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INFORM988

Voices from the Field: A Report on 911 and 988 Interoperability

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THE UNIVERSITY OF CHICAGO HEALTH LAB

FOREWORD

In 2020 Health Lab launched Transform911 to chart a path towards a 911 system that equitably and reliably increases access to wellbeing for those who need emergency assistance, the professionals who staff 911, and those deployed to respond. The Transform911 Blueprint for Change, released in 2022, is a consensus document informed by over 130 experts across the country that sets a course towards a 911 system that equitably and reliably increases access to wellbeing. Shortly after the Blueprint's release, also in 2022, the 988 Suicide and Crisis hotline was implemented nationally. Many of the partners involved in Transform911 had questions and insights related to 988. To help bridge knowledge and practice, Health Lab sought to bring together and expand upon the Transform911 community of practice to inform 988's rollout, and thus the Inform988 Community of Practice and Engagement (COPE) workgroup was assembled.

The Inform988 COPE was formed in 2023 to offer awareness into the needs and gaps associated with 988's rollout, and to create real-time strategies and solutions to address experienced challenges. The members of the COPE are key leaders in several of the areas that 988 relies upon to succeed, and they generously volunteered their time and expertise to join these conversations. The COPE convened biweekly through 2024 and discussed the ways that 911 and 988 can and should be working together (and separately) to best meet the needs of the public facing crises and the professionals responsible for running these systems.

Together, the COPE explored numerous key topics, creating a system-level and human-level understanding of the areas of interest. Confident that we had highlighted key challenges facing 911 and 988, we set out to examine the opportunities to overcome these obstacles. This took the form of a series of follow-up conversations with COPE members, which are highlighted in text boxes throughout the report that follows.

The Inform988 report reflects the urgency of the time in which it was ideated – in the turbulent aftermath of George Floyd's murder and the national COVID-19 pandemic, which put mental health front and center on the national stage. That political and cultural moment greatly informed the COPE's conversations, and is reflected in this report. Without the COPE's contributions, this work would not have been possible, and we are grateful for their considerable time and effort. We have tried to faithfully capture conversations, opportunities, and challenges in this report.

While our goal – to inform a system of care that provides equitable and reliable access to wellbeing for all – remains the same, the national context has changed substantially. In the time since the inception of this body of work, national dialogue surrounding race, mental and behavioral health, reproductive rights, immigration, and gender identity has become increasingly challenging. For some, the threat of punitive repercussions for existing in a marginalized population has contributed to a growing fear of 911 and 988 in a time where access to crisis care is more important than ever.

The future of 988 is uncertain given changes in national priorities. The suicide lifeline for LGBTQ+ youth, a service embedded within 988's original design, which had connected LGBTQ+ youth with specially trained crisis counselors, was cut in July 2025. It's estimated that this path to culturally competent care received over 1.2 million calls since 2022, with a spike in the months before the cut was announced. Some local crisis centers are attempting to address this service need and gap, but the removal of the LGBTQ+ option is straining already overburdened centers. In April 2025, the Health and Human Services Secretary indicated that the agency was planning to restore the LGBTQ+ option, which is aligned with the findings and recommendations contained within this report.

Our hope is that the insights explored by the COPE and documented in this report can offer guidance and inspiration as we navigate new terrain. The national political landscape and context may change, but the existing local 911 and 988 crisis call centers and their associated professionals remain steadfast in trying to provide relief from distress. The lessons learned from the COPE and communicated in this report can help to create a system that promotes their success.

ACKNOWLEDGMENTS

None of this work would have been possible without the tireless dedication and effort put forth by the members of the Inform988 Community of Practice. We are inordinately grateful to these individuals, who committed a tremendous amount of time sharing their views both during meetings and outside them. This membership list with short biographies is included in Appendix A.

We would also like to thank Dave Stone and Billy Morgan at the University of Chicago Harris School of Public Policy for their help with distributing this report. Further, we are extremely grateful to the Health Lab staff who provided critical feedback and suggestions, namely Sara Hayden, Jason Lerner, and Amy Li.

Finally, we would like to express gratitude to Melissa M. Beck and the Sozosei Foundation for their continued leadership in the area of mental health, and for their financial support of these efforts.

The Health Lab strives to improve public health, its impacts, and how it's discussed. If you identify an area of our work that you believe misses a critical perspective or employs language that needs improvement, please contact us at: inform988@uchicago.edu.

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INTRODUCTION

Each year, at least 240 million calls are made to 911 across the U.S. These calls are fielded by a dedicated group of 911 professionals, which includes operators, call takers, call handlers, dispatchers, and managers in Emergency Communications Centers (ECCs), who aim to provide callers with relief from distress. Despite 911's role as the gateway to emergency response, the majority of calls to 911 are for issues that fall outside the scope of emergency calls requiring fire, EMS, or police response. One such area is mental and behavioral health crises. In response to the need for tailored services, the National Suicide Hotline Designation Act of 2020 assigned 988 as the mental health helpline. In July 2022, this alternative crisis service line was launched nationwide under the purview of the Substance Abuse and Mental Health Services Administration (SAMHSA).

Research on how 988 is working in practice is in its infancy. And, while many experts are focused on training and staffing 988 helplines, the specific intersection of 988 and 911 remains in need of further examination. The future success of 988 hinges, however, on understanding the ways in which 988, 911, and other hotlines work together to provide relief from distress to users across the country. In this spirit, the University of Chicago Health Lab launched Inform988 to examine and offer insights into 988's national rollout, with particular emphasis on interoperability with the 911 system. Adapting its consensus-building approach from Transform911, Health Lab convened the Inform988 Community of Practice and Engagement (COPE) workgroup – a multidisciplinary and geographically diverse partnership including 988 and 911 practitioners, government representatives, researchers, and advocates, that met biweekly from September 2023 through April 2024 to examine challenges and opportunities at the intersection of 988 and 911. The COPE membership roster can be found in Appendix A.

In these groundbreaking conversations, this group applied the relational principles of trust, partnership, and equity to answer questions in three overlapping themes identified as important both to the success of 988 and to understanding its rollout:

1. Connecting 911 and 988: transfer of relevant calls bidirectionally between 911 and 988 when appropriate;
2. Staffing 988: sufficient and qualified 988 workforce to meet demand; and
3. Responding appropriately: achieving the right response, at the right time, with the right resources.

Developing a rich understanding of these three overlapping issues was necessary to identify a course towards achieving our North Star – which we adapt from Transform911 – where any person in crisis has around-the-clock access to appropriate care, provided by expert staff, regardless of where the call was received.

What follows is a report of systemic challenges and potential solutions brought forth by those working directly in, for, and with crisis response systems. The contents of this document are largely sourced from COPE discussions and follow-up conversations with its members.

