Reimagining Mental Health Crisis Response through 988: Local Lessons on 988 Implementation and Coordination with 911 from Three New York State Counties

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Introduction

In July 2022, the federal government launched the three-digit 988 Suicide and Crisis Lifeline, creating an easier-to-remember alternative to reach the existing 10-digit National Suicide Prevention Lifeline (NSPL) number and providing quick access to a network of over 200 state- and locally-funded crisis centers. Between July 2022 and May 2023, 988 received almost 5 million contacts, including 2.6 million calls, over 740,000 chats, more than 600,000 texts, and nearly 1 million contacts via the Veteran's Crisis Line (a subset of 988 intended for military veteran callers).[1] Additionally, in the year following 988's launch, total crisis contacts grew by 15% nationally. As more crisis centers opened and more staff were trained, call answer rates increased from 83% to 89% and call wait times decreased (to an average of 35 seconds in May 2023 from 1 minute and 33 seconds in July 2022).[2]

Alongside providing enhanced access to the Lifeline, the roll out of 988 is being positioned as a catalyst for a transformed behavioral health crisis system in the United States.[3] The Substance Abuse and Mental Health Services Administration (SAMHSA) describes the ideal crisis system as having three essential elements: "someone to contact" (e.g., a number to call or text), "someone to respond" (e.g., mobile crisis team services), and "a place to go" (e.g., crisis receiving and stabilization services).[4] Local communities have used the time leading up to, and since, the launch of 988 to survey their crisis care continuums and to identify gaps and areas for investment. Local 988 call centers must be capable of triaging calls, tracking callers' physical locations, redirecting certain calls to sister crisis lines (e.g., 988 to 911), and deciding what and how in-person mental health crisis outreach resources are dispatched. Crisis researchers and policy makers have paid less attention to this latter aspect, or 988's role in coordinating in-person, crisis care service delivery. Although some evidence suggests that up to 80% of calls to emergency mental health hotlines can be resolved over the phone, this still means that 20% of callers will require emergency mental health care services.[5] Building a safety net that can address the needs of a person in crisis is therefore a complicated task that requires not only tracking where people are calling from in moments of crisis but also determining how those calls are triaged and how decisions are made about what resources get sent out.

This report contributes to a national discussion of and guidance on 988 by sharing case studies from three New York State counties that document local 988 implementation efforts and describe the collaboration between 988, 911, and other crisis lines. These three counties—one urban, one suburban, and one rural—demonstrate the wide variability in resource availability and preferences that dictate local 988 make-ups. We do not intend for this report to be evaluative—there is no absolutely "right" way to respond to mental health crises. Rather, we present a sequence of case studies that local municipalities might reference when developing their own crisis care systems. For instance, this report might be used to: (1) identify communities implementing model crisis programs; (2) learn from peer communities that have implemented innovative crisis policies and procedures; and (3) understand barriers and facilitators to crisis services implementation. We first present a brief background on the 988 and 911 systems. We then provide a brief overview of our methods followed by the county case studies. Finally, we highlight common implementation issues across jurisdictions and provide suggestions for future policy work and research.

988 and the Broader Emergency Response Call System

988 is a newcomer to an established system of mental health emergency hotlines in the United States. 911—the most widely used hotline in the country—was established in 1968 and serves as an all-purpose, public emergency response system for dispatching police, fire, and emergency medical services. 911 receives over 240 million calls each year.[6] Calls to 911 are routed to the nearest Public Safety Answering Point (PSAP), either based on the address linked to the phone number (for a landline call), or to the location of the nearest cell phone tower (for a cell phone call). There are over 6,000 PSAPs in the U.S. that vary in size, structure, and call taking approach. PSAPs range from large emergency communication centers that handle calls for an entire region to small police departments that serve a single town. Call takers may rely on structured protocols to gather information from a caller or may have considerable freedom in the questions they ask; no universal protocols exist for call taking so jurisdictions often rely on unique processes to triage emergency calls, identify appropriate services, and collect the information they need to respond.

In 2004, SAMHSA launched the NSPL as an alternative for behavioral health emergencies. In 2020, through the National Suicide Hotline Designation Act, the NSPL was nationally rebranded to the shorter, and easier to remember, 988 Suicide & Crisis Lifeline. NSPL, and subsequently 988, provide free, confidential phone, text, and chat access to trained emergency mental health staff and volunteers who are capable of providing immediate counseling, as well as referrals to local mental health resources.[7] Today, there are over 200 local- and state-funded crisis centers across the country that operate on a 24/7 basis. 988 calls route to call centers based on the caller's area code (thus, without geolocation tracking as with 911). Should a local 988 call center be unable to answer a given call, the call is routed to a national backup network. As with 911 call takers, each 988 volunteer and staff member receives training from their individual call center. There are no national requirements for training frequency, modality, or evaluation.[8] Of note, Vibrant Emotional Health (the organization SAMHSA chose to oversee and administer 988) recently launched an online learning management system and could foreseeably be implemented nationally to standardize 988 call taker training.

In addition to 911 and 988, other mental health crisis hotlines exist. These include national crisis lines such as Crisis Text Line as well as a multitude of locally run crisis lines. There are also hotlines that specialize in minoritized populations such as LGBTQ+ youth (e.g., the Trevor Project), and transgender individuals (e.g., Trans Lifeline). There is limited research on how, and for whom, these hotlines work and what outcomes they produce.[9] As our case studies below demonstrate, and as other recent research suggests, consideration for how these existing crisis lines mesh with 988 is critical.[10] Many communities are actively engaged in thinking about whether local lines should be kept operational or phased out in the setting of 988's growth.

New York State's Approach to 988 Implementation

New York State (NYS), with its diverse population, geography, mental health crisis systems, is an excellent case study of state-level 988 implementation. NYS envisions 988 as "more than a number," and instead a "portal for convenient access and rapid entry into the coordinated crisis response system."[11] The State has made a significant financial investments in expanding 988 call center capacity, including $35 million and $60 million, respectively, in the 2023 and 2024 fiscal year budgets and $10

million in supplemented Federal Mental Health Block Grant resources. As of July 2023, NYS had 14 total call centers answering calls 24 hours a day for residents in all the State's 62 counties. Should a given call center be at call capacity, NYS even has a back-up call coverage network for 48 of its 62 counties. Due to this in-state back-up, the State rarely needs to outsource excess call burden to the national 988 backup network. Alongside this call center capacity investment, the NYS Office of Mental Health has engaged in several robust 988 implementation efforts including the creation of a multi-stakeholder 988 Planning and Implementation Coalition; the development of systems to ensure that local resource and referral listings are comprehensive; guidance around relationship building between 988 call centers, mobile crisis teams, and 911; and a public messaging campaign about the range of 988 services and the difference between 988 and 911.[12] This state-level funding, publicization, and implementation should not obscure the fact that 988 implementation itself is a locally driven process. This local perspective on how NYS counties implemented 988, and built collaborations between 988 and 911, is the focus of this report.

Methods

This report draws on over two years of qualitative research in three NYS counties. We conducted research prior to and after 988's launch (August 2021 – November 2023). The counties of focus—Monroe (urban, given it contains the Rochester metro area), Westchester (suburban, given its location directly north of New York City), and "North Country," or the combination of Essex, Clinton, Franklin, and Hamilton Counties (rural)—were chosen for their combined geographic and population diversity, their differences in pre-988 crisis services resources, and their variable plans for 988 implementation (see Figure 1).

We conducted a first research phase prior to the launch of 988. We aimed to identify how stakeholders defined mental health crisis, how they anticipated utilizing 988 versus 911, and what services they expected they could access through these two crisis lines. We elicited this information from 15 stakeholder focus groups that included 76 participants. Focus group participants included mental health consumers, family members of consumers, community members, mental health providers, and crisis call takers (including 911 call takers). We published the results from this first phase elsewhere.[13]

In the year following 988's launch, we conducted a second research phase. We aimed to understand 988 implementation in relation to other county crisis services. In particular, we examined the interface between 988 and 911, and explored how crisis call takers made decisions around crisis triage and resource dispatch. We conducted site visits to observe 988 and 911 call center workflows (Monroe and Westchester). We also observed 988 call taker training and 911 dispatcher trainings (Monroe), 911 diversion training (Westchester) and local mobile crisis team operations (Westchester). Finally, in North Country, where 988 implementation took a longer period of time, we participated in monthly 988 planning calls with county

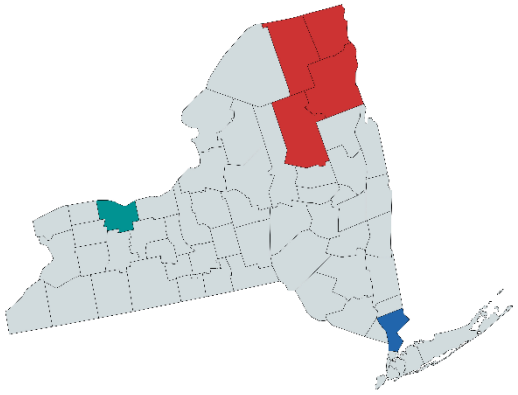

Figure 1. Monroe County (Green), Westchester County (Blue), and North Country (Red)

mental health leadership and the local 988 provider organization. In addition to site visits and observations, we conducted 23 interviews with a total of 26 participants (two interviews included more than one participant). Interviewees included 988 call center leadership and staff, 911/emergency call center leadership and staff, police, mental health providers, and crisis response teams. We selected interviewees based on the key contacts that we developed during the first research phase. Additionally, for call taker interviewees, we used asked center leadership to circulate interview opportunity to call takers. We further describe our interview sample in Table 1 below.

Table 1. 988 Study Interview Participants

Role	Monroe County	Westchester County	North Country
988 Leadership	3	1	1
988 Call Takers	2	2	2
911/Police	3	2	
Mobile Crisis	4		
Local Mental Health		2	4
TOTAL	12	7	7

We conducted interviews between November 2022 and November 2023. All interviews lasted one hour, were conducted remotely using Zoom, and were recorded and transcribed. The New York State Psychiatric Institute Institutional Review Board approved all study procedures. We used a thematic approach (Braun and Clarke 2021), to guide interview analysis. We developed a codebook based deductively on our primary research and interview questions, as well as inductively based on interviewees' responses. Codes were refined over time through review of transcripts until a final set of codes were developed. Two members of our research team coded all interviews in Dedoose. Members of the research team then developed code reports and drafted summary memos to produce the case studies presented below.

Case Study: Monroe County

The implementation of 988 in Monroe County sheds light on a larger story of building collaboration across multiple entities in a complex ecosystem of mental health crisis services and emergency response. Monroe County is the ninth most populous county in NYS and is home to the city of Rochester (210,000 residents). Monroe's diverse population spans urban and rural geographies. Rochester itself is demographically diverse; the population is 45.1% White and 38.4% Black or African American; 20.9% of Rochester residents speak a language other than English at home; and a high percentage of Rochester residents live in poverty (29.3% in Rochester compared to 13.9% statewide).[14] Prior to 988, to meet the needs of its population, Monroe County built a robust mental health crisis response system that includes a 211/LIFE LINE, 911, a Forensic Intervention Team (FIT), a Person in Crisis Team (PIC), and additional mobile crisis teams. Notably, Monroe developed some of this infrastructure after 2020, when Daniel Prude, a 41-year-old Black male, died by police physical restraint while he was experiencing a mental health crisis. Prude's death impacted the Rochester community deeply and set the stage for local crisis system transformation.[15]

This case study examines how Monroe County has developed strong partnerships across crisis response systems in order to dispatch the most appropriate response to mental health crisis calls that are placed to 988 or 911. We outline the primary crisis lines and range of crisis response options in the county before describing how field responses are dispatched, how key partners have built trust across mental health and law enforcement systems, and how further educating callers is a necessary next step for improving the system.

Overview of Crisis Call Lines and Available In-Person Responses

As diagrammed in Figure 2, people experiencing mental health crises in Monroe County can contact three primary crisis lines: 211/LIFE LINE, 988, and 911. Goodwill of the Finger Lakes, a non-profit organization, has long operated 211/LIFE LINE as a 24/7 crisis line in Monroe County. Calls to 211/LIFE LINE and the NYSPL are routed to Goodwill, which provides phone mental health crisis support and information about accessing basic resources such as food, clothing, and shelter. Goodwill is also the regional provider for 988 (and before that, was the regional provider for the NSPL). Goodwill now answers 988 calls for Monroe County, as well as for 8 neighboring counties. People experiencing mental health crises in Monroe can also call local hotlines and warmlines. Further, such individuals can—and often do—call 911. Since 1986, Monroe County has operated a single, centralized Emergency Communications Department. This Department now serves 84 different public safety agencies and handles over 1 million calls for service each year.

Depending on which crisis line a person calls (211/LIFE LINE, 988, or 911), and what services the person requires or requests, a range of in-person field responses are available, including:

- **Forensic Intervention Team (FIT):** FIT, a program operated through the Monroe County Office of Mental Health, entails mental health clinician and law enforcement co-response to behavioral health crises. FIT operates countywide 24/7 and is only available via calls to 911. For certain call codes, FIT clinicians are automatically co-dispatched with officers. Officers can also request clinician co-dispatch at any time. FIT aims to de-escalate crisis situations, provide appropriate referrals, and offer the least restrictive level of mental health care. Per Mental Hygiene Law, FIT can place involuntary mental health holds and involuntarily transport persons to the emergency room. FIT clinicians can provide post-crisis follow-up.
- **Person in Crisis Team (PIC):** The Rochester Department of Recreation and Human Services operates PIC, a team-based crisis response model, within Rochester city limits. PIC is available 24/7 via calls to 988 or 911. PIC teams either dispatch alone (in teams of two consisting of social workers, mental health counselors, and/or peer support workers) or in co-response with police. PIC aims to de-escalate crisis calls and to increase callers' connections to community mental health services. Unlike FIT, PIC only offers voluntary services.
- **Mobile Crisis Teams:** The University of Rochester Medical Center and Rochester Regional Health also operate one mobile crisis team each. These teams are not available 24/7. They do dispatch countywide.

Determining the Right Response for the Right Call – 988 versus 911

A Monroe County caller's initial decision to contact 988 versus 911 dictates many downstream processes. A 988 call is routed to Goodwill, where a call taker will attempt to engage the caller, build trust, and understand the caller's reason for calling. As recommended by Vibrant Emotional Health (Vibrant), Goodwill 988 call takers ask suicide assessment questions early in the call. These questions—geared at assessing suicidal desire (e.g., suicidal ideation), intent (e.g., plan with known method), capability (e.g., history of attempts), and buffers (e.g., immediate supports)—provide critical information to the call taker about the severity level of the call. Goodwill staff describe their asking these questions as "a complex art… an art of having a conversation and not making it feel like we're drilling [the caller]."

Based on the information collected, a call taker must then determine "what the caller's actual risk level is and the level of intervention that's necessary to keep them safe." This can be challenging. As one call taker described, "Not every call is like a black and white situation, so there's definitely those gray areas." In most cases, calls are resolved over the phone with the same core set of tools described by Goodwill leadership: "being nonjudgmental… help[ing] callers identify their own resources, their own supports, their own solutions… and [having] listening skills such that we can validate, we can affirm people, encourage people, and help them express themselves in an environment where they're comfortable." In some cases, a call taker will work with a caller to develop a safety plan. A call taker might suggest, or provide direct referrals to, local resources. A 988 call taker can request the involvement of, and provide detailed referral information to, a PIC team (if the caller is within Rochester city limits) or a mobile crisis team (county-wide). With a caller's consent, a 988 call taker can transfer a call to 911. In urgent situations (i.e., when there is a high risk of harm to the caller or to others), a 988 supervisor can call the 911 ECC and request involuntary police dispatch. Per Monroe 988 call takers, sending police is "always a last resort." 988 call takers know that "trauma will probably be inevitable" in involuntary police-involved dispatch scenarios. Even when police are sent, 988 call takers try to secure caller collaboration. Of note, 988 to 911 call transfers occur relatively infrequently in Monroe County. In the first year of 988's operation, under 2% of 988 calls were transferred to 911.

A 911 call is routed to the Monroe County Emergency Communication Center (ECC). The ECC uses a structured protocol for call taking and dispatching. Distinct staff members take calls (telecommunicators) and dispatch responses (dispatchers). A 911 telecommunicator begins each call with the same directive to the caller: "Tell me exactly what happened." Sometimes, the caller will immediately ask for a transfer to 211/LIFE LINE or 988. The telecommunicator can make this transfer as long as the caller confirms that they do not require ambulance assistance. More commonly, the caller describes the issue they are experiencing. If, in the course of providing this information, the caller indicates that their call has a mental health or crisis component, the telecommunicator launches their Priority Dispatch ProQA EMD software. This software uses an International Academies of Emergency Dispatch protocol to walk the telecommunicator through case entry and key questioning for medical-related 911 calls. The software directs the telecommunicator to Card 25, which is used for mental health crisis, and which prompts with key crisis severity triage questions, including: caller's level of alertness, weapon availability and access, and whether this is a suicide attempt. Once the telecommunicator enters the information provided by the caller, a process of selective dispatch occurs. The telecommunicator gives each call a specific code, which is associated with a specific response types (i.e.,

police only, police and PIC team co-response, PIC team only, police and FIT co-response) (see Figure 2). A dispatcher then reviews the code and confirms the appropriate response. Of note, the ECC medical director assigned codes to response options after completing an extensive review of Card 25 911 calls that ended in involuntary transportation to the hospital for psychiatric assessment. Upon learning that certain codes were associated with cases ending with involuntary transport *and* quick emergency room discharge—thus suggesting that hospitalization was not the required level of care—county officials re-assigned these codes to PIC and FIT, which focus on on-scene crisis de-escalation and care.

Building Trust and Balancing Concerns about Safety

The development of structured systems for in-person mental health crisis service dispatch, for transfer of appropriate 911 calls to 211/LIFE LINE and 988, and for dispatch of non-police responses (i.e., PIC) and co-responses (i.e., FIT) is the result of considerable, years-long investment in relationship building across local crisis systems. Interview participants described how the relationship between Goodwill and the 911 ECC has grown over time with the establishment of multidisciplinary workgroups and new mental health outreach teams. One interviewee noted that Goodwill and the ECC have had "zero negative experiences" collaborating around mental health calls. Similarly, the Monroe PIC and FIT teams described their robust partnerships with local law enforcement. One interviewee said that these law enforcement partnerships require "strong intentional investment around building and maintaining" collaboration. This investment has included mental health education efforts aimed at law enforcement officers; mental health workers' acknowledgement of, and respect for, law enforcement's authority over a given outreach scene; and a focus on collaborative problem solving and "mutual respect for the work" of mental health crisis care.

Monroe's collaborative focus does not mean that mental health crisis dispatch processes have always run seamlessly, however. One unresolved issue involves call transfers from 911 to 211/Life LINE or 988. This issue harkens to a long-engrained 911 call center culture of, "When in doubt, send everyone out." Such a culture is not built around call transfers and there remains reluctance to send out non-police responses to a given crisis situation, particularly because of concerns about liability (see *Shared Implementation Challenges* section on *Liability* in the Discussion section below). One Monroe dispatcher described the challenges he faced when determining whether it was safer to send a mental health outreach team to a crisis situation with or without police accompaniment. The dispatcher noted that, on the one hand, "A lot of us feel uncomfortable just sending them [PIC or FIT] there by themselves without [police], you know, like okay, is this going to be okay?" But, the dispatcher also recognized the potential problems with police co-dispatch:

> It's kind of touchy too because, as I said, the whole idea of like a counseling team of a PIC or a FIT for us is that the police… may have shortcomings in dealing with mental health problems. That's why these teams [PIC and FIT] exist in the first place. So, it's kind of touchy whether you're stepping on the toes of these PIC or FIT teams to have the police go. Like we want them [PIC and FIT] to be safe. Certainly. But at the same time, you don't want to make matters worse for the person [in crisis] who might be intimidated by police.

In response to this challenge, the dispatcher in question described proactively utilizing available ECC technology to gather more detailed historical information about the caller (e.g., looking at previous call

records), sharing this additional information with the PIC team, and then directly asking the PIC team whether the team would prefer police co-dispatch to a given call.

Monroe interviewees also wondered whether additional calls, which were being managed solely by 911, might be transferred to 988 in the future. At present, Monroe 911 mental health crisis callers themselves must directly request 988. If a given caller does not request 988, the 911 telecommunicator will follow normal call-taking procedures and the likelihood of transfer to 988 as a final call disposition is unlikely. For example, once the Card 25 mental health card is launched, an in-person response will automatically be dispatched. Unsurprisingly, in 988's first year of operation, 911 dispatchers transferred few calls to 988. One Monroe interviewee commented on how the crisis response system might function better if case triage aligned with call center [i.e., 911 vs. 988] expertise: "I think it's essential we lean on our partners [988 call centers and associated outreach teams] with the expertise to do it [mental health crisis response] well versus forcing people [at 911 call centers] to go outside their expertise to try to handle something and making it more dangerous in the long run." This means "relying on those partnerships to kind of stay in their lane, so to speak." Thus, future work could be geared toward further refining what calls can or should be diverted to 988.

Educating the Public about Monroe County's 988 Line

This issue of aligning case triage with call center expertise entails the need to further educate the public about the distinct services that 211/LIFE LINE, 988, and 911 offer. Monroe interviewees described how callers presently "kind of go with what they know." This might entail, for example, calling 911 to access the PIC team, even though the PIC team can also be accessed by calling 988 or 211/LIFE LINE. These public knowledge issues are further compounded by the fact that, in Monroe, 211/LIFE LINE was originally designed to function as both a human services (e.g., resources for basic services like housing, shelter, food) *and* a mental health crisis line. Goodwill described that they would likely move toward further differentiation between 211/LIFE LINE and 988, including through marketing materials that stress that 211/LIFE LINE is primarily for human services and 988 for mental health crisis issues. Monroe interviewees suggested that public education about 988 should focus more on what a caller might expect after placing a 988 call. One 911 dispatcher remarked, "People like to know what to expect and if they haven't called it [988] before, that's difficult. I don't feel like the campaigns that they've done so far really discuss what happens when you actually call [988]. They [the campaigns] say some stuff about when you should call, but then they don't tell the person what's going to happen next. And I think that's a little bit detrimental." Additional communication and education about 988 in Monroe County are critical steps toward continuing to strengthen partnerships across the county's various crisis lines and has the potential to reduce reliance on 911 and in-person responses for mental health emergencies. In a county with a relatively strong mental health service infrastructure, such education could allow for a more refined understanding of the emergency service ecosystem and improved ability to match specific services to callers based on their needs and preferences.

Case Study: Westchester County

Westchester County's 988 implementation is part of a broader, countywide effort to create an integrated mental health crisis response and diversion system. Westchester is a suburban county located directly north of New York City with a population of just under one million people. Westchester

County's largest cities are Yonkers, New Rochelle, and Mount Vernon. Westchester's racial/ethnic makeup is estimated to be 72% White, 17% Black or African American, 26% Hispanic or Latino, and 6.9% Asian. Westchester has an increasing rate of foreign-born citizens and ranks lower than the national average in percentage of residents who are United States citizens. Westchester residents are relatively well-educated, with almost 90% of residents over the age of 25 having a high school diploma and 50% having a bachelor's degree. Westchester's median household income is over $100,000.[16]

Although Westchester has been building out its crisis response system for some time, intensive investments in the past few years have largely been the result of Project Alliance, the County's five-pronged approach to mental health crisis response. Westchester launched Project Alliance in 2021 at the behest of the Westchester County Police Reform and Reimagining Task Force (which Westchester established in June 2020 in response to the killing of George Floyd and to comply with then NYS Governor Andrew Cuomo's Executive Order 203[1]). Project Alliance's five prongs include: (1) Establishment of a countywide behavioral health crisis response line (now 988); (2) Development of a 911 Diversion Program through which mental health-related 911 calls are diverted to qualified mental health professionals; (3) Co-location of mobile crisis response teams (MCRTs) within local police departments; (4) Crisis Intervention Team (CIT) development within law enforcement agencies; and (5) Enhanced mental health training for Emergency Medical Services (EMS) personnel. Below, we examine the first three of these prongs. We focus on Westchester's development of 911 diversion programs and MCRT partnerships alongside the 988 rollout. We describe how these three elements—911, MCRT, and 988—fit together to ensure that Westchester-based behavioral health emergencies are met with behavioral health, and not solely law enforcement, responses.

Overview of Crisis Call Lines and Available In-Person Responses

Westchester residents experiencing behavioral health crises have three primary options for 24/7 telephonic support: the Crisis Prevention Response Team (CPRT), 988, and 911 (see Figure 3). St. Vincent's Hospital operates the CPRT and 988 lines. Dedicated call takers are assigned to both lines, each serving distinct purposes as described further below. St. Vincent's is a longtime local provider of inpatient and outpatient mental health and addiction services, mobile crisis response, and a range of residential services for people with serious mental illnesses or co-occurring mental illnesses and substance use disorders.

People in Westchester County also continue to call 911 when experiencing a mental health crisis. While a central Westchester County Emergency Communications Center (ECC) dispatches for fire and EMS services agencies, there are approximately 40 different Public Safety Answering Points (PSAPs) in the county that answer 911 calls for service. This results in a highly complex system for handling requests for service. If someone in Westchester calls 911 from a landline-based telephone, their call will be directed to the local PSAP (most often a local police department). On the other hand, if someone calls 911 from a cell phone, their call will be directed to the New York State Police, who will then

[1] Governor Andrew Cuomo signed Executive Order 203 on June 12, 2020. The Order required each local government entity with a police agency to "perform a comprehensive review of current police force deployments, strategies, policies, procedures, and practices, and develop a plan… for the purposes of addressing the particular needs of communities served by such police agency and promote community engagement to foster trust, fairness, and legitimacy, and to address any racial bias and disproportionate policing of communities of color."

forward the call to the local police department or, if an ambulance is needed, to the county ECC. Each PSAP has its own protocol for assessing caller risk and triaging dispatch options. If an ambulance is needed, a PSAP may dispatch the ambulance directly, or transfer the call to the county ECC. Although the system is complex, the local PSAP structure is arguably also more personal since people who call 911 are generally talking to a call taker at a very local level who knows the community and its residents.

For a person experiencing mental health crisis in Westchester; who calls the CPRT, 988, or 911 line; and who requires or requests an in-person mental health response, dispatchers can send two primary mobile crisis options:

- **Crisis Prevention Response Team (CPRT) mobile team:** The CPRT is an interdisciplinary, mobile team comprised of social workers, a child and family specialist, and a psychiatrist. CPRT staff provide a range of mental health services including assessment, crisis intervention, supportive counseling, information and referrals, and linkage with appropriate community-based services for ongoing treatment and follow-up. CPRT has a public phone line, as well as a police-only line for their 911 Diversion Program (described further below).
- **Mobile Crisis Response Teams (MCRTs):** Westchester has eight MCRTs, each of which serve a given catchment area. MCRTs are embedded within police departments and are staffed by a mental health clinician and a peer or a Credentialed Alcoholism and Substance Abuse Counselor (CASAC). Callers can reach a MCRT either by contacting 911 or the local police department. Police departments themselves can determine if a situation warrants co-response with MCRT response and can reach out to the MCRT to request this. In addition to providing immediate response to crisis calls, MCRT staff can assist with follow-up and social service connections throughout the County.

Building a 911 Diversion Program

The Westchester 911 Diversion Program aims to dispatch mental health-specific in-person outreach crisis services, without accompanying law enforcement, when safe to do so. As one interviewee stated, in reference to the Program, “It’s a mental health call. It should get a mental health response.” To build its 911 Diversion Program, Westchester engaged in an ambitious effort to reach, and train, all PSAPs. 911 call takers from local police departments complete a one-day training that includes instruction on how to assess caller risk level to self or others, determine if a call requires police response at all, is eligible for a co-response with the MCRT, or can be transferred to the CPRT. Figures 4 and 5 display Westchester’s Emotionally Distressed Caller Risk Assessment tool and corresponding risk category matrix used in 911 diversion, both of which were develop with input from the model in Los Angeles (co-developed by the Los Angeles Police Department and Didi Hirsch Mental Health Services). The tools covered in training are intended to help call takers better understand a caller’s intent, plan, timeframe, or means of harming themselves or others. Depending on the call taker’s assessment, a caller will receive a law enforcement-based response (with or without the MCRT) or a warm handoff to a member of the CPRT using a police-only access line (to which the public does not have access). During an ideal warm handoff, the 911 call taker who decides to divert a given case will provide the name of the caller and a brief summary of the crisis situation to orient the CPRT.

Certain challenges remain with the 911 Diversion Program despite broad success. To start, some PSAPs have yet to implement 911 diversion. Buy-in hesitancy might be due to several factors: time

requirements for training 911 call takers on new procedures, traditional law enforcement culture, lack of standardization across PSAPs, and concerns about the liability police departments might face in diverting 911 calls. One interviewee elaborated on how Westchester's unique PSAP arrangement may contribute to these buy-in challenges:

> "Westchester has 39 PSAPS. So, everybody has their own little [emergency response] kingdom in Westchester County and it's a challenge to get all of them on the same page…. you really need 39 champions. You need somebody in house [at each PSAP] that can provide that quality assurance when calls are coming in."

"Champion" cultivation is hindered by the fact that the process itself—call diversion from law enforcement to community responders—is relatively new, is "outside the box" for most police departments' cultures, and requires police departments to trust their community crisis response partners. As one interviewee reflected, "Police are reluctant to turn over things to other people." Another interviewee focused on the time that it takes to build trust across agencies:

> I think that there are still times that the police agencies are apprehensive to either deploy a [community responder] team itself or hand over the call [to community responders] because they're still feeling some level of ownership and I can't blame them. The reality is they've [the police] been on the front lines of this for the past 50 years, and the mental health system has responded after the fact 2-3 days later. Why would they [police] trust us [community responders]? It's a matter of not only using the protocol but also continuing to build the trust and credibility with the dispatchers and police officers in the community and the police chiefs.

A final challenge that Westchester's 911 Diversion Program faces pertains to police liability concerns about diversion. During the above-noted trainings, Diversion Program leadership emphasized to police officers and leadership that such liability concerns are likely overblown given that mental health professionals are better trained than most police officers to assess and triage mental health concerns. As one interviewee stated, "We're [911 diversion] taking the liability off the police agency and putting it on the Crisis Prevention Response Team… If the Crisis Prevention Response Team believes that they need additional resources, they're gonna call [the police] back." This interviewee, as well as others we interviewed, stressed that traditional police responses themselves entail serious liability concerns: "Sending out lights and sirens increases the risk of injury to the person… we're increasing liability by sending out the wrong resources." Still, in part to address these police liability concerns, 911 Diversion Program leadership has developed standardized policy and procedure templates and provide these templates to police departments to use to document their 911 diversion procedures.

Enhancing Mobile Crisis Response Options

Within the last year, Westchester County's Project Alliance developed and deployed eight mobile crisis response teams (MCRTs). These teams—which are co-located in police departments—provide 24/7 behavioral health crisis support in each of the eight County catchment areas. Staff are determined to stay with clients as long as necessary for the clients to feel comfortable and safe. This approach is exemplified by the MCRT motto, "It takes as long as it takes." MCRTs can connect individuals in crisis to social services, follow-up with these individuals—without police presence—for home visits after initial crisis responses, and address healthcare and social service barriers. For example, MCRT staff can attend court appointments and advocate for clients. Staff can also liaise on a client's behalf with the

Department of Social Services. As one MCRT interviewee hopefully noted, “We’re gonna find out this [MCRT] is working when… we’re not getting called anymore… or it's [mental health crisis] not a police problem anymore.”

A MCRT may deploy as co-response with, or by request from, the police. In a co-response scenario, a 911 call taker requests both MCRT and police dispatch, MCRT and police arrive at the crisis situation together, police establish scene safety, and the MCRT then enters the scene to complete their work. In a non-co-response dispatch scenario, police officers may also assess a scene, recognize that there is an individual in mental health crisis who could benefit from MCRT, and call MCRT to the scene. In each of the above instances, police serve as a “filtering mechanism” for MCRTs. As a police sergeant stated, “Once it [the scene] feels safe, call for mobile crisis.”

In general, Westchester law enforcement and MCRTs have collaborated efficiently. Police report, “Good feedback [about MCRTs] from guys [police] in the field, and they [police] have been using it [MCRT], leading to a mutual response on several jobs.” Police and emergency communications interviewees agreed that “When someone is in crisis, police response is not always the best way to handle it.” These interviewees further noted that they have begun to see a higher volume of police requests for MCRT. This suggests increased support for MCRT interventions from law enforcement.

At present, Westchester MCRTs confront two significant implementation challenges in growing their crisis response roles and responsibilities. First, and perhaps not surprisingly given the novelty of the MCRT model to Westchester County, is law enforcement’s hesitancy to dispatch MCRTs alone to mental health crisis scenes. When one interviewee was asked how they felt about dispatching MCRTs without police, he responded, “I don't like that. I like the co-response… it takes somebody who’s suicidal like a split second to become homicidal. You know, there’s that fine line and you never want to put people in danger.” This interviewee further noted that, unlike the police, MCRT civilian responders are unarmed, have no body armor, and are not trained to handle violent situations.

A second MCRT implementation challenge involves ongoing questions about 911 diversion processes. For instance, County officials have not decided whether 911 mental health-related calls should, by default, be diverted to the CPRT per the 911 Diversion Program protocol, or whether these calls should be triaged, and low risk calls sent directly to MCRTs (i.e., without CPRT involvement). One interviewee from 988 noted that, “There’s still a lot of confusion and probably a lot of overlap… [there is a] gray area where either one of us [CPRT or MCRT] could probably intervene.” This idea is further complicated by the question of MCRTs being a county-wide resource that could be utilized by 988 and the CPRT, rather than solely being used by police agencies. As originally designed, MCRTs are deployed and used at the discretion of law enforcement. However, as time passes and the need for mobile crisis response increases, requiring law enforcement approval to dispatch the MCRT may be a barrier to timely or adequate crisis response.

Launching and Supporting 988

St. Vincent’s, which had successfully run the local crisis line (and CPRT) for many years and had been a key partner in the 911 Diversion Program, was a logical place to house 988. 911 dispatchers and law enforcement agencies were already acquainted with processes needed to efficiently redirect low-risk, non-emergency mental health crisis calls to the CPRT using the police-only number. The launch of

988 thus raises somewhat unique questions for Westchester in terms of how to align its operations with the established functions of CPRT within the county.

Historically, the Westchester CPRT has been oriented around quick triage and action. People who reach out to CPRT are, as one interviewee commented, "Calling because they want some type of action taken." Since 988's roll-out in July 2022, CPRT calls, and associated dispatch responses, have continued to be largely action-oriented. In contrast, and perhaps because of CPRT's established action-oriented approach, calls to 988 to date have tended to be less acute. As one 988 call taker noted, most 988 calls entail, "People that have issues that are bothering them, but they're not issues of life or death." Another call taker observed a high frequency of low acuity, but high frequency 988 "repeat callers," as well as new callers where, "Loneliness seems to be the overall theme."

As CPRT and 988 appear to be receiving qualitatively different types of calls, the two lines have tended to operate in distinct ways. One interviewee from Westchester's 988 line described this as follows:

> It's different in the sense that the 988 is more like a warm line, that talk line [on which] you [the call taker] can spend a little extra time [with a caller who does not need an in-person crisis response]. Whereas with the crisis team [CPRT], their main function is kind of how can we evaluate this person [who is in crisis] and link them to treatment? So, the call, the whole kind of outline of the [CPRT] call is different. It's more like well what's your name, what's your address, getting all the demographics like immediately in the conversation. Whereas 988 – it's anonymous. So, we don't obtain that information a lot of times [and we don't need it because the calls are generally low-severity and do not require in-person response].

Although the types of calls going to 988 and the CPRT may change over time, this kind of call distribution between CPRT and 988—with CPRT operating more as a high-risk crisis line and 988 operating more as a low-risk warm line—has implications for St. Vincent's call taker training as well as for public education. Westchester 988 call takers note that Vibrant's training focuses heavily on acute, high-risk crisis calls that require call takers to do things like complete safety plans with the caller and dispatch in-person response teams. In part due to less emphasis on low-risk callers, these same call takers initially felt less prepared to answer calls that aren't, as one interviewee put it "a real crisis situation" (i.e., that entail low-risk of harm to self or others). Regardless of the call division between CPRT and 988 moving forward, St. Vincent call takers note that they could use training for responding to low-risk, "warm line"-type calls—what one person referred to as "middle of the road clients". Westchester County might also consider proactive public education efforts to maintain, or attempt to change, the current call risk level distribution between CPRT and 988 so that residents know what to expect when the call each line.

Case Study: North Country

The implementation of 988 in North Country, a rural region in the northern part of New York State, provides an illustrative case study about the provision of crisis care for rural communities with low population densities, large geographic areas, and limited services. North Country consists of seven counties (Essex, Franklin, Clinton, Hamilton, St. Lawrence, Lewis, and Jefferson) and has a population of 418,000 full-time residents, the majority of whom are White (85%). Bordered by Lake Champlain to the east, the Adirondack Mountains to the south, Lake Ontario to the west, and the St. Lawrence River and

Canadian border to the north, North Country is also a popular tourist destination, and therefore experiences substantial seasonal population increases.

While crisis services have been developed and studied extensively in urban and metropolitan areas, little attention has been given to how rural communities in the U.S. are developing their crisis care continuums. This lack of focus on rural communities is an important research and policy gap given that about 60 million Americans, or 1 in 5 people, live in rural areas like North Country (U.S. Census Bureau, 2022). Here, we focus on how four counties in North Country (Clinton, Essex, Franklin, and Hamilton) are collaboratively building a regional crisis response program through 988. We describe the current landscape of crisis response in the region, outline the unique challenges of providing crisis care in rural areas, and document the creative ways that North Country providers are providing such mental health services. We also highlight evolving partnerships across 988 and 911, including the critical role that 911 continues to play in behavioral health crisis response.

Overview of Crisis Call Lines and Available In-Person Responses

Figure 6 provides a simplified schematic of the available telephonic and in-person crisis response options in Clinton, Essex, Franklin, and Hamilton counties. The Mental Health Association in Essex County, Inc. (MHA-Essex) is the 988 provider for these four counties. MHA-Essex also operates the HOPELINE, a 24/7 warm line. Each of the counties also has a dedicated, local crisis line that was operational before the roll-out of 988 and continues to be in place to date. In Essex and Hamilton counties, the county mental health offices operate crisis lines (in Essex it is answered by Essex County Mental Health staff whereas in Hamilton it is answered by the Sheriff's office who contacts the mental health office). In Clinton and Franklin counties, contracted, local behavioral health organizations operate them. Individuals in these counties also can call 911 in the case of a behavioral health crisis. Each of the four counties has a dedicated PSAP that can dispatch law enforcement—either local police, the sheriff's office, or state police depending on the location of the emergency—as well as EMS.

Depending on the caller's county of residence, in-person, mental health-specific crisis response options may or may not be available. Notably, for reasons that will be elaborated below, each of the four counties consistently utilizes law enforcement collaborations to respond to psychiatric crises. Mental health crisis response options include the following:

- **Mobile Crisis Teams**: Clinton, Essex, and Franklin counties each has a mobile crisis team that can provide face-to-face assessment, crisis intervention and de-escalation services, and referral to community mental health and social services. A newer North Country Mobile Integration Team (a mobile crisis team) also serves residents in these counties. Notably, given its small population, low volume of crisis calls, and limited mental health services in general, Hamilton County has no mobile crisis services; however, they were recently given funding by OMH to develop mobile crisis services.
- **Counselor and Law Enforcement Partnership (CALEP)**: Citizen Advocates, a local provider, launched CALEP in Franklin County in 2021. The CALEP program includes a full-time, mental health clinician who works in partnership with one of the local police departments. Police can call this clinician to psychiatric crisis situations. (The clinician does not "ride along" with law enforcement, but instead travels separately to the scene). Once at the scene, the clinician can

complete a psychiatric assessment and refer the individual in crisis to appropriate mental health and/or addiction services.

Building a Regional 988 Call Center

North Country's 988 implementation is first and foremost a story of local advocacy. Like all counties in New York, Clinton, Essex, Franklin, and Hamilton counties have Directors of Community Services (DCS) who, per state statute, are county mental health commissioners and are responsible for the oversight and management of the local mental hygiene system. Perhaps unlike other counties in the State, however, the North Country DCSs work together on a regular basis to collaboratively tackle the challenges of providing behavioral services in their rural area. Barriers to care in rural communities are well documented. All of the individuals who we interviewed in North Country reflected on these difficulties, which include, among others, large geographic expanses and long travel times to access and provide mental health services, limited internet and telephone access in some areas, lack of services (e.g., Hamilton County does not have a hospital), and behavioral health workforce shortages. The result, as described by one North Country DCS we interviewed, is that "My department has to go out of its way to be very creative in how we meet the needs of our community." Said another DCS, "We do things differently here. Just because we're a rural county."

When the national government mandated 988 implementation, the North Country DCSs thus understandably united to advocate for a regional 988 provider with innate understanding of their region. The DCSs described reaching out to the State to assess its willingness to select a local provider, and also reaching out to local providers to see if they would consider operating the 988 call center. One DCS described this process: "We did a lot of advocacy, from our perspective, in terms of, 'We need something local. We need something that recognizes the rural landscape that we are in.' Because [another] County or some other 988 call center across the country, you know, I don't see how they can support [our residents]." Another DCS expanded on concerns about selecting a non-local 988 provider: "We were extremely concerned that a non-rural type of provider would be, you know, kind of plunked down in our region and may not know how to effectively work with us."

Interview participants were grateful that the State agreed with their requests for a 988 provider with knowledge of the local, rural communities. The participants reflected on how the choice of a local 988 provider would lead to better crisis response services for their region's residents. As one DCS noted, "Our collaborative efforts—we've been meeting consistently—will lead to a response that is reflective of the actual services we have and reflective of people that understand the geography and some of the issues in the North Country." While the DCSs acknowledged that 988 implementation would be a heavy lift, they also believed that having a local 988 provider was an opportunity to continue building out their regional continuum of crisis care. "Having that local provider, knowing the services, who to speak to… it [the regional continuum of crisis care] will only increase as we use it and our relationships [across providers and with residents will be] even more solidified," noted one DCS. "We just keep working the system and do better at triaging and I think we'll be able to identify the needs and gaps in where things need to be tweaked [in the mental health crisis response system], which is super important."

Staffing 988 in North Country

North Country leaders have collectively made a concentrated effort to staff the new regional 988 line with local call takers. The staffing challenge is not unique to North Country. As our research in Monroe and Westchester counties likewise demonstrated, county officials must make considerable investments in hiring and training new staff—particularly in the face of chronic shortages in the behavioral healthcare workforce across much of the nation.

Notably, MHA-Essex had early success in hiring and training new 988 call takers. This success can likely be attributed to three factors, as described further below; MHA-Essex's hiring strategy, the comprehensive caller training that they are providing, and the opportunities that they have made available for mutual support among call takers.

MHA-Essex has used diverse avenues to find and hire call takers for their 988 line. One call taker we interviewed found the job through the recommendation of friends who recognized the call taker's listening skills as a suitable match for a call-taking role. Another call taker discovered the position through a local newspaper. Once hired, call takers participated in robust training to prepare them for the anticipated work. Among other modules, training includes modules in cybersecurity and HIPAA regulations to ensure caller confidentiality and security is maintained for 988 call data; a webinar on suicidality, which emphasized the need for 988 call takers to primarily be good listeners; and actively working through simulations in Vibrant's training portal where call takers had opportunities to work through call types (e.g., third-party callers, making safety plans, COVID considerations). Further, call takers received two days of SAMHSA's Applied Suicide Intervention Skills Training (ASIST) in which there was an opportunity to practice taking mock calls and learn about the Pathway for Assisting Life (PAL) model of building rapport with callers at risk for suicide, understanding callers' choices, and collaborating with callers to create and confirm a safety plan. MHA Call takers now have ongoing access to the National Resource Center, which contains crisis-related videos, simulations, and referral standards.

Given the above trainings and on-the-ground supports, the MHA call takers we interviewed felt prepared to answer crisis calls. One caller taker described her realization that she needed to be confident in her training given how comprehensive it was, stating, "All of the training, all of those mock calls, everything we did. I had to know it took place and it was effective." Call takers also reflected on the extent to which their work is supported at MHA-Essex through the accountability and oversight of supervisors. For each shift, Administrators on Call, or AOCs, are available via Microsoft Teams for call takers to reach out to as needed. Call takers are trained to reach out to their AOC if there is a concern about a caller's immediate safety, if the caller is asking for resources that call takers do not have immediately available, or if the call taker has other questions or concerns. Furthermore, within the first few months of working as a call taker there are many opportunities for supervisors to provide feedback and consultations, via weekly meetings between each call taker and a supervisor. This level of support and guidance has served to strengthen and provide stability for the new MHA-Essex 988 workforce.

A few additional factors have contributed to satisfaction among the emerging North Country 988 workforce. The two call takers we interviewed were both satisfied with their salaries and workloads and appreciated the flexibility MHA-Essex offered in terms of working remotely or in-person. Further, the call takers appreciated the ongoing opportunities for team bonding, resource sharing, and

community building among the call takers at MHA-Essex. One interviewee noted how the team sometimes gets together for social events (e.g., lunch). This interviewee described how activities like this "build a bond, it keeps us together. So, when we have problems or questions or anything, we can lean on each other." Although MHA-Essex has experienced some turnover in call takers since launching, their efforts to build strong team bonds has allowed existing call takers to feel well supported and integrated into their positions as a new frontline for regional crisis response.

Launching 988 – Early Reflections on Caller Needs and Available Resources

MHA-Essex went live with 988 in August 2023 and is currently answering calls Monday through Friday from 8am-7pm. Local calls placed to 988 during off hours rerouted to backup 988 centers located outside of North Country). Given that we interviewed MHA-Essex leadership and call takers only a few months after launch, it is likely that there will be considerable evolution in the kinds of calls 988 receives in North Country. Nonetheless, several reflections are worth noting about who is calling 988 in North Country and what type of support 988 is offering.

To date, and in general, North Country's 988 calls have been of relatively low severity. Call takers described how callers often are looking for a good listener to talk to but are not in need of immediate interventions. Some of these callers are lonely and some are "frequent callers" (an issue described further below in the section on Shared Implementation Challenges); others do not have any apparent mental health or crisis concerns but are looking for resources. These trends may be linked to relative resource constraints in North Country counties. As one call taker noted, some callers are "dealing with food insecurity" and other concrete resource needs. Other callers are looking for alternative services that may not exist. For example, a call taker noted that a caller hung up on him after he suggested that the caller go to the emergency department because the caller described having had a prior bad experience at that particular hospital. Unfortunately, the call taker did not have another hospital within any reasonable distance to suggest. One call taker described the challenges at length:

> I feel like what we're doing is treating a symptom essentially and it's not to discredit any [call takers] or anything about this program but it feels like for some of these folks it's when they're at the end of a long line of challenges, that's where they find themselves calling us; because there's nobody in their life, and very few options, and a long list of medical and mental health problems.

In such cases, social determinants of health—limited or distant resources, lack of access to health care, lack of basic resources to meet needs—is what ultimately may lead North Country residents to call 988. This phenomenon can leave call takers feeling ill-equipped to handle social services-related calls and may, over time, affect how 988 is used and perceived among local residents. In the meantime, MHA-Essex staff are collaborating to build out their regional resource database to be optimally prepared for all callers.

A particular strength of North Country's 988 program, in part due to its low call volume, is that call takers have opportunities to follow-up with callers after their initial call to 988. Call takers described how callers reported appreciating these follow-up calls and, given the follow up, were likely to recommend 988 to others in the community. As reported by one call taker, "[the caller] was glad to know that there was someone out there that just listened to him and was concerned enough to actually make that follow-up." Thus, although there are unique challenges to resource provision in North

Country, there are likewise benefits to a regional call center operating in a close-knit community with relatively low call volumes and the capacity to provide follow-up contacts and services.

Law Enforcement Partnerships and Future Collaboration Across 988/911

Given that 988 launched in North Country around the time our study concluded, we are not able to describe, in detail, how 988 and 911 call centers collaborate to respond to mental health crises. As of December 2023, MHA-Essex is working with 911 centers in each of the counties to finalize memoranda of understanding that lay out this partnership between local PSAPs and 988. As in other places throughout the State, concerns about geolocation and liability (documented below in Shared Implementation Challenges) have slowed this collaborative process. Three points may be instructive, however. First, behavioral health providers in North Country already have strong relationships with law enforcement in part due resource shortages and the associated necessity of often relying on law enforcement in mental health crisis situations. As one DCS reflected, "We really do have pretty tight knit relationships here [between mental health crisis services and law enforcement]—very trusting relationships." Some individuals we interviewed did not anticipate 911's role in crisis response changing with the 988 rollout as there remains limited capacity to provide mobile crisis services in the region. If the types of calls going to 988 remain relatively low-level in terms of severity, it is feasible that there could be limited interaction between 988 and 911 in North Country going forward.

Second—and related to the resource shortages and unique rural geography and paucity of psychiatric resources—there is some worry that 988 will duplicate existing crisis resources or create a parallel system of crisis care entirely, rather than building on existing mental health crisis care collaborations in the region. North Country has spent several years investing in improved behavioral health responses from law enforcement. This includes the CALEP program mentioned above and investment in Crisis Intervention Team (CIT) training for law enforcement in the region. It also includes a Law Enforcement Mental Health Referral System that operates in Essex and Clinton counties (as well as other neighboring counties) whereby law enforcement officers can submit an online referral to the county mental health agency if they encounter a person with a behavioral health condition who could benefit from mental health care coordination and services. Given these close collaborations with law enforcement, along with the fact that residents of the region are familiar with 911, and that 911 already maximizes many of the local and available resources to respond to psychiatric crises, there are questions as to whether embedding mental health-specific call-takers in 911, rather than creating a new 988 line, would have made more sense from a sensible resource allocation standpoint for North Country.

At the same time, our interviews revealed an evolving appreciation for the role 988 could play in reducing pressure on 911 amidst an ongoing, national mental health crisis. "I think that emergency services will feel like they are getting some support from the mental health side of things, that they won't feel so burdened with mental health," remarked one interviewee. They continued, "It'll be a slow build. But it will be a positive outcome with more cohesion, more collaboration, and the individuals in the region getting better services." To the extent that North Country can achieve its vision of 988 as an efficient conduit to mental health service engagement within participating counties, the region may soon have even fewer mental health crisis calls as well as less reliance on law enforcement in crisis response.

Shared Implementation Challenges

Monroe County, Westchester County, and the counties in North Country have faced many of the same challenges in efficiently and effectively integrating a novel mental health crisis hotline—988—into their service continuums. Below we outline three of these shared challenges. We anticipate this discussion of shared challenges across diverse implementation sites to be relevant to mental health crisis policy makers both within, and outside of, New York State.

Geolocation

One ongoing point of discussion and debate around 988 is whether a 988 call should be conveyed to call centers with geolocation information—that is, the ability to know precisely where the caller is located. While 911 call centers can access dispatchable caller location information, 988 call centers do not have geolocation capabilities. During the time period of our study, all 988 calls were routed to Lifeline's toll-free number and then to an appropriate call center based on the caller's area code. Not surprisingly, this routing strategy frequently resulted in mobile phone callers, who make 80% of the calls to Lifeline, being routed to 988 call centers far from their current physical locations.[17]

The federal government launched 988 without geolocation for several reasons. First, a 988 system with geolocation capabilities would have been more expensive to implement. Additionally, without geolocation, 988 callers have a level of privacy not afforded to 911 callers. 988 marketing materials stress that when a person contacts 988, they don't have to say who or where they are in order to get free mental health support.[18] Interviewees described privacy as a key feature of the 988 system and thought that geolocation could discourage callers. As one interviewee noted, "I can understand why people might be hesitant to use 988 if geolocation is part of that experience." Another interviewee reflected, "I guess I would be concerned that people [in mental health crises] wouldn't call [988 if the system had geolocation abilities], and the most important thing is that they [persons in crisis] just call and talk to someone." Such perspectives align with those of mental health advocates, who support strong client privacy protections and argue that failure to safeguard such privacy discourages help-seeking behaviors, particularly among vulnerable populations who fear that 988 calls might result in police intervention and/or forced psychiatric hospitalization.[19]

Interviewees, however, also described several limitations related to this lack of 988 geolocation capability. With the ubiquity of cell phones, many people do not have phone numbers associated with the area codes in which they physically live. 988 call takers thus often field calls from non-local callers. This presents two primary challenges. First, a 988 caller in imminent mental health crisis, and whose area code does not match their physical location, will almost inevitably receive a slower than optimal in-person crisis response. While interviewees viewed in-person rescue as a "last resort," they also described situations that required such intensive resources. In these situations, especially when callers are not able to clearly provider their physical locations, 988 call takers might need to contact 911 for geolocation assistance (using GPS data or cell phone tower triangulation). As one 911 call center interviewee observed, "They can't ping a cell phone from 988… so it makes the whole process a lot more complex and very time consuming and a lot of time is—I don't want to say wasted—but a lot of time is spent, and a lot of time passes while this person is feeling in whatever kind of way… this isn't CSI Miami…. I [at 911] can get that [locating] process started but it is not that fast." Other interviewees

worried that time delays in responding to such high-risk situations could lead to serious harm. “I’m afraid someone will get hurt” commented one. Another reflected, “I’m assuming that at some point, [locating a 988 caller] will come into play. I just hope that it’s not at the cost of crisis [in the meantime].” Due to technical challenges, costs, and privacy concerns, 988 is not likely to get geolocation capabilities for some time. As one reflected, "It would just make it easier for everyone if we could just do it [i.e., locate callers through 988]. But that’s placing a lot of trust in the system.” In the meantime, interviewees we spoke to hope that creative, local solutions might better balance privacy protections with prompt and accurate crisis service allocation.

Interview participants also described how the mismatch between a 988 call center and a caller’s physical location also limited the extent, and timeliness, of the local resources that a given 988 call center could offer a caller. One 988 call taker noted that, for out-of-county callers, their 988 center is, “Really limited on resources and if that person [who is in crisis] needed intervention there’s only so much we can do.” This call taker further shared a situation that had just occurred with an out-of-county caller: “We [988] had someone calling today from [outside the county but I had limited resources and I knew they [the caller] were kind of getting frustrated a little bit with me too because you’re essentially having to Google on the fly where to connect [the caller to].” A North Country call taker also commented on the large number of North Country seasonal residents who call 988 using non-North County mobile phone area codes and are connected to distant call centers. “I don’t know what the Boston call center knows about Franklin County, knows about Essex County, knows about Clinton County,” she commented.

As of early 2024, SAMHSA announced the roll out of geo-routing on a rolling basis across the country. Geo-routing (as opposed to geo-location) allows calls to be directed to the 988 Lifeline crisis center closest to the caller’s physical location without providing detailed information about the exact location of the caller. Although geo-routing will not solve all of the above caller location issues, it will help to match callers with the 988 call center physically closest to them.

Liability

Participants in our study expressed concerns about personal and agency liabilities during mental health crisis responses and this may not be unique given reports from the field.[20] Participants in our study expressed similar fears. One interviewee stated, “The reality is that you can get sued for anything in any way. Anything you do in today's world, [including crisis response], you're likely to get sued for.” These liability concerns are understandable in two contrasting scenarios: over-response with lethal or harmful methods and under-response with unprepared or unqualified response teams.

Life-or-death behavioral health crises can unfold in unpredictable ways.[21] Elevated call taker liability fear can lead to call taker overestimation of crisis risk and greater likelihood of involving the police. Some of this risk assessment is shaped by organizational and other constraints as well as the cultural norms within the agency. As one policing researcher writes, “Calltakers do try and resolve or divert calls that do not require a police response, but they are also constrained by their organizations’ rules and liabilities, expectations of citizens, and policies and procedures of law enforcement agencies. All these constraints can result in some calls, no matter whether made in error or however trivial, receiving a police response.”[22]

Different call takers also make varied risk level assessments. They may also have varying degrees of personal comfort in deploying available in-person crisis response options, including the police. As one 911 call taker noted about his call taker colleagues, "It's 60 different takes on each individual call about whether they [the caller] actually need an ambulance or doctor, whether you [the caller] need the counselor and stuff. So, if the ambulance is going, then the police are going to go too. So, when in doubt, send everybody out." This interviewee continued to explain how he errs on the side of "overutilizing resources" and has learned from experience that it is better to send "too much rather than not enough" resources to a given crisis situation.

Crisis call takers' and in-person responders' liability concerns may interfere with mental health diversion opportunities. Call takers and responders might resist using new programs, such as 988, as they may see these programs as liability risks relative to established programs like 911. This despite the real possibility that diversion alternatives, like 988, may reduce police liability in mental health crisis situations. Law enforcement offers handle most interactions with people with mental illnesses without incident. Yet, those with mental illnesses are still at greater risk of experiencing injury and death at the hands of police.[23] Communities are beginning to hold police departments liable for excessive use of force and for departments' failures to train officers in safe methods for interacting with people with mental illnesses.[24] One interviewee described the premise of diverting calls away from 911 to alternative responses:

> If you have a low-risk person with a suicidal ideation, it's more liability for you to send a police officer on that call than it is for you to transfer that call to a mental health professional, because when you send that police officer on that call and his or her training tells them that they will force this person to go to the hospital. Now you've opened yourself up for use of force, you've opened yourself up for a potential injury to that person or the officer, and you've opened yourself up to the trauma and everything else that can go along with that family that has to observe what you're about to do to that person. So, my argument is that it's more of a liability on some of these calls to send a police officer as opposed to connect the person with a mental health professional… But to me connecting the person with a mental health professional is the best possible care you can give for that person. So, if you got sued for that, you're going to get sued for going hands on with that person too.

To mitigate liability concerns, communication and collaboration are crucial, as are the development of clear policies, clear levels of risk within risk-assessment procedures, and a framework for call response that centers around caller safety.

Frequent Callers

Call taker interviewees shared their experiences with frequent callers, or persons who call crisis lines often. Frequent callers pose challenges for crisis services by reducing call takers' capacities to respond to other calls.[25] In each county we surveyed for this report, at least one stakeholder mentioned frequent callers who they recognized by name. These discussions about frequent callers revolved around two main themes: (1) the potential for 988 to manage frequent callers and to reduce call pressure on 911; and (2) the possibility of proactively, and longitudinally, following up with frequent callers to reduce the likelihood that they seek crisis services again in the future.

When asked about their expectations for how 988 could change crisis response in their respective counties, one interviewee discussed, “diverting 911’s familiar calls to 988 or other crisis lines to see if they [988 or other crisis lines] could alleviate 911 callers dealing with them.” In other words, given its recognizability and long history in emergency response, 911 receives too many calls, some of which come from frequent callers who could be encouraged to call, or even transferred to, 988 in order to lessen 911 call volume. 988 might be better positioned to connect these frequent callers to needed services and reduce future interaction with law enforcement.

To reduce the number of frequent callers, several interviewees discussed implementing crisis follow-up services. One interviewee noted the lack of such follow-up services in their community and how this dearth was associated with repeated calls to 911: ”It doesn't seem like there's any follow back up with somebody [who was in mental health crisis] during, you know what might be a lucid time or a sober time or something like that for them to say like, hey, you [person in crisis] called us 60 times over the weekend, you know, perhaps we should get some help to you somewhere, right?” Considering the high call volume, limited staffing, and potential burnout faced by call takers, exploring methods to minimize frequent calling, such as improved follow-up services, appears to be beneficial for both callers and call takers. Communities might therefore consider how 988 might be better positioned to handle frequent callers and where follow-up procedures can be built into 988 operations so that crisis services can better support individuals in need while optimizing resource allocation.

Conclusion

The implementation of 988 has been described as a remarkable milestone in the United States—marking a shift in the accessibility and provision of crisis care throughout the country. This study makes an important contribution to our understanding of how counties are building up their 988 systems and, critically, how 988 systems interface with 911 and other local crisis lines and services. In particular, the three case studies from NYS provide in-depth insights into the wide variability in how communities are managing mental health crisis calls, how 988 fits into the local provision of emergency mental health care, and what shared challenges communities face as they continue with implementation. The case studies also highlight core themes that jurisdictions across the U.S. will need to consider as they look to build on the promise of 988: the importance of building trust across mental health crisis responders and within the community, the necessity of developing a range of models—including alternatives to law enforcement—that can meet community needs, and the need to educate the public and raise awareness about the intended purpose of different crisis lines and the services they can expect to receive from each. As implementation continues, it will be important to continue tracking the development of 988, the extent to which it meets callers’ needs, and how it serves as a conduit to the broader continuum of crisis care.

References

[1] Saunders, H. (2023). Taking a Look at 988 Suicide & Crisis Lifeline Implementation One Year After Launch. Kaiser Family Foundation. https://www.kff.org/mental-health/issue-brief/taking-a-look-at-988-suicide-crisis-lifeline-implementation-one-year-after-launch/#:~:text=Year%20After%20Launch-,Taking%20a%20Look%20at%20988%20Suicide%20%26%20Crisis,Implementation%20One%20Year%20After%20Launch&text=On%20July%2016%2C%202022%2C%20the,and%20state%2Dfunded%20crisis%20centers.

[2] Substance Abuse and Mental Health Services Administration. (2023). *988 Performance Metrics*. SAMHSA, U.S. Department of Health and Human Services. www.samhsa.gov/find-help/988/performance-metrics

[3] Substance Abuse and Mental Health Services Administration. (2021). *988 Appropriations Report*. SAMHSA, U.S. Department of Health and Human Services. https://www.samhsa.gov/sites/default/files/988-appropriations-report.pdf

[4] Substance Abuse and Mental Health Services Administration. (2020). *National Guidelines for Behavioral Health Crisis Transformation: A Best Practice Toolkit.* SAMHSA, U.S. Department of Health and Human Services. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[5] Brooks Holliday, S., Matthews, S., Bialas, A., McBain, R. K., Cantor, J. H., Eberhart, N., & Breslau, J. (2023). A Qualitative Investigation of Preparedness for the Launch of 988: Implications for the Continuum of Emergency Mental Health Care. *Administration and policy in mental health*, *50*(4), 616–629. https://doi.org/10.1007/s10488-023-01263-0

[6] Neusteter, S. R., Mapolski, M., Khogali, M., & O'Toole, M. (2019). The 911 Call Processing System: A Review of the Literature as it Relates to Policing. Vera Institute of Justice. https://www.vera.org/downloads/publications/911-call-processing-system-review-of-policing-literature.pdf

[7] Zabelski, S., Kaniuka, A. R., A Robertson, R., & Cramer, R. J. (2023). Crisis Lines: Current Status and Recommendations for Research and Policy. *Psychiatric services (Washington, D.C.)*, *74*(5), 505–512. https://doi.org/10.1176/appi.ps.20220294

[8] Ibid.

[9] Ibid.

[10] Brooks Holliday, S., Matthews, S., Bialas, A., McBain, R. K., Cantor, J. H., Eberhart, N., & Breslau, J. (2023). A Qualitative Investigation of Preparedness for the Launch of 988: Implications for the Continuum of Emergency Mental Health Care. *Administration and policy in mental health*, *50*(4), 616–629. https://doi.org/10.1007/s10488-023-01263-0

[11] New York State Office of Mental Health. (February, 2022). 988: More Than a Number. New York State 988 Implementation Plan Report. New York State Office of Mental Health. https://omh.ny.gov/omhweb/statistics/988-report-to-legislature.pdf

[12] New York State Office of Mental Health. (February, 2022). 988: More Than a Number. New York State 988 Implementation Plan Report. New York State Office of Mental Health. https://omh.ny.gov/omhweb/statistics/988-report-to-legislature.pdf

[13] Pope, L.G., Patel, A., Watson, A.C., & Compton, M.T. (2023). Making Decisions about Calling 988 v. 911: Understanding End-User Views Prior to the Launch of 988. Under review.

[14] U.S. Census Bureau. (2022). Population estimates, July 1, 2022, (V2022) – Monroe County. https://www.census.gov/quickfacts/fact/table/monroecountynewyork/PST045222

[15] Monroe County Mental Health & Substance Abuse Disorder 90-Day Task Force. (January 4, 2021). Priorities and Action Plan. https://www.monroecounty.gov/files/mh/MH%20SUD%20Taskforce%20Report%20Final.pdf

[16] U.S. Census Bureau. (2022). Population estimates, July 1, 2022, (V2022) – Westchester County. https://www.census.gov/quickfacts/fact/table/westchestercountynewyork/PST045222

[17] Wireless Competition Bureau. (April 15, 2021). 988 Geolocation Report – National Suicide Hotline Designation Act of 2020. https://docs.fcc.gov/public/attachments/DOC-371709A1.pdf

[18] Substance Abuse and Mental Health Services Administration. (2023). 988 Suicide & Crisis Line Fact Sheet. https://www.samhsa.gov/sites/default/files/988-factsheet.pdf

[19] Wipond, R. (January 29, 2022). Roll-out of 988 Threatens Anonymity of Crisis Lines. *Mad in America*. https://www.madinamerica.com/2022/01/roll-988-threatens-anonymity-crisis-hotlines/

[20] Hatch, M., & Kamin, D. (March 2021). 911 Distressed Caller Diversion Program in Broome County, New York. https://www.theiacp.org/sites/default/files/MHIDD/BroomeDiversion-508.pdf; Lum, C., Koper, C.S., Stoltz, M., Goodier, M., Johnson, W., Prince, H., & Wu, Z. (2020). Constrained Gatekeepers of the Criminal Justice Footprint: A Systematic Social Observation Study of 9-1-1 Calltakers and Dispatchers. *Justice Quarterly, 37*(7), 1176-1198. https://doi.org/10.1080/07418825.2020.1834604

[21] Wood, J.D., & Anderson, E. (2023). Triaging Mental Health Emergencies: Lessons from Philadelphia. *Law and Contemporary Problems, 86*(1),29-53.

[22] Lum, C., Koper, C.S., Stoltz, M., Goodier, M., Johnson, W., Prince, H., & Wu, Z. (2020). Constrained Gatekeepers of the Criminal Justice Footprint: A Systematic Social Observation Study of 9-1-1 Calltakers and Dispatchers. *Justice Quarterly, 37*(7), 1176-1198. https://doi.org/10.1080/07418825.2020.1834604

[23] Saleh, A. Z., Appelbaum, P. S., Liu, X., Scott Stroup, T., & Wall, M. (2018). Deaths of people with mental illness during interactions with law enforcement. *International journal of law and psychiatry*, *58*, 110–116. https://doi.org/10.1016/j.ijlp.2018.03.003

[24] Hanna, A.C. (2017). Municipal Liability and Police Training for Mental Illness: Causes of Action and Feasible Solutions. *Indiana Health Law Review, 14*(2), 221-266. https://doi.org/10.18060/3911.0039

[25] Spittal, M.J., Fedyszyn, I., Middleton, A., et al. (2015). Frequent callers to crisis helplines: Who are they and why do they call? *Australian & New Zealand Journal of Psychiatry, 49*(1), 54-64. https://doi.org/10.1177/0004867414541154

Figure 2. Monroe County Mental Health Crisis Call Triage

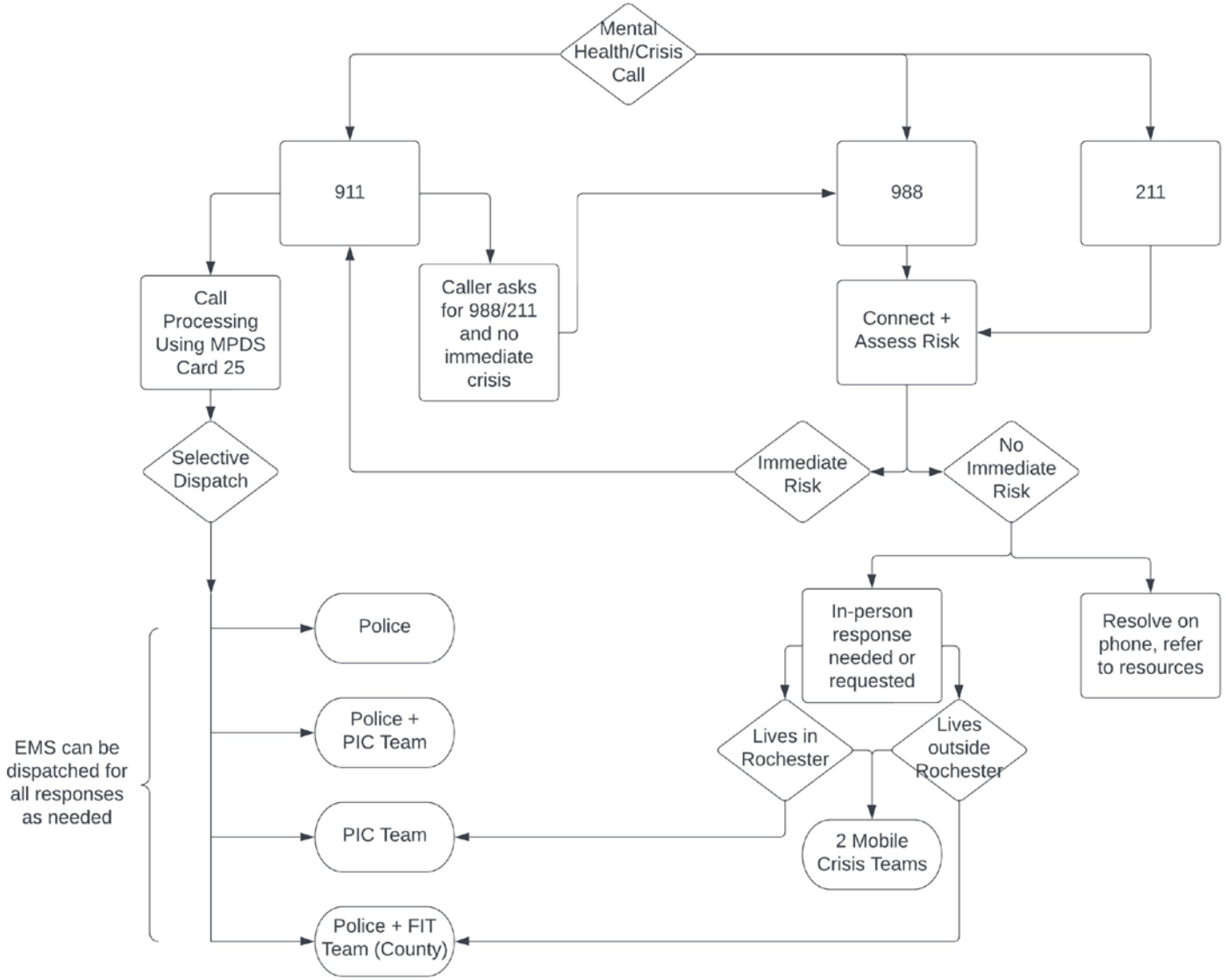

Figure 3. Westchester County Mental Health Crisis Call Triage

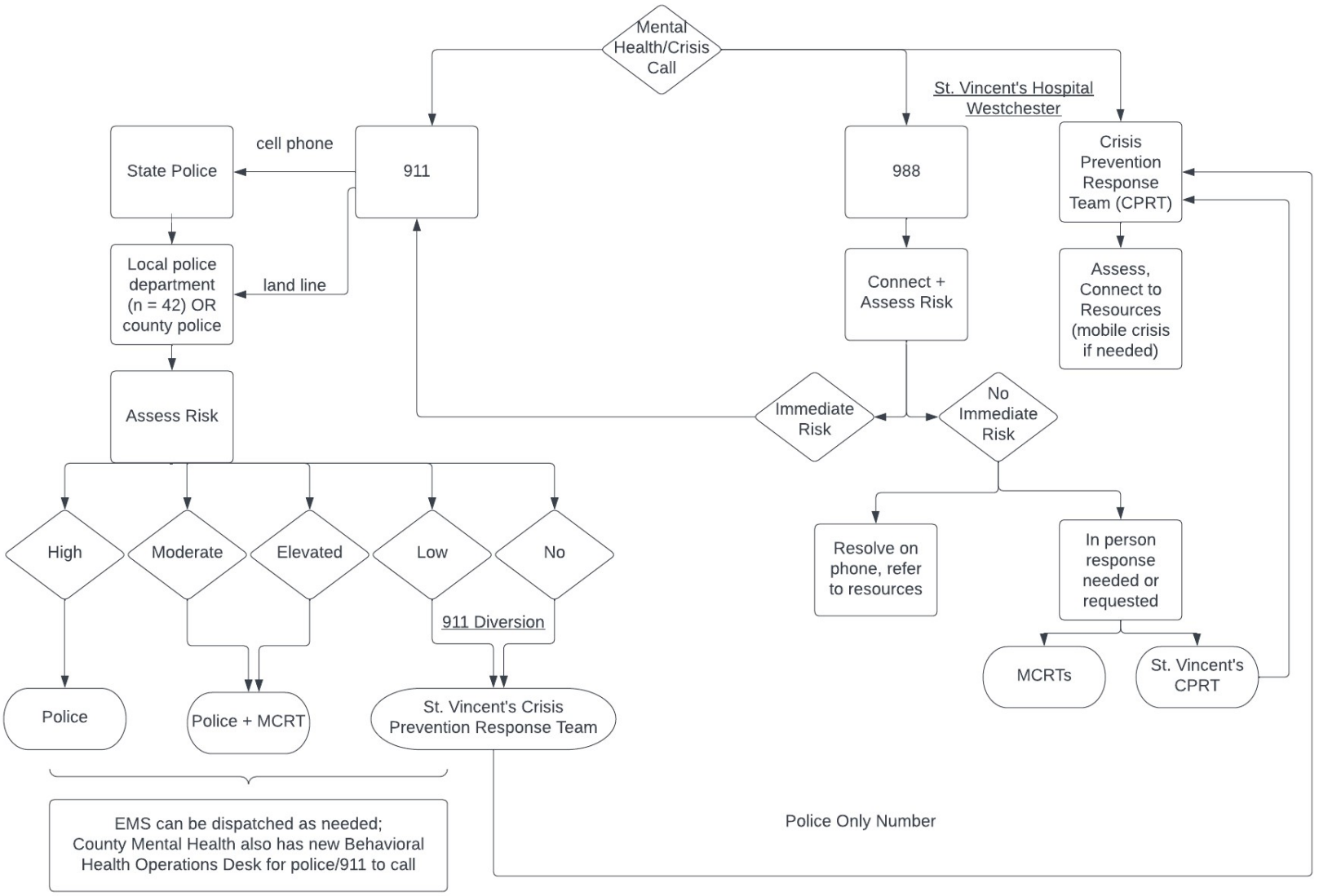

Figure 4. Westchester Emotionally Distressed Caller Risk Assessment

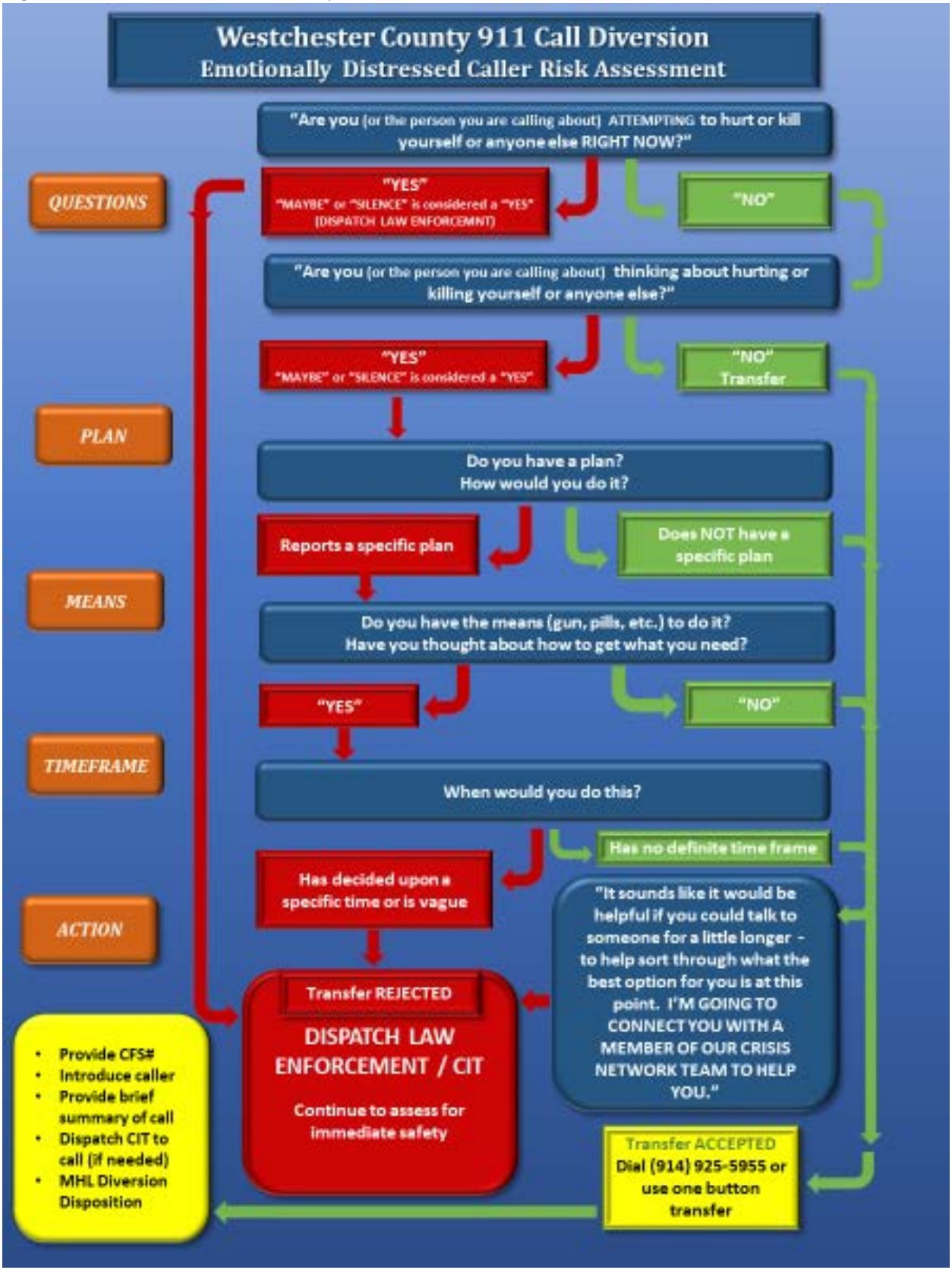

Figure 5. Westchester County Crisis Response Guide

Westchester County Crisis Response Guide		
HIGH RISK	**IMMEDIATE THREAT TO PUBLIC SAFETY (SELF/OTHERS)**	**ACTION**
4	Is the person and other people in immediate danger? • The person is threatening the personal safety of others. • The person is engaged in a suicidal act. • The person is known to have access to dangerous weapons. • The person is barricaded. • The person has taken hostages. • The person has a known history of violent crimes or serious acts of violence.	Deploy Law Enforcement Emergency Service Response. Stage EMS and/or Mobile Crisis Response Team if appropriate.
MODERATE RISK	**CALLER NEEDS IN PERSON ASSESSMENT (LE/MH)**	**ACTION**
3	Is the person themselves at risk of danger? • The person is alone in their home and experiencing thoughts of suicide but others are not in danger. • The person has a specific plan, access to the means and a time frame. • The person is exhibiting signs of intoxication. • There is not enough information to use the Risk Assessment Tool because it is a third party caller.	Deploy Law Enforcement CIT or ESU MCRT EMS may be required
ELEVATED RISK	**CALLER NEEDS IN PERSON ASSESSMENT**	**ACTION**
2	Is the person at a lower risk of danger? • The person has a specific plan but does not have access to the means. • There the person is exhibiting odd or unusual behavior that is of concerns to others. • The person themselves or a family member has requested in person support. • The person is not exhibiting signs of being under the influence of alcohol or other drugs.	Deploy Law Enforcement Co-response with MCRT to establish scene safety.
LOWER RISK	**CALLER NEEDS IMMEDIATE SUPPORT VIA PHONE**	**ACTION**
1 ***911 Diversion***	Does the person require immediate support but does not require an in person assessment? • The person has expressed vague suicidal ideation or is angry at others. • The person does not have a specific plan. • The person does not have the means to die by suicide, self-harm or harm to others.	Divert call to Crisis Network Team 914-925-5955. (POLICE ONLY NUMBER) LE at response at discretion of tour commander
NO RISK	**CALLER NEEDS SUPPORT SERVICES OR WARMLINE**	**ACTION**
0 ***911 Diversion***	Does the person simply need someone to speak to or is the person in need of access to non-emergent supports? • The person expresses concerns of a non-emergent nature. • There is no concern of suicide or self-harm. • There is no concern for the safety of others.	Divert to Crisis Network Team to connect to a peer support warm-line or other supportive services as appropriate.

Figure 6. North Country Crisis Call Triage