups, individuals with lived experience, law enforcement and first responders, legislators, state Medicaid authority, behavioral health providers, NAMI, Lifeline Call Centers, etc. Examples of how these groups are being helpful include:

- Engaging as part of a statewide coalition organizing their networks to interact with 988.
- Being involved in the planning of 988 implementation and bring ideas to subcommittees.
- Sharing perspectives on the impact of 988 implementation on their own systems, populations they serve and their families.
- Participating in core planning meetings developing implementation plan, and data analysis.
- Viewing 988 implementation as an enhancement of the overall crisis management system.
- Participating in planning committee, interested party legislative meetings, calls with 988 staff, working with legislative members, and sharing information with their stakeholders.

The biggest areas of concern or resistance to 988 integration identified were:

- 911 diverting calls to 988—law enforcement feels it is their role to manage emergencies of any kind and they have liability if they do not.
- Dispatchers worried about funding being pulled.
- Concern about loss of local connection to crisis providers if centralized dispatch of mobile crisis is implemented.
- Level of funding that will be required.
- Peer and emergency response sectors.
- Call centers are somewhat resistant to change in accordance with national 988 guidelines, particularly the addition of chat and text capability to their existing phone service.
- Level of possible telecom fee.
- Funding for capacity building as well as anticipated increase in call volume for services.
- Concerns about existing call centers and crisis lines that are not Lifeline providers.

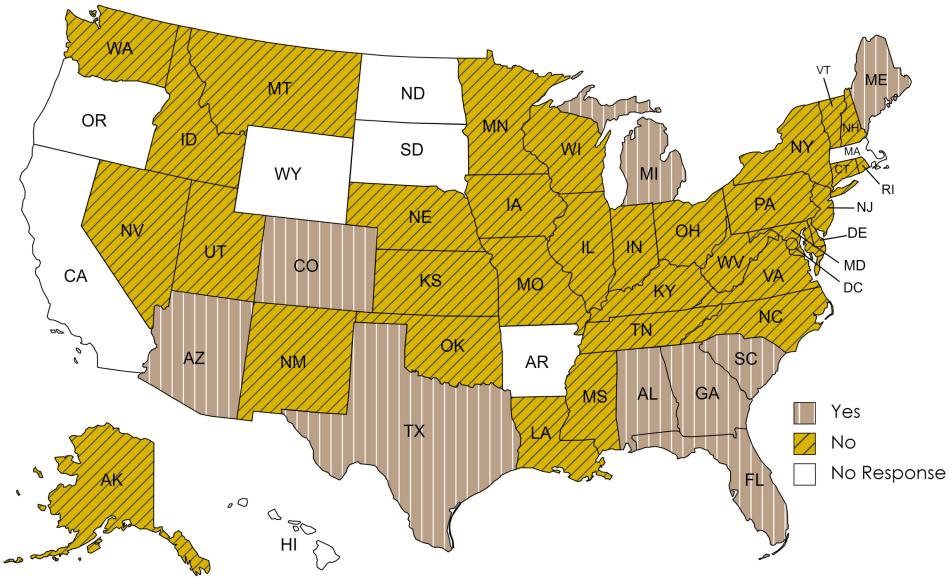
Groups or entities that are raising the most resistance include telecom providers, PSAPs, law enforcement, first responders, current call centers, and crisis service providers. To address their concerns, states are implementing policies or actions. Examples include:

- Legislative bills.
- Engaging them in coordination and joint planning.
- Talking about the cost benefits of 988, the need for 988, relief on 911 and emergency rooms.

Crisis System Technology

In 10 states, the existing state crisis system uses technology to integrate calls, text, and chat to dispatch mobile crisis and/or link with crisis stabilization (see Figure 14). In three (Alabama, Michigan, and South Carolina) of the 10 states, the state's current technology platform is compatible with Lifeline technology.

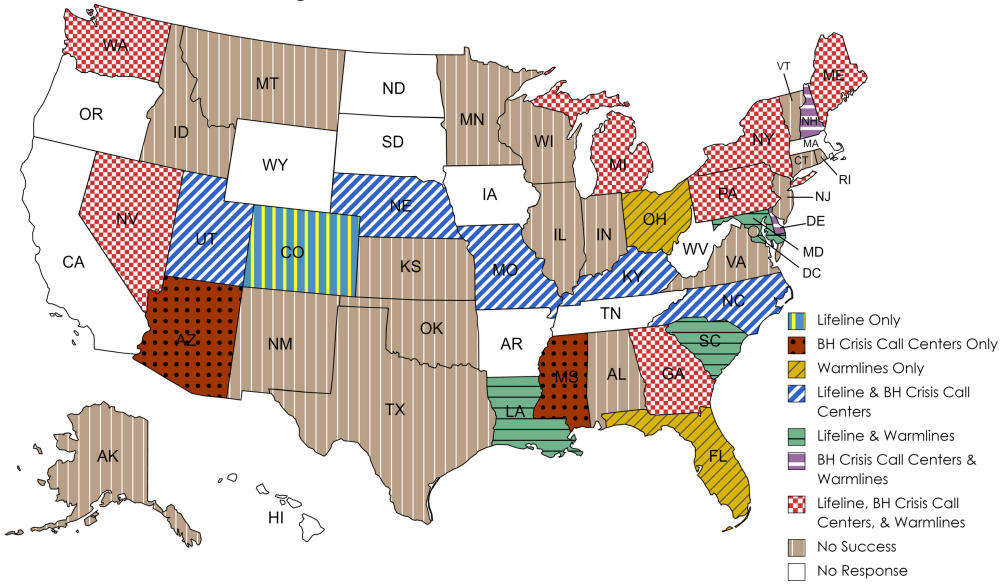
Figure 14: State's Crisis Technology Compatible with Lifeline Technology



Funding Call Centers

A few states have had some success in working with Medicaid, private insurance, or other funding sources to gain reimbursement or funding support for Lifeline Call Centers, behavioral health crisis call centers, and warmlines in their states. Eighteen states indicated they have not had any success working with Medicaid, private insurance, or other funding sources (see Figure 15).

Figure 15: State Success in Working with Medicaid, Private, Insurance, Other Funding Sources for Crisis Hotlines and Warmlines



Biggest Surprises in Working on 988 Plans

States were asked to describe the biggest surprises they have experienced in working on 988 plans. Examples of this include:

- "The biggest surprises have been that law enforcement and behavioral health organizations did not realize what the crisis call center does and how well it is done. They were pleasantly surprised and through workgroups and discussions, people are invested in discussions about how to collaborate and develop a more coordinated system. The positive responses from the telecom providers have also been surprising. Open and transparent discussions have been very important, as well as presentations and hearing their feedback."
- "Geolocation—calls are routed based on area code and not geolocation, causing people who live in a state to potentially not receive services in the state. Vibrant had many iterations on call volume projections, causing confusion for states in their planning."
- "General population being unfamiliar with the federal legislation passed and that it is part of a larger system of care."
- "The lack of knowledge about available resources among providers and other community stakeholders."
- "Telecommunications industry lobbying for low fees. Delays in the required reports from SAMHSA which is delaying states' planning in a short turnaround for implementation, legislative planning, etc. Lack of shared visioning and collaborative support from the U.S. Department of Health and Human Services (Substance Abuse and Mental Health Services Administration, Centers for Medicare & Medicaid Services, Health Resources and Services Administration)."
- "The complete lack of any consistent approach or contractual type requirements of the existing NSPL call centers in the state, which makes planning a consistent, system-wide approach very difficult. There are centers that operate part time, some that only serve a county, others that have inconsistent staffing because they use volunteers. We have asked—but have not received a clear response—how/if we are expected to incorporate such diverse centers into a call center hub model that has capacity that includes dispatch."
- "The receptivity and support from the state legislators and the amount of people who want to be involved in the planning process."
- "Lack of coordination between EMS and crisis response services, and legal barriers to a coordinated response."
- "Lack of sustained funding sources, lack of national guidance on certain 988 considerations like text and chat, lack of data on current crisis center operations and 911 as well as emergency responder costs, lack of strong standards for training, data collection, mobile crisis, etc."

Greatest Successes in Working on 988 Implementation

States were also asked to share some of their greatest successes in working on 988-implementation thus far. Examples include:

- "The biggest success has been bringing so many people together and having funding to support the collaboration. New attention to partnerships and learning about what each part of the crisis system can offer and then discussing how these connections can be made has been a success. A large part of the work is helping people make connections to see the possibilities for coordination. Not just in theory but discussing the details and allowing time for question about each other's organizations."
- "Community buy-in. Support from local and state legislators as well as state agencies. Creation of the 988 surcharges to help fund crisis services in the state."
- "Bringing awareness to the Crisis Call Center and its role in behavioral health. It has also been a success to be able to bring together a core group of stakeholders who dedicate time to 988 planning and implementation."
- "Developing strong political will and support for 988 and Crisis Now implementation."
- "Creating a coalition of crisis providers to coordinate and collaborate across sectors to consider and plan a more efficient and effective crisis system."
- Bringing together new partners—911, Public Service Commission, law enforcement, etc.—to review existing crisis response system and exploring opportunities for greater efficiencies and integration with 988."
- Elevating voice of specific communities such as Native Americans, LGBTQ, and immigrants about experiences of accessing crisis care; gaining support from 911 community; building support among legislators and state leaders."
- "Largest legislative investment in crisis services in state history which includes expansion of Urgent Recovery Centers/Crisis Centers, mobile crisis teams, private mental health transportation, and iPads for all law enforcement to connect to community providers. These will be integrated with 988 call centers to create a full crisis continuum."

Some states provided some additional comments/questions or insights regarding their 988-implementation work. Examples include:

- "This is a large project and requires many difference facets. Project management support is curial as well as engaging leadership and organizations that are impacted by the crisis system and users of the system."
- "With the national leadership emerging from Vibrant—a leader with primary experience in call center functionality—the additional elements of the 988 law are not addressed with the same fullness. Readiness in states must address the infrastructure services undergirding the call center implementation. Additionally, the didactic nature of the Vibrant COP calls does not adequately yield the state's learning between and among themselves as state authorities."
- "We were surprised by the lack of funding for this national network to date and are concerned about the availability of funding for increased volume in the future."
- "The task is more complex and has more barriers than we initially thought. Additionally, unknown at the federal level (geolocations, funding, etc.) have made it difficult to create implementation plans in very large, very rural, and very regionalized states."
- "One challenge has been that it does not sound like there is very clear guidance from the national level about 988. What should state be focused on with 988? Should the focus be on 988 Lifeline Centers or the large Behavioral Health System continuum? How much of the 988 implementation work should be focused on the system?"
- "Braiding multiple, large funding opportunities to create a full crisis continuum of care requires a significant amount of coordination and strategy beyond 988 call centers. But 988 will be the front door in most instances for connection to the system that is being built with these large one-time investments. Clarification to the state' future role in 988, Lifeline, and call flow procedures to ensure the best coordination to services would help with planning and implementation of the continuum."
- "It would be great to know what the free platform is so that we can be more planful about 911 and 988 integration."

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