I. A NOTE ON TERMINOLOGY

In 2020, Health Lab launched an ambitious, community-informed, and evidence-based initiative to transform 911. The following year, Transform911 brought together over 130 forward-thinking, collaborative leaders in 911 and related domains to serve as ambassadors for the work, producing the June 2022 Transform911 Blueprint for Change to enable purposeful legislative and community level action, and to establish a baseline understanding of the field. This group collaboratively decided to employ language that may differ from standard vernacular used in the field, including key terms that are used throughout this report:

911 Professionals: The people who serve as call takers, call handlers, dispatchers, and other roles in Emergency Communications Centers, which are the first point of access to response in an emergency. This term is used instead of telecommunicators, operators, or other titles, as the co-chairs and members of the Transform911 workgroup on this topic believe this term better reflects both the role and credibility of these key personnel, especially in light of the complexity of their jobs and the distinct and invaluable role they play in society. In this report, we similarly use 988 professionals to refer to the call handlers in a 988 center.

Emergency Communications Centers (ECCs): This is the preferred term (in lieu of Public Safety Answering Point, PSAP, or call center) of many 911 professionals for the entity that is designated to receive and respond to requests for emergency assistance.

Several terms are referenced often in discussions about 911, 988, and how they interact: consent, warm handoff, interoperability, and imminent risk. There is variability in what each of these terms mean to communities across the country. The Inform988 COPE developed definitions for these terms to ground this discussion and offer an opportunity for the field to consider whether these definitions fit their circumstances.

Consent

911 and 988 professionals typically ask the caller for permission to transfer their call (either to 911 or 988), although the practice is not universal. This is the basic step for gaining consent. The call taker should clearly explain why they want to transfer the call. If the caller declines, then the call taker would not make the transfer unless they are required to by policy. This requirement typically applies in cases where the person has called 988, has not been able to develop a safety plan, and is at imminent risk of harm to self or others. In these instances, the guidance provided by Vibrant[1] for 988 communications centers is to transfer the call to 911 even if the call taker does not have caller consent.

> *"988 centers are required to engage in non-consensual active rescue in situations where there is an active risk to the caller or someone else, [but] that is always the last option."* – Neil Olson, former Senior Director of Clinical Operations at Crisis Connections and Inform988 COPE member.

[1] Vibrant Emotional Health, commonly referred to as Vibrant, is the entity that was responsible for administering 988 at the time of this writing.

There may also be cases where people are unable to provide consent – for example, if they are extremely intoxicated to the point of losing capacity to make their own decisions, or otherwise incapacitated. As above, if the 988 professional feels the person is at imminent risk, policy may dictate that they transfer the call to 911 without caller consent by policy.

> *"[It] gets complicated on an involuntary call – often because the person hung up, disconnected, or stopped responding. [We need to send someone, but we] didn't have opportunity to find out what they were comfortable sharing."* – Ashley-Laren Smalls, former Program Manager of 911 Engagement at Vibrant Emotional Health and Inform988 COPE member.

Communications centers may operate on the principle of "passive consent" or "implied consent," whereby the person is told the call is being transferred and they are not asked. When the person stays on the line, it is argued, this demonstrates their "passive or implied consent" to the transfer. While this may be common, it does not qualify as a "warm transfer," and is not advisable.

Warm Handoff, also referred to as an "Attended Transfer"

The term warm handoff is often used to describe best practice for transferring calls between 988/911. The COPE defined a warm handoff as inclusive of the following elements:

- *Inform the caller about the transfer.*
- *Attempt to gain consent where appropriate and possible* (see above).
- *Stay on the line:* The person transferring the call remains on the line to share information about the situation, so the caller does not need to repeat themselves. In some cases, one call taker stays on the line with the caller while another contacts 911/988 to explain the situation and navigate the appropriate response.
- *Share only pertinent information:* Protect the individual's privacy while prioritizing their safety.
- *Ensure a meaningful connection has been made to the next responder:* In cases where a mobile response is being dispatched, the call taker remains on the line until the responder has arrived. When the call is being transferred to another call taker, stay on the line until the other party has answered.

> *"[NAMI's] practice is to do warm handoffs to both 988 and 911. When we get a call that comes in, to the extent possible we will stay on the line and continue to provide support until someone from the other line picks up and we can ensure that the transfer has been made."* – Shannon Scully, Director of Justice and Policy Initiatives, National Alliance on Mental Illness and Inform988 COPE member.

> *"[During a transfer,] 988 counselors will stay on the phone the entire time and try to reduce the lethality of their means and safety plan. Meanwhile, a bachelor's level or master's level clinician will be on the phone with 911 letting them know the situation. There is a lot of supervision and a lot of oversight and training on this to prevent death by suicide as much as possible."* – Neil Olson, former Senior Director of Clinical Operations at Crisis Connections and Inform988 COPE member.

Interoperability

The COPE defined interoperability as “the transfer of calls and relevant information seamlessly through clearly defined technical and human collaboration mechanisms to ensure people access needed resources safely.” This definition contains many terms that require further definition. Interoperability is complex and involves both people and technology. An interoperability policy should include:

- Mechanisms to transfer calls **seamlessly** across lines and route callers to the resources they need. Including technologies that work together to **send audio and call data with minimal human intervention**, allowing for **data sharing** for best service and quality assurance.
- Clear and defined **collaboration** between entities on best practices for de-escalation and caller safety.
- Clear parameters for **who responds when, based on a shared understanding** of accountability and responsibility.
- A **no wrong door** policy whereby whichever number the person in crisis calls, they will get the support they need.

Imminent Risk

Similar, though not identical, definitions of imminent risk are offered by different sources.

Inform988 COPE member and SAMHSA Crisis and Justice Initiatives Chief Officer Tiffany Russell defined it as “an immediate and impending threat.”

The National Emergency Number Association (NENA) defines imminent risk as: “Evaluation by a crisis line of an individual’s risk of suicide. There must be a close temporal connection between the person’s current risk status and actions that could lead to serious bodily injury or death. The person indicates intent to die, a plan, and the capability to carry out their intent. Beyond 988 crisis center processes, imminent risk is further defined as an immediate risk to self or others.”

988 Lifeline defines imminent risk as “a situation where a person’s current risk status is believed to indicate actions that could lead to his or her suicide.”

Finally, according to SAMHSA SAFE-T Suicide Assessment – Five Step Evaluation and Triage, “high risk” individuals are those with "suicidal ideation with [a] plan (when and where), a method (how), and an intent to carry out the suicide plan.”

II. CURRENT STATE OF PLAY

988 Basics

Launched nationwide in July 2022, 988 connects people who call or text the hotline to a trained call taker who will listen and provide support and connections to needed resources. The 988 Lifeline is a national network of over 200 contact centers, including centers that were formerly accessible through the National Suicide Prevention Lifeline and ones that were only offered at a local level. 988 can also connect callers to dedicated resources for veterans and service members. Military service members and veterans can press 1 to be directly connected with the Veterans Crisis Line (VCL). Pressing 1 can also connect veterans to care at the Veterans Health Administration (VHA).

The 988 network is managed federally by the Substance Abuse and Mental Health Services Administration (SAMHSA),[2] an organization within the U.S. Department of Health and Human Services (HHS). As the federal organization under which 988 operates, SAMHSA published National Guidelines for Behavioral Health Crisis Care. These guidelines detail best practices for managing emergencies throughout the crisis care continuum, including "essential elements" of a Regional Crisis Call Center that operates 24/7/365 and meets National Suicide Prevention Lifeline standards.

Although SAMHSA oversees 988, at the time of this writing, Vibrant Emotional Health (Vibrant) administers the hotline. As the administrator, Vibrant sets the minimum standards that agencies must have in place to become a 988 communications center. These standards stipulate that centers must:

- Support real-time care coordination, enabling immediate collaboration between communications centers, mobile crisis teams, and healthcare providers.
  - This also includes required data-sharing capabilities to prevent gaps in care.
- Consistently cover designated geographical area – 24/7 coverage is preferred but not required.

While 988 is a federally-mandated service, it is up to states to ensure the availability of services for its residents. The National Suicide Hotline Designation Act of 2020 allows states, tribal governments, and territories to collect funds to administer the 988 system to their jurisdiction. As of June 2025, 12 states had enacted a 988 fee as a revenue source to support system operations. Five more have recurring state funding established through appropriations legislation, while another five have 988 fee legislation pending.

COPE members identified some key pain points with the current structure of 988 and offered the following suggestions:

Coordination between Federal and State Administrators

- SAMHSA should offer general guidance, while leaving space for flexibility so that localities and individual centers can tailor programs to best serve their populations. The national guidelines mentioned above fit the bill, but the complex web of federal (SAMHSA and Vibrant), state, and local jurisdictional responsibilities, funding, and regulations have made it unclear what is required and who is adhering to what standards or practices. To operate successfully, going forward 988 will need greater clarity.

[2] As of April 2025, a reduction in personnel at SAMHSA resulted in layoffs of 988 staff. As of this writing, it is unclear how these reductions will or have already impacted 988.

- On the other side, federal partners face a significant challenge in staying connected to the massive array of resources offered at the state and local levels. Bidirectional communication is critical to allowing for the best 988 experience for all users and staff.

Understanding Variety Across States

- 988 must be responsive to unique needs that vary throughout the country. It cannot operate under a one size fits all policy. There is a need for multiple design models to fit various geographical and resource differences. The structural factors that impact mental health crises and resources vary by community. Administrators should conduct comprehensive needs analysis of the nature and extent of emergency response service demand and the current community capacity to meet this demand at state levels. This can include partnership with non-988 entities.
- Mental health resources and training vary. 988 centers share some common training resources, but each decides on their own training curriculum. In-person services are hyper-local. Some things are done nationally, others are not. There are opportunities for collaboration and shared learning here.

The Role of State Advisory Boards

The Inform988 COPE noted that creating a state advisory board to guide the rollout of 988 nationally was a best practice. As of March 2025, eight states had enacted legislation to create State Advisory Boards according to the National Alliance on Mental Illness (NAMI). These include:

- California (AB 988) created a State 988 Technical Advisory Board.
- Illinois (HB 1364) created a 988 Suicide and Crisis Lifeline Taskforce.
- Kansas (SB 19) created an advisory body for rollout.
- Massachusetts (S 3097) created a state 988 Commission.
- Oregon (HB 2757) created an advisory body.
- Utah (SB 155) amended duties of existing commission to create 988.
- Washington (HB 1477) created an Improvement Strategy Committee.
- Wyoming (HB 65) created an advisory body.

The states' legislation varies in language around what these advisory boards are designed to accomplish, but their activities generally include:

- Identify legal and regulatory barriers to the transfer of 911 calls, then develop technical and operational standards to allow coordination between 911 and 988 (California, Utah).
- Review emerging practices from other state models for coordinating across crisis lines (Illinois, Utah, Washington).
- Gather feedback, monitor progress, identify barriers and challenges, and provide guidance/recommendations regarding improvements in planning and implementation (Kansas, Oregon, Washington, Wyoming).

Several advisory boards require representation of people with lived experience (such as Oregon, Utah, Washington, Wyoming) and those from tribal nations (Washington).

Public Awareness and Utilization

Nine months after its launch, only 13% of U.S. adults had heard of 988 and knew its purpose. Just 3% of people in the U.S. polled had called 988 for themselves, and 3% had called for a loved one. However, utilization is on the rise (Table 1). This poses an exciting opportunity to meet the moment and provide the increasing number of people seeking support with the services they need, though recent cuts to SAMHSA and 988's federal infrastructure could curb this rise in people seeking access to care via 988.

Table 1. Contacts routed by call, text, or chat to 988 (excluding Veterans Crisis Line)

	Calls	Texts	Chats	Total
2022	2,500,317	328,142	915,168	3,743,627
2023	3,235,523	867,470	737,543	4,840,536
2024	4,435,213	1,232,516	788,802	6,456,531
2025*	4,336,016	1,127,427	948,626	6,412,069

*2025 includes only January - October, further data had not been released at the time of this publication

> *"Despite being a valuable resource, there is a lack of public education about 988 and how it is differentiated from 911 in the minds of many members of the public. There is confusion about the distinctions between hotlines: which handle acute crises, which are warm lines, and which provide general support. Clarifying this can significantly impact how people seek help and trust these services."* – Jessica Gimeno, Mental Health Policy Analyst at Access Living and Inform988 COPE member.

The rising numbers of contacts to 988 are also indicative of an impressive investment in data and performance level infrastructure – in just two years, there is already more data known and a more robust platform for data collection and performance measurement for 988 compared to what exists for 911, which has been in operation since 1968.

Uncovering the State of Interoperability

The decision to assign a three-digit number to the National Suicide Hotline and expand its scope beyond suicidality is a response to complex and expanding need. The COPE's expertise, which spanned several of the intersecting fields that 988 relies upon to succeed, generously volunteered their time to join these conversations in an effort to understand the challenges that 988 faces and to chart a course forward. There is ultimately great potential for 988, which is why so many organizations and researchers are devoting their time to learning about and explaining this new system. The Inform988 COPE homed in on the interactions between 911 and 988. The facilitators and barriers to that partnership, as well as emerging practices that allow for strong collaborations and responsive service that the Inform988 COPE uncovered are described below.

III. INFORM988 COPE DISCUSSION THEMES

Overview

Over the course of 15 meetings, the Inform988 COPE uncovered several challenges to successful interoperability. More information on the topics discussed in these meetings can be seen in Appendix B. A thematic analysis of meeting minutes and recordings revealed three levels of challenges: human, system, and technological.

Human-level challenges

Though not unique to the emergency response space, employing new processes is often inherently challenging because all involved parties must modify the practices they are accustomed to. Beyond this, Inform988 COPE members described a handful of dynamics at play that appear to give both 911 and 988 professionals pause in making transfers. These include the following:

- Lack of trust: communities may not trust 911 and/or 988; 911 and 988 may not trust each other.
- Fear of liability: 911 professionals reported fearing personal and organizational liability if they transfer a call away from 911 to 988 and an adverse outcome occurs.
- Lack of collaboration: collaboration across agencies, and with people with lived experience, is essential for success but is often lacking, which can impact successful interoperability.

System-level challenges

The individually designed systems of 911 and 988 each have their own dynamics to contend with and were not created to operate in partnership. Interoperability along the following dimensions should be prioritized:

- Staffing: Maintaining a well-staffed and supported workforce in both 911 and 988, and training these respective professionals to know when and how to successfully work together.
- Accessibility: Providing services that offer relief from distress to all, regardless of the callers' abilities.
- Inconsistent standards: Varying processes for transferring calls between 911 and 988, and inconsistent presence of protocols and guidelines.

Technology-level challenges

The 911 and 988 systems were designed to operate largely independently of each other and without shared technology, which poses difficulties for the two to work together.

- Geolocation: Unlike 911, calls to 988 may not be tied to the caller's exact location, resulting in challenges when calls are transferred to 911 without crucial location data but adhering to safety and privacy concerns of some.
- Call transfer technology: Some systems have technology in place to transfer callers from 911 to 988 or vice versa, while others require callers to hang up and redial the other hotline. In these cases, the 911 or 988 professional is unable to confirm whether the caller has actually accessed the other hotline. Both individual hotlines require investment in technology.
- Data sharing: 911 and 988 are governed by different data collection, storage, and sharing guidelines, inhibiting transfer of information between the two. This is detailed below in the "Data Sharing" section and in Table 2.

The Inform988 COPE benefitted from the lessons learned of many innovative leaders in their fields. Over the course of the meetings and a series of individual follow-up conversations, we uncovered several emerging practices and solutions. These are presented in the following sections, along with deeper discussion into the challenges highlighted above.

A. Human-Level Challenges

Building Trust

Trust is foundational to any successful relationship. It takes time to foster and must be grounded in historical context and landscape. The lack of trust that can impede 911 and 988's ability to interact and best serve the community flows in many directions – bidirectionally between the hotlines themselves, as well as between the hotlines and the communities they seek to serve.

On the part of the 988 professional, staff are often reluctant to transfer calls to 911 because they fear that an emergency services response, specifically an armed police response, might put the person in crisis at risk of injury or arrest. Additionally, advocates are concerned about how people with arrest and conviction records will be treated when they call the hotline. Similarly, advocates are concerned about how people who use or have used drugs (or are perceived to be using drugs) will be treated when they call the hotline.

Federal Regulations and EMS Involvement in Crisis Calls

Robert McClintock, Assistant to the General President for Technical Assistance and Information Resources at the International Association of Firefighters and Inform988 COPE member

Emergency Medical Services (EMS) have an important role in the emergency response to behavioral health crisis calls to 911. In such instances, EMS is often dispatched with police, and remains in the background until police have secured the scene and confirmed that it is safe to interact with the person in crisis. One key challenge with involving EMS in these calls is that they are only authorized to transport the person in crisis to a hospital emergency department, where the person will be assessed for involuntary custodial treatment, which is an unwanted outcome for most.

Efforts are underway to allow EMS to transport patients to places other than hospitals, such as urgent care centers and outpatient crisis stabilization centers, which would provide more therapeutic environments. A research project showed the potential of significant savings in Medicare costs of care following ambulance transport if EMS either treated low acuity patients in place or transported them to low acuity settings rather than taking them to an emergency department. A Center for Medicare and Medicaid Services (CMS) pilot – Emergency Triage Treat and Transport Model (ET3) – was introduced to test these processes in 2019 and reduce Emergency Department volume. After the pilot period ended, CMS indicated they remain interested in this approach and hope to use lessons learned in the future. Several membership groups – International Association of Fire Fighters (IAFF), International Association of Fire Chiefs (IAFC), National Association of EMTs (NAEMT), American Ambulance Association (AAA) – have been advocating together for further federal action for another pilot project in hopes it will demonstrate cost savings and better outcomes for people in need.

Trust Between 911 and 988

At the heart of addressing these issues is collaboration between 911 and 988 communications centers to determine how calls will actually be transferred between hotlines and what hotlines will do for callers after the call is transferred. Inform988 COPE members discussed how important it is to have "earned legitimacy," where partners learn to trust each other through relationship-building. A key to this is to have a trusted liaison between the two hotlines, which can include embedding clinicians in the 911 communications center. Sharing outcomes of transferred calls between centers could also build rapport and trust between two agencies.

Inform988 COPE member Tiffany Patton-Burnside served as Senior Director of Crisis Services for the Chicago Department of Public Health during the launch of Crisis Assistance Response and Engagement (CARE), an alternative crisis response program. CARE was the result of a multi-agency partnership that relied on communication and a commitment to service, and it took time and effort to build the requisite trust.

> *"It has taken a long time to indoctrinate our program into the call center, even with the clinicians there almost every day, to facilitate trust in the work we're doing as an outside entity and to give us more information."* – Tiffany Patton-Burnside, Senior Director of Crisis Services at the Chicago Department of Public Health and Inform988 COPE member.

This sentiment was echoed by Inform988 COPE members in Washington state, where Valley Communications 911 and Crisis Connections were negotiating a co-location pilot program that would embed 988 professionals in the 911 communications center. Members from both organizations participated in Inform988 COPE meetings, and shared that they had built a strong and trusting relationship. Leaders from both teams were committed to achieving this goal and met frequently. This earned legitimacy allowed the work to proceed, and the program is now operational.

> *"It takes time to build relationships and trust. Go slow and smart and be intentional. Meet in different forums, build camaraderie and shared vision."* – Lora Ueland, former Executive Director of Valley Communications 911 and Inform988 COPE member.

Building Trust Between 911 and Mental Health Service Agencies: Insights from Mental Health Service Providers

Madyson Ganeles, former 911/988 Liaison at Rocky Mountain Crisis Partners (RMCP) and Inform988 COPE member

Building trust between 911 communications centers and mental health service providers is a multifaceted process that involves leveraging existing relationships, maintaining regular communication, showcasing successes, and adapting to feedback. Collaborative projects and community involvement also play crucial roles. These strategies can help establish and sustain trust, ultimately leading to a more integrated and effective emergency response system. These strategies are recommended for agencies if applicable to their landscape.

Building Trust Between 911 and Mental Health Service Agencies: Insights from Mental Health Service Providers (continued)

Key Strategies for Building Trust:

Leverage Existing Relationships and Networks:

- Background in Law Enforcement and Mental Health: Staff at the mental health service agency had previous law enforcement experience and were CIT (Crisis Intervention Team) training coaches, providing them with direct contacts in the public safety community.
- CIT Training: This training helped establish credibility with law enforcement because staff at RMCP were CIT training coaches and had trained law enforcement in this capacity. The training also provided a platform to build new relationships. Training sessions facilitated interactions with various public safety and community organizations, fostering trust.
- Organizational Connections: Partnerships with reputable organizations such as the National Alliance on Mental Illness (NAMI), combined with collaboration across their existing networks, were instrumental in establishing credibility, fostering trust, and strengthening community relationships.

Regular Communication and Engagement:

- Monthly Meetings: Regularly meeting with the ECC directors provided a consistent touchpoint that reinforced the relationship by maintaining ongoing dialogue, addressing concerns, sharing successes, and working on barriers.
- Clear and Open Communication: Providing ECCs with detailed information about 911/988 diversion programs, including how the call-transfer infrastructure was built, how and when calls could be seamlessly routed between 911 and 988, and what operational criteria guided those transfers, helped manage expectations and maintain transparency.

Showcase Successes and Data-Driven Outcomes:

- Data Sharing: Initially providing detailed data reports on call dispositions, average call length, number of calls, and other metrics helped demonstrate the program's effectiveness and built confidence among ECCs.
- Quarterly Reports: During transitions or waiting periods, sharing verbal updates and trends helped maintain trust by keeping ECCs informed.

Adapt and Respond to Feedback:

- Soliciting Feedback: Actively asking ECCs what data or information they found most valuable and then working to provide that information demonstrated responsiveness and adaptability, crucial for building trust.
- Adjusting Protocols: Understanding the unique needs of each ECC and customizing policies and procedures accordingly ensured that solutions were relevant and practical.

Engage in Collaborative Projects:

- Cross-Disciplinary Projects: Involvement in projects with national, state, regional, and local associations provided additional credibility and showcased a commitment to industry-wide standards and best practices.
- Research Partnerships: Pursuing research opportunities with academic institutions can provide a data-driven perspective and further validate the program's effectiveness.

Building Trust Between 911 and Mental Health Service Agencies: Insights from Mental Health Service Providers (continued)

Build a Shared Vision:

- Shared Goals: Emphasizing the common goal of providing appropriate care and reducing unnecessary law enforcement involvement helped align the priorities of ECCs and mental health services.
- Involvement in Broader Community Initiatives: Participation in community-wide efforts to address issues like mental health and homelessness illustrated a holistic approach and commitment to the community's wellbeing.

Trust of Communities in 911 and 988

Building trust between agencies is difficult. Demonstrating to communities who have been historically harmed by authorities that they can and should trust 988 is another challenge entirely. Inform988 COPE member and 1 Million Madly Motivated Moms Founder Tansy McNulty has dedicated her work to ending police violence through prevention-focused strategies, including a Right Response Directory of non-police resources for individuals and communities in crisis.

> *"Trust is deeply rooted in equity. Communities of color have distrust in 911, and that distrust spilled over into 988."* – Tansy McNulty, Founder of 1 Million Madly Motivated Moms and Inform988 COPE member.

Furthermore, trust in these services can be difficult to maintain. COPE member and Director of StrongHearts Native Helpline Lori Jump expressed concern that any trust callers have in 988 professionals could be erased if they are transferred to 911, especially in Native communities.

Providing Culturally Competent and Reliable Support to Native American Communities
Lori Jump, Chief Executive Officer of StrongHearts Native Helpline and Inform988 COPE Member; and Rachel Carr-Shunk, Deputy Executive Director of StrongHearts Native Helpline

StrongHearts Native helpline is a hotline for survivors of domestic and sexual violence that was created by and for people who are Native American. The advocates who answer the phone are also from tribal nations. StrongHearts, despite its eight years of service, struggles with reaching all their communities, even though they continue to engage in intensive, multi-pronged education strategies. Leaders at StrongHearts offered lessons for how 988 can earn the trust of people from Native communities.

Conduct Outreach and Education: Awareness of resources like the 988 helpline and StrongHearts Native Helpline is still limited, especially in remote tribal communities with unreliable access to cellular networks, the internet, radio, or newspapers. Outreach efforts for 988 must be tailored to tribal community needs, with a focus on building personal relationships through in-person engagement.

Providing Culturally Competent and Reliable Support to Native American Communities (continued)
Lori Jump and Rachel Carr-Shunk, StrongHearts Native Helpline

Build Trust Amid Historical Trauma: Historical trauma has caused tremendous mistrust of external systems and is a significant barrier to asking for help from outsiders. Further, a history of discontinuation of federally funded programs has reinforced tribal nations' skepticism of and their reluctance to depend on external resources. Those not from these communities must acknowledge this history and commit to reliable, long-term support to rebuild trust. Transferring crisis calls from 988 to 911 can harm trust, especially in communities that have strained relationships with law enforcement. Ensuring callers feel understood and supported without fear of unnecessary police involvement is vital.

The first Native and Strong Lifeline launched in Washington state in November 2022 is part of 988, and calls are answered by Native crisis counselors who are tribal members and descendants closely tied to their communities. Such initiatives reduce barriers to access and ensure services are designed for and by Native populations.

Although data indicate that less than 2% of calls are transferred from 988 to 911, those incidents are critical. The balance of safety with an individual's autonomy – thinking about not just the outcome of this call, but the willingness to call next time, is very difficult. Ultimately, callers deserve to understand the potential outcomes of contacting 911, which is why Health Lab has created a companion Callers' Bill of Rights.[3] Open communication and setting of expectations can go a long way in building trust with communities. Several Inform988 COPE members raised the point that language means different things to different people and in different industries, and there is a need to marry the two languages of 911 and 988 to improve both communication and trust.

Fear of Liability

It is also critical to address concerns about liability that call takers express. Both 911 and 988 professionals report feeling responsible for callers and their outcomes. Several Inform988 COPE members from the 911 field expressed concerns that if they transferred a call to 988 and something went wrong, they personally and their organizations would be held accountable. Conversely, at the time of this writing there were lawsuits underway in several locations (including in New York and Oregon) where 911 is being sued for sending police in response to mental health calls.

Like several other ECCs nationwide, the Tulsa, Oklahoma ECC has an embedded clinician (see the call out box "Embedding a clinician in 911: Building a cohesive unit" for more), and their warm transfer involves the call taker getting up, walking over to the clinician, and asking them to do a call back – they operate in this way instead of transferring the call because of concerns with liability. It is worth noting that in December 2025, SAMHSA published a toolkit that provides guidance on liability risk, among other factors to 911/988 interoperability that was not yet available during the COPE sessions but offers useful information to decision makers.

[3] The 911 Callers' Bill of Rights is a guide developed by a workgroup of 911 professionals, community leaders, and mental health advocates. This guide outlines what users should expect when they contact 911, centering dignity, safety, and equitable access to emergency care for all communities. It is available at https://www.transform911.org/911cbor/.

Liability in the Context of 911 Transfers to 988

A 2024 report by the Law Enforcement Action Partnership (LEAP), reviews state, federal and worker's compensation laws and how they could be used to claim a law enforcement or 911 agency liability for failing to send a law enforcement officer in the context of a "Community Responder Program." Community Responder Programs are defined by LEAP as "unarmed teams dispatched as first responders to 9-1-1 calls." While distinct from transferring calls to 988, it is similarly not a police response. Community responder agencies, which manage the day-to-day operations of community responder programs, are typically led by fire departments, police departments, nonprofit organizations, and/or other city or county departments.

LEAP's analysis consistently demonstrates that community responders dispatched instead of police to "low risk" calls actually reduces liability, partly because these responders are unarmed and as such less likely to use force. Moreover, they are often better suited to respond to a person with a disability. The report recommends that when community responders are deployed their agency implement clear protocols and training, carry needed insurance and have contractual arrangements that clearly spell out the roles and responsibilities of all partners.

Much like the issue of trust, the fear of liability can be eased by greater levels of understanding and strong working relationships.

> *"A way that we were able to bridge this fear of liability is to discuss with 911 workers that the transfer to 988 is getting the call to a higher level of care. Further, shadowing both ways, between 988 and 911 caller takers, to gather more understanding of the two entities, was helpful."* – Margie Balfour, Chief of Quality and Clinical Innovation at Connections Health Solutions and Inform988 COPE member.

Collaboration

Meaningful collaboration across agencies, and between agencies and the people they serve, is fundamental to successful interoperability between 988 and 911. The trust building between agency staff discussed above is an essential component of any meaningful collaborative approach. Examples of meaningful collaboration between agencies and the people they serve, people with lived experience – are described throughout this section.

California Health and Human Services (CalHHS) engaged people with lived experience while developing their five-year implementation plan for 988 and a comprehensive crisis system. CalHHS partnered with a healthcare consulting firm and a tribal nation, woman-owned consulting firm to recruit participants for and then facilitate a series of focus groups involving more than 100 individuals who might be at risk when connecting with 988. There was wide representation of people with lived experience of behavioral health conditions and involvement with the justice system. Tribal community engagement was facilitated in person and hosted by tribal leaders in three counties where tribal leaders often present. All participants were paid for their time.

Several cross-cutting themes emerged, and many specific recommendations were made about how to improve the crisis system for people with lived experiences of different kinds. These recommendations were reflected in the five-year plan: hiring, training and supporting crisis workers with lived experience; offering peer-run, trauma informed services; and reducing contact with law enforcement.

In Ohio, a Crisis Response Pilot set out to advance interoperability between 911 and 988 using strategy from the SAFECOM Interoperability Continuum. To improve 911/988 interoperability, they recommended providing continued support and accountability, tailoring supports to each site, prioritizing peer learning and call center visits, providing guidance on when and how to include other partners, and planning for a longer interoperability development timeframe.

Beyond Tokenism: Engaging People with Lived Experience
Keris Myrik, Vice President of Partnerships at Inseparable and Inform988 COPE member

How can an organization meaningfully and effectively involve people with lived experience (PwLE) in program development and implementation? By using a "Lived Experience-Engaged Organization Ladder," which is adapted from the work of Hart and Arnstein (1969), an organization can examine the ways in which it is and should engage people with lived experience. The goal is to have lived experience contribute at all levels.

At the bottom of the nine-step ladder are such activities as "marketing, tokenism and job tokenism," where people tell personal stories for marketing or are asked to join just for "show." In the middle of the ladder are engagements such as "input, no influence," "separate but equal," "input and influence but no leadership." Sometimes there are "separate but equal" groups that are a good idea. This is the case when the PwLE want to meet separately so they can express themselves more freely. The idea of separateness should always be left up to the group.

Ultimately, it is very important to engage PwLE at the top of the ladder – where they are "initiating partnerships," "leading," and "contributing at all levels." In these cases, PwLE are partnering and leading work around 988 and mental health services. Organizations should track how they are engaging PwLE at each rung of the ladder, how often those engagements are happening and how deeply they are ingrained into the work.

There are many advantages of involving PwLE. For example, there has been misinformation in the peer community about what 988 is and what resources might be available through accessing 988. In interviews with people leading efforts in marginalized communities, many such resources were unearthed (see Unapologetically Black Unicorns Playlist on 988 & Crisis System Reform), especially for peers and for Black people who have had adverse events when police responded to crisis calls. If peers are not engaged in 988 efforts, how do 988 professionals know about these resources? How can they be part of 988 responses? It is critical to know these customized resources exist because people who are marginalized are very reluctant to connect with the rest of the mental health community.

How Lived Experience Shapes the Implementation of 988 in the Cook County Sheriff's Office
Matt Fishback, Public Policy Manager, Cook County Sheriff's Department and Inform988 COPE member

Matt Fishback is a liaison between the Cook County Sheriff's Office, which houses one of the largest ECCs in the nation in addition to their patrol and jail duties, and 988. Through his role, he participates in committees reviewing 911 protocols to facilitate the transfer of appropriate calls to 988. Mr. Fishback's position as someone with lived experience of bipolar disorder working within law enforcement gives him an important perspective and role in this work.

- **Bridging the Gap Between Systems:** Mr. Fishback acts as a bridge or boundary spanner between the traditional law enforcement/emergency response system and the mental health community. He understands both the challenges and perspectives of law enforcement, as well as the needs of individuals experiencing mental health crises. This allows him to translate between these two worlds, explaining the nuances of mental health crises to law enforcement and advocating for more appropriate responses. He can speak the language of both sides and identify areas of misunderstanding, miscommunication, and opportunities to build trust and advance practice.
- **Advocating for Change from Within:** Because Mr. Fishback works within the Cook County Sheriff's Office, he has a platform to advocate for change from within the system. His lived experience lends credibility to his proposals and allows him to speak with authority on the need for expanded responses to mental health crises. He's not just an external advocate; he's an internal champion for change.
- **Challenging Assumptions and Promoting Understanding:** When serving as an instructor to law enforcement officers, Mr. Fishback highlights "indecent exposure" calls that don't often involve intentional criminal acts. Instead, he teaches that such incidents often involve individuals experiencing mental health crises who may be unaware of their actions or unable to control them. He draws on his personal understanding of mental illness to explain how seemingly criminal behaviors may be manifestations of a crisis rather than intentionally harmful acts. This perspective helps to humanize individuals experiencing crises and encourage a more compassionate and nuanced law enforcement response.

B. System-Level Challenges

Staffing

The workforce of a crisis response hotline is one of the most critical components of an appropriate response. Maintaining staffing levels is already a challenge, with many 911 Emergency Communications Centers operating at below 50% optimal staffing levels. Prior to 988's launch, workforce experts, practitioners, and researchers had concerns that the new 988 workforce would draw from the same underfilled pool of candidates that might join the 911 workforce. This was not a reality, however, that was reflected in many Inform988 COPE discussions. The conversations did continuously return to training. Although there are common training resources among crisis hotlines, each center has its own conditions and practices and thus unique needs for associated training curricula.

Crisis counselors may be hired without educational prerequisites, which makes on-the-job training even more critical. Some centers expose trainees to real 988 calls and run through extensive role-play practice, while others receive no exposure prior to their first time handling a call. When Crisis Crowd Founder Dan Fichter presented at the Inform988 COPE meeting on the 988 workforce, he shared the following quote from a counselor that he had interviewed: *"Crisis counselors are often recruited straight out of school or as volunteers and provided inadequate training to deal with life or death using zero physical cues… Throwing them to the sharks in crisis is unfair, not trauma-informed, and downright dangerous."*

Inform988 COPE members discussed that they feel more confident when they have guidelines and training to prepare and support them. This extends to interoperability – 911 and 988 staff alike must be trained to collaborate in their work together ahead.

Although burnout is a significant contributor to attrition rates in many industries, burnout among 911 professionals exceeds that of many other professions. This workforce is routinely exposed to both primary and secondary trauma, which takes a toll on their mental health and wellbeing as well as their willingness and ability to stay in the role. A 2022 survey administered by the U.S. Marshall's Service assessed the wellness of public safety personnel across the country and found that 911 professionals have significantly higher rates of depression, anxiety, PTSD, and suicidal ideation than both their first responder counterparts—including sworn law enforcement and fire professionals—and the general population.

Workforce troubles also plague 988. As with 911, many 988 workforce challenges can be attributed to burnout. However, unlike 911 professionals who frequently answer non-emergency and non-crisis related emergency calls as well as a great deal of variation in call types, 988 crisis counselors often solely answer calls from individuals personally experiencing or supporting someone currently experiencing mental health distress. In January 2024, Inform988 COPE member Dan Fichter of Crisis Crowd released a first-of-its-kind survey of 988 crisis counselors from crisis centers across the country. These first-hand experiences allow us to gain further insights into the realities of this role. As one counselor reported, *"Most of the coworkers I started with left well before I did, and a number of crisis counselors I worked with experienced PTSD or severe burnout [related to their job]."*

These workforces deserve and require wellness supports. It is unfair and unrealistic to expect someone to perform at their best when they are suffering, and 911 and 988 professionals' work can have life-altering impacts on those seeking aid during a crisis.

Discussions Around Embedded Staff

Several members of the Inform988 COPE were in various stages of implementing a co-location or embedded staff program. This type of program involves physically bringing 988 or other mental health counselors into an ECC so 911 professionals can transfer calls directly across the floor to a trained professional.

Embedding a Clinician in 911: Building a Cohesive Unit

Belinda McGhie, Director of Public Safety Communications at the Tulsa Police Department and Inform988 COPE member

Tulsa, Oklahoma began embedding a mental health professional in their Emergency Communications Center beginning in late 2021. Overcoming trust issues and building a cooperative, cohesive unit including mental health and 911 professionals required patience and persistence. By training collaboratively, holding regular meetings involving all stakeholders, and having support from city leadership, Tulsa was able to move from a state of mistrust and operational silos to a more integrated and effective emergency response team. Though their work was targeted to support co-location of a clinician in a 911 ECC, the lessons and considerations below can be applied to any partnership between 911 and 988.

Key steps and considerations included:

- **Open Communication and Transparency:** Regularly scheduled meetings involving all relevant parties fostered transparency and kept everyone informed about ongoing initiatives, changes, and challenges. For instance, their First Responder Advisory Committee was a platform for police, fire, and mental health professionals to meet and discuss issues together.
- **Cross-Training and Joint Exercises:** Joint training sessions and simulated exercises helped team members understand each other's roles, capabilities, and limitations. These activities build empathy and ensure everyone is on the same page during an actual crisis.
- **Shared Goals and Unified Mission:** Establishing clear, shared objectives helped align the efforts of different departments. When everyone understands that the goal is to provide the best care and safety for the community, it becomes easier to work collectively. They began by emphasizing that the purpose of embedding clinicians was to divert police from mental health issues, focusing on providing appropriate care without unnecessary law enforcement involvement.
- **Leadership and Buy-in:** Leadership at all levels must be committed to the integrated approach. This includes support from mayors, chief officers, and directors. The appointment of a Chief Mental Health Officer and involvement of the Mayor's Office provided the necessary leadership and support for the integrated approach in Tulsa.
- **Addressing Trust Issues:** Historical mistrust, such as that between the police and fire departments, needed to be acknowledged and addressed through facilitated discussions, mediation, and team-building activities. The incorporation of Healthy Minds, a policy organization, and COPES, a crisis services provider, to lead the team-building efforts and mediate between different departments was strategic and effective. It transformed potential conflict into cooperation.
- **Data Sharing and Transparency:** Sharing data and success stories across departments can help in building trust. When departments see the tangible benefits of collaboration, they are more likely to support and trust the integrated approach. Tracking and sharing statistics on mental health crisis calls helped demonstrate the impact and necessity of the operational changes.

Embedding a Clinician in 911: Building a Cohesive Unit (continued)

- **Community Involvement:** Involving community organizations and stakeholders in the program helped to create a supportive environment. Community groups provided feedback and support that reinforced the collaborative efforts. Meetings that included community groups representing diverse populations (LGBTQ+, hearing impaired, etc.) promoted inclusivity and trust.
- **Recognizing and Celebrating Success:** Acknowledging and celebrating small wins also helped build trust. When different departments see that their collaborative efforts are being recognized and making a difference, it fosters a positive working relationship.

Accessibility

There are many dimensions to and important considerations around accessibility. Availability of non-English speakers at the 988 centers is also uneven. Further, if a person has many identities (e.g., queer and a veteran), many mental health concerns (e.g., they have psychosis and have autism), or are experiencing a non-suicide crisis, participants noted that centers do not have adequate capacity/expertise to address all caller needs. There are many ways to access the national 988 system, including through ASL, text, and chat, but challenges remain in making the best use of these accessibility measures. Given the limited time and expertise available to the Inform988 COPE, conversations focused on dimensions that face very particular, specific, and resolvable challenges, as detailed in the call out box below.

Accessibility for the Deaf and Hard of Hearing Community

Currently, DeafLEAD is the only communications center with ASL capabilities for 988. It is located in Missouri, although its staff are spread around the country. DeafLEAD is working to expand the number of centers: just one center to serve the entire country means that people are not getting the same access to local resources as they would if they were hearing, and routing all requests to one center makes for longer response times. Further, relying on just one center to serve this population is a real vulnerability. In the event of a service outage – which is not uncommon – there are limited viable alternatives.

American Sign Language (ASL) 988 responders can have up to four active chats at a time, which can result in delayed response time and potentially dangerous outcomes. Accessible technology for deaf, deaf-blind, deaf-disabled, late-deafened, and hard-of-hearing people is lacking in both the 911 and 988 systems. Several 911 emergency communications centers use teletypewriters (TTY); however, for many deaf and hard-of-hearing people, the only way to contact 911 continues to be through a relay system or third party. For a significant portion of the deaf and hard-of-hearing people, ASL is their primary language and English is their second. Requiring deaf and hard-of-hearing people to make emergency calls or texts in their second language opens up the possibility of miscommunication and decreases accessibility. For example, a common question to assess psychosis is to ask whether a person is hearing voices.

Accessibility for the Deaf and Hard of Hearing Community (continued)

A partially deaf person may answer this question in the affirmative to convey that they are able to hear voices, but the 988 professional might interpret this as a sign of psychosis.

Next Generation 911 (NG911), a digital IP-based system that will replace analog 911 infrastructure, will offer the opportunity for video connection, but this implementation has been incredibly slow. Similarly, SAMHSA has provided funding for a partnership between Vibrant and DeafLEAD to increase ASL access, but development to build this out is needed.

There are also opportunities for call takers to be trained in how to collaborate with an individual who needs ASL services/translation and conduct a warm transfer. To increase accessibility to 988 services that are interoperable with 911, future work must focus on understanding public knowledge of 988, particularly in deaf and hard-of-hearing communities. There is great potential here to leverage technology to increase accessibility. Deaf and hard of hearing people must be included in the process, however, so that any tools developed suit the needs of the community they are designed to serve.

Inconsistent Standards

Workgroup members raised concerns about inconsistent processes for transferring calls between 911 and 988, noting that some agencies follow the National Emergency Number Association (NENA) standards (see below) while others have no policies or clear guidance on which calls to transfer or what a warm handoff/transfer means. Of note, at the time of this writing, NENA was the only major national 911 professional association to have issued standards for 911 and 988 interoperability – neither the Association of Public-Safety Communications Officials (APCO) nor the National Association of State 911 Administrators (NASNA) offer similarly detailed guidelines for their members.

NENA Standard for 911/988 Interactions
The National Emergency Number Association. Inc. (NENA) has established a standard for 911 and 988 interactions (NENA-STA-045.1-2025), that addresses some of these terms, and offers the following general transfer considerations:

- Both 911 and 988 SHOULD avoid disconnecting with callers when it's unclear that the caller will seek additional assistance from a more appropriate resource upon disconnect. In these instances, the receiving Emergency Communications Center SHOULD transfer to, or directly connect with, the external agency or center.
- Best practice strongly recommends against blind/cold transfer for both 911 and 988. Emergency Communications Centers SHOULD follow ECC-to-ECC transfer processes in the NENA Call Processing Standard, NENA-STA-020.1-2020 [7].
- Warm transfers are a recognized best practice of both 911 and 988.

COPE members shared that they would feel safer following standards, and without them the professionals are at risk. While standards do exist, their application and uptake across communications centers is inconsistent.

Navigating Uncertainty: Governance, Innovation and the California Solution
Eric Rafla-Yuan, Psychiatrist and 988 Technical Advisor for California Governor's Office of Emergency Services and Inform988 COPE Member

The 988 hotline involves multiple layers of authority, including federal, state, and local entities, which may create confusion about who is ultimately in charge. At the time of this writing, SAMHSA and Vibrant provide federal oversight and guidance, and state and local crisis centers have the autonomy to either contract with Vibrant (and follow their requirements) or operate their crisis hotlines independently. This layered governance has created some challenges nationally and at the state level in the development of consistent nationwide and statewide crisis care.

In California, state law requires its 988 centers to operate in ways that are different from how Vibrant requires them to operate. For example, California has requirements regarding how calls are routed within the state that are different from how Vibrant's tech platform – Entrada – is working. To address this, California developed its own platform to meet state-specific laws and ensured it was interoperable with Vibrant and their subcontractors. This allowed California 988 centers to abide by state law alongside Vibrant and SAMHSA requirements.

C. Technology-Level Challenges

Georouting and Geolocation

Callers in the 988 system are not tracked to their specific geographic location in the way that many 911 callers are. Prior to October 2024, which is when most of the conversations informing this report took place, 988 calls typically were routed to the closest call center based on the area code of the number initiating contact with 988. For example, if someone was living in Chicago, but calling from a phone with a New York City area code, this would mean they would be connected with a center in New York City rather than the one that is closest to their current location in Chicago. This policy served two key purposes in 988's rollout:

1. **Speed of rollout:** building a geolocation system with the capabilities of the 911 system is incredibly complex and would have significantly slowed the speed of the rollout. 911 was designed with landline telephones in mind, which are much easier to geolocate than the mobile devices that are now the most common method of communication. This increase in mobile device utilization has required expensive technology upgrades to 911 that have not yet been fully implemented, so requiring these same updates for 988 would cause significant delays.

2. **Privacy concerns**: 988 callers are often hesitant to call and are concerned for their privacy. When the caller's location is unknown, they may feel safer divulging information and getting help virtually without fear of a responder being deployed to their location without their consent.

Privacy and accessibility remain vital concerns in emergency calls. At the same time, in the small fraction of cases that cannot be resolved over the phone, in-person resources and emergency response, whether from a mobile crisis team, law enforcement, or healthcare can be necessary and lifesaving. As call transfer and data sharing technology are further developed for 988, both considerations must be taken into account.

There are several circumstances, however, where the ability to locate a caller more accurately is necessary to connect them with the resources they need. Before transferring a call to 911, the 988 center should always attempt to obtain consent. If a 988 center wanted to connect a caller with a mobile crisis team or another in-person support resource, they would only have access to the resources in their state, county, or region. This is especially dangerous if the caller is in imminent need of a team but is calling from outside of their area code, and as a result the 988 center is unable to connect the caller with tailored local supports.

For these reasons and others, the Federal Communications Commission adopted a rule in October 2024 requiring all wireless calls to 988 to be geo-routed to the call center closest geographically to the caller. This intends to allow callers to speak with someone in their community, while still withholding their exact location and thereby protecting their privacy. This rule required nationwide carriers to meet the obligations within 30 days of the rule's publication. More research and action are needed to fully examine the impacts.

As noted above, geolocation still proves to be a challenge for 911, which was designed for landline use but is now more commonly interacting with wireless and internet-based communications. Nationwide, many ECCs cannot automatically detect a caller's exact location, and the precision of others' tracking abilities varies. In addition, some technologies designed to automate 911 processes may be outpacing development of protocols to monitor these automations. Indeed, the fast pace of technology advancement makes it difficult for ECC leaders to personally assess which new technologies are necessary or superfluous instead of relying on the guidance of vendors who have a vested interest in their adoption. The Transform911 Blueprint examