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911/Law Enforcement and 988: New Opportunities for Crisis Call Line and Crisis System Integration

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Reducing the flow of people with mental illness into the criminal justice system has been a widespread policy goal for years, certainly since Munetz's and Griffin's (2006) seminal paper on the Sequential Intercept Model.[1] The problems associated with the criminalization of mental illness are serious and impact all parties involved. Police have been redirected from their primary public safety responsibilities to serve as the de facto mental health crisis response system. Periodically, encounters between officers and individuals experiencing mental illness have resulted in tragic deaths. And countless people needing care have instead been channeled into jails rather than treatment. Yet, despite advocacy and innovation at the intersection of criminal justice and mental health, criminalization has persisted. Today, the challenges are amplified by questions about the role of policing and the inadequacies of the mental health system.

Ironically, the strength of the 911/first responder system in the United States has perhaps made reducing the criminalization of mental illness more difficult. For over 50 years, the 911 system—which now handles millions of calls through about 6,100 local public safety answering points (PSAPs)—has been refining its approach to efficiently direct calls to police, fire, and ambulance services. With the volume of calls and with diverse problems needing to be addressed quickly, 911 protocols are detailed and comprehensive. The reliability of the 911 system is impressive. And like any well-functioning system, it produces the results it is designed for—in this case, the efficient routing of calls to police officers or emergency medical technicians (EMT) to respond to individuals in crisis, including mental health crises.

The complexity of 911 protocols and the local nature of 911 means that changing services to divert individuals with mental or substance use disorders to care is challenging, and there is no reliable corresponding infrastructure for mental health crisis response. The National Suicide Prevention Lifeline (NSPL) is funded specifically to handle situations related to suicide risk and is not sufficiently resourced to address the full range of crisis response. In most communities, there are insufficient mental health-focused mobile crisis staff to respond quickly to the scene even if a crisis has been identified as involving mental or substance use disorders. And when police officers respond and find an individual in mental health crisis, there is often no mental health facility to efficiently take people into care.

To break this cycle, two fundamental changes are needed. First, there must be a more consistent approach to mental health crisis care across the U.S. Second, this new approach must operate in a fashion that is fundamentally oriented toward both reducing the burden of mental health crisis response on the 911/law enforcement system and especially toward reducing the criminalization of people in mental health crisis. And now, because of national action, for the first time these changes are possible. What is needed in order to

1 Mark R. Munetz and Patricia A. Griffin, "Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness." Psychiatric Services 57, no. 4 (April 2006): 544–49. https://doi.org/10.1176ps.2006.57.4.544.

effect the necessary transformation is shared planning and action between the 911/law enforcement system and the emerging mental health crisis system. For information on national crisis system developments, visit #CrisisTalk's Learning Community.

Why Now?

National and state policy, legislation, and investments are combining to create a national mental health crisis response approach. This effort may be traced to 2016, when the Crisis Task Force of the National Action Alliance for Suicide Prevention released *Crisis Now: Transforming Crisis Services is Within Our Reach*. This report highlighted the problems associated with inadequate crisis care: suicide, criminalization, and emergency department "boarding," where people with mental and substance use disorders were detained, sometimes for days, waiting for an appropriate treatment bed. However, the task force also discovered that the individual elements of an ideal, well-functioning crisis system were widely understood and already in place in many communities. But in the absence of national standards and funding for crisis systems, the report found most communities had only parts of the needed system, and that a partial approach could not function effectively. According to the report, "core elements of crisis care include: 1. Regional or statewide crisis call centers coordinating in real time 2. Centrally deployed, 24/7 mobile crisis 3. Short-term, 'sub-acute' residential crisis stabilization programs 4. Essential crisis care principles and practices."[2]

One of the essential principles recommended by the task force was crisis care partnerships with law enforcement to reduce criminalization and increase safety. In making this recommendation, the report noted "We also find that the absence of comprehensive crisis systems has been the major 'front line' cause of the criminalization of mental illness, and a root cause of shootings and other incidents that have left people with mental illness and officers dead."[3]

Seeking to create momentum for this work, the task force recommended "national- and state-level recognition that effective crisis care must be comprehensive and include the core elements listed above."[4] In 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) published National Guidelines for Mental Health Crisis Care, a toolkit that followed and extended the task force's recommendations. Then, as part of the FY21 federal budget, Congress provided dedicated funding for crisis systems for the first time. The new 5 percent Block Grant Crisis Services Set-Aside has now been released to states. The SAMHSA national guidelines document and new funding send a strong signal that crisis care is now a priority.

A second, bigger effort to improve crisis care then emerged from Utah, resulting in national legislation. Frustrated at the patchwork of mental health crisis lines, leaders sought to designate a single statewide three-digit number for mental health crisis—a complement to 911. Accomplishing this at the state level proved difficult. However, members of Utah's congressional delegation, especially Senator Orrin Hatch, advanced the issue nationally. First, 2017 legislation required a study of the feasibility and utility of such a three-digit number, to be completed by the Federal Communications Commission (FCC), SAMHSA, and the U.S. Department of Veterans Affairs (VA). When the review indicated that such a number would be useful and feasible, the agencies acted. In July 2020, the FCC designated 988 as the single national number for routing all suicide prevention and mental health crisis calls, to be effective in July 2022.[5] Momentum for reforming crisis care accelerated. In October 2020, the President signed the National Suicide Hotline Designation Act. The legislation elevates the FCC designation of 988 to law, clarifying that the system will be for "the national suicide prevention *and mental health hotline* system" (emphasis added).

2 National Action Alliance for Suicide Prevention: Crisis Services Task Force, *Crisis Now: Transforming Services is Within Our Reach* (Washington, DC: Education Development Center, Inc, 2016), 3. Center, Inc.

3 Ibid, 35.

4 Ibid, 42.

5 Federal Communications Commission, "FCC Designates '988' as 3-Digit Number for National Suicide Prevention Hotline," July 16, 2020, https://docs.fcc.gov/public/attachments/DOC-365563A1.pdf.

The act also required SAMHSA and the VA to submit a report in Spring 2021 that "details the resources necessary to make the use of 9-8-8…operational and effective." (As this is written, the report has not been released.) The Designation Act signals Congress' intent to consider funding for 988 implementation—potentially funding that goes beyond just paying for call centers, This is significant, as federal funding for the NSPL has been minimal, and mostly devoted to national administration of the NSPL system. Additionally, the act follows precedent established for 911, allowing states, localities, and tribal governments to impose fees on cell phone providers to address the costs of the 988 service as well as costs associated with "personnel and the provision of acute mental health, crisis outreach and stabilization services." Further, the legislation focuses on "a strategy…to allow LGBTQ youth, minorities, rural individuals, or members of other high-risk populations to access specialized services."

Even prior to delivery of the agencies' report and the FY 2022 federal budget, other federal actions begin to define the scope and focus of the emerging crisis system. SAMHSA's 2020 national guidelines for mental health crisis care, the first of their kind, formalized and extended the recommendations of the Crisis Task Force, including such pivotal recommendations as the following:

- → real-time coordination of crisis and ongoing services;
- → linked, flexible services specific to crisis response, namely mobile crisis teams and crisis stabilization facilities; and
- → crisis receiving and stabilization services that offer walk-in and first-responder drop-off options.

Additionally, funding for crisis care is included in the fiscal year 2021 (FY21) federal budget. The FY21 SAMHSA budget includes an additional $35 million[6] as a "set-aside" for mental health crisis services in the Mental Health Block Grant, which is distributed by formula to all states. And the $1.9 trillion American Rescue Plan supports community-based mobile crisis intervention services via an additional $1.5B[7] for the Mental Health Block Grant and by increasing Medicaid matching payments for these services for a 3-year period.[8]

There is momentum to implement widespread 988/mental health crisis response systems that can serve as partners for local 911/law enforcement systems. The 988 mental health crisis line will establish a parallel structure that can facilitate providing care instead of taking people into custody. A national framework to facilitate collaboration that enhances care and reduces the criminalization of mental illness will be available. However, achieving needed outcomes will still require work and coordination. The 988/mental health crisis response system will take time to build. The 988 effort will largely be driven at the state level, while 911/law enforcement crisis response is local. And, while reducing the burden on law enforcement and the criminalization of people with mental illness is one of the goals of mental health crisis reform, it is not specifically mandated or assured of success. To achieve reform, mental health and law enforcement partners will have to make it work. The following section shares how some communities are already solving the problem and suggests a framework for action.

Strategies and Successes for 911/Law Enforcement and 988/Mental Health Crisis Collaboration

In Table 1 below, we illustrate how the 911/law enforcement and the emerging 988/mental health crisis response systems line up. Each system has three major components: call center, responders, and facilities. In the absence of collaboration, the 911/law enforcement system is on its own to resolve reported mental health crises. As the table illustrates, with collaboration, diversion into care is possible at each level. Further discussion below illustrates diversion opportunities and successful models for each stage.

6 Consolidated Appropriations Act, 2021. p. 396: "That of the funds made available under this heading for subpart I of part B of title XIX of the PHS Act, $35,000,000 shall be available to support evidence-based crisis systems"

7 SEC. 2702. Funding for Block Grants for Prevention and Treatment of Substance Abuse. In addition to amounts otherwise available, there is appropriated to the Secretary for fiscal year 2021, out of any money in the Treasury not otherwise appropriated, $1,500,000,000

8 SEC. 1947. State Option to Provide Qualifying Community-based Mobile Crisis Intervention Services.

911/Law Enforcement and 988/Mental Health Crisis Response Systems Integration: New Opportunities				
Crisis System Components	**911 System**	**988 Crisis System**	**Diversion Opportunities**	**Key Challenges**
Call Center	Public Safety Answer Point (PSAP)	Crisis Call Center	• Encourage mental health crisis callers to call 988 • Joint handling of Behavioral Health (BH) calls • PSAP transfer calls to 988	• Build call center capacity by July 2022 • Call center adds mobile dispatch/"bed board" capacity • Joint planning
Responders	Police EMTs	Mobile BH Crisis Team	• 911/988 agreement to divert appropriate call-outs to mobile teams • Co-responder teams e.g., CIT officer/clinician	• Add mobile team capacity if needed • Joint planning toward shared protocols and ongoing collaboration
Crisis Facilities	Jail Emergency Department	• Crisis Receiving Facility • Crisis Residential • BH Urgent Care	• Direct drop-off of BH clients at receiving facility	• Clinically adept crisis receiving facility among crisis facility options • Design, e.g., sally port • Ongoing shared planning, data review

Table 1, Mike Hogan, 2021

Collaboration at the PSAP/988 Call Center Level

The 988 phone number will be implemented as a national routing system for suicide and mental health crisis calls on or before July 16, 2022. The network of local and state call centers will build on the current call centers (about 180 of them) that participate in the NSPL. The NSPL system is planning now for the 2022 launch of 988. The planning process underway at the state- and call center-levels is described at the NSPL's 988 Planning Grants page. Initial plans are to be submitted to Vibrant (the Lifeline operator) by August 30, 2021, with final implementation plans due by December 31, 2021. Advocacy for a diversion agenda is timely.

As 988 is promoted as a national suicide prevention and mental health crisis line, more calls will go directly to this system. However, the impact will occur gradually. While 988 will be much more recognizable than the current NSPL number (1-800-273-8255), it will take months and years for a sizable proportion of the population to learn the new number. Since 911 has been promoted and used for many decades, getting people to substitute the new number will take many years. Therefore, some innovators are exploring collaborations that divert applicable 911 calls to mental health call centers. One of the first and best-known collaborations is in Houston:

→ Houston's Crisis Call Diversion Program (CCDP)

- In Houston, the high volume of mental health-related calls to 911 has led to several innovations. First, the Houston Police Department implemented a Crisis Intervention Response Team (CIRT). It operates under a "co-responder" model, with a police officer and a masters-level clinician from the Harris Center for Mental

Health and IDD, Houston's key behavioral health provider, responding jointly to the scene of mental health crises. Even with CIRT, however, thousands of calls with a mental health nexus were still made to 911. The next innovation was to station trained Harris Center "tele-counselors" within the 911 call center, to help with these calls. The CCDP has been able to handle a high proportion of less urgent mental health calls, but also to resolve many calls that previously would have required a face-to-face CIRT response. Evaluation of the program reveals savings to the Houston Police Department of over $800,000 annually, to say nothing of the impact on individuals with mental illness who have avoided inappropriate hospitalization or contact with the justice system.

Houston's experience demonstrates that diversion at the PSAP level is feasible. The collaboration in Houston was facilitated by the fact that the Harris Center for Mental Health and IDD is a very robust mental health provider which also operates a NSPL call center. As one of the nation's largest cities, Houston also has the scale to make the results significant. And years of community collaboration provided a strong foundation for this successful initiative.

Another innovative solution in Georgia demonstrates additional elements of a comprehensive and proactive mental health call center:

→ The Georgia Crisis and Access Line (GCAL)

- Following devastation across the Southeast United States by Hurricane Katrina, Georgia officials sought to build a single statewide crisis line, launching GCAL in 2006. The capabilities of GCAL have been steadily enhanced. In addition to serving as a crisis hotline and as part of the NSPL, GCAL now handles statewide mobile crisis team dispatch, links individuals with emergency visits at mental health clinics, maintains real-time data on crisis and detox beds, and coordinates access to state-funded or -operated inpatient services. The GCAL system served as inspiration for the concept of 24/7 "care traffic control" described in the 2016 Crisis Now report, whereby call centers "graduate" from simply handling calls to dispatching and coordinating care (see: https://behavioralhealthlink.com/).

Generating collaboration at the 911/988 call center-level can be challenging. In the PSAP/law enforcement environment, day-to-day business is demanding. In the emerging 988 space, the NSPL call centers that will form most of the eventual 988 infrastructure are under-resourced and simultaneously planning for the transformational changes involved in moving from a core suicide prevention mission to a much broader mental health crisis role. Most current NSPL centers do not possess the "care traffic control" capabilities that are necessary in an optimal crisis care system. State mental health agencies are working with the NSPL, its operator (Vibrant), and SAMHSA to get ready for July 2022. Law enforcement partners should be at the table for this planning, but the 911 system is highly local, and statewide planning isn't sufficient for local integration.

Collaboration at the Responder Level

A core strength of the 911/law enforcement system is the ability of police, EMT, and fire departments to respond to the scene. In the mental health world, mobile crisis teams perform a similar function. Therefore, there is potential to substitute a mental health mobile team response in the many cases where a police response is not essential for public safety reasons. As Table 1 illustrates, there are two main strategies for shifting toward a treatment response, as opposed to a law enforcement response: implementing co-responder models, such as the Houston CIRT approach discussed above, and diverting the response from law enforcement to mental health mobile crisis response where appropriate. One of the earliest and best-known examples of a dedicated non-police crisis team in Eugene, Oregon:

→ Crisis Assistance Helping Out On The Streets (CAHOOTS)

- CAHOOTS is a mobile crisis program developed by the White Bird Clinic, focused on responding to non-violent crisis calls routed to the program from 911 or general local law

enforcement calls. Each mobile team includes a medic (nurse, paramedic, or EMT) and a mental health crisis worker. Dispatchers are trained to recognize mental health-related crises that are non-violent and to route these to CAHOOTS. Program data show that CAHOOTS responds to about 20,000 crises per year, with police backup requested in only about 300 cases. Estimated savings to the Eugene Police Department are about $8.5 million per year.

Because of the need to provide a helpful crisis response that does not unnecessarily rely on law enforcement and the documented effectiveness of this approach, increased funding for mental health crisis response (based on but not limited to the CAHOOTS approach) was made available in the recent coronavirus relief legislation (American Rescue Act). The legislation provides for an increased Medicaid reimbursement rate (to 85 percent of costs) for mobile teams as well as $15 million for state planning grants. Since states will be planning now to expand mobile crisis services, the timing for a collaborative approach that includes law enforcement and anticipates 988 implementation is perfect.

Comprehensive Crisis Response, Including Urgent Care/Crisis Receiving Facilities Accepting Police Drop-off of Individuals

As Table 1 indicates, the "third leg" of crisis response systems is facilities providing immediate access for crisis assessment and stabilization. The goal for individuals requiring more than a crisis call or mobile team visit is to place them—with minimal first responder effort—in a program that can quickly assess and provide for stabilization needs. Having a specialized crisis receiving facility can reduce reliance on jails and hospital emergency rooms (which are generally not suited to assess and stabilize crises related to mental health).

There are a wide variety of crisis stabilization programs, including residential programs providing a short-term alternative to hospitalization, some operated and staffed by peers. The innovation that has provided the most value from a criminal justice diversion perspective is crisis receiving facilities—almost always in communities with strong police Crisis Intervention Team (CIT) programs—that are designed and operated to facilitate speedy, direct drop-off by CIT officers. The state with the most comprehensive system of these facilities is Arizona. Their statewide crisis system and crisis receiving facilities are national models:

→ The "Arizona Model"

- Arizona's crisis system and prioritization of criminal justice diversion have been described in a Vera Institute of Justice report. The key aspects of the "Arizona model" include regional crisis systems, with central real-time crisis call centers and coordination; mobile crisis teams and crisis receiving facilities within each regional crisis system; and required collaboration with law enforcement, including an expectation that police drop-off can be completed at crisis receiving facilities within 10 minutes.

Conclusion

The longstanding movement to increase access to mental health services as an alternative to law enforcement response and incarceration has gotten a remarkable boost with promised improvements in crisis care. There are emerging opportunities to facilitate engagement and diversion at all three levels of crisis care:

→ through collaboration to divert calls from 911 to mental health crisis call centers, especially as these centers are strengthened and linked by a new national 988 routing system effective next year;

→ via increased use of mental health mobile crisis teams to respond to crisis calls judged to not require a police response and increased use of "co-responder" models employing both a law enforcement or EMT staffer and a mental health counselor; and

→ by expanding the availability of crisis receiving facilities, especially those which can partner with law enforcement to offer timely direct drop-off by police, without requiring prior medical clearance (because the crisis facility can address this).

These opportunities will be facilitated by national commitments to crisis care: the designation of a national 988 mental health and suicide prevention number effective in 2022, as well as increased funding for mobile crisis teams and other crisis services at both the national level and in many states. However, these opportunities can only be realized by partnerships between leaders in the 911/law enforcement system and the 988/mental health crisis system. Partnerships, as always, will take commitment and persistence as each system is working hard on its own mission, dealing with emerging challenges, at different stages of development, and often managed at different levels (e.g., statewide vs. local). But the time has never been better to continue and deepen collaboration, for the benefit of communities and people in need.

About

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation focuses on expanding access to services for people with mental and/or substance use disorders who come into contact with the justice system.

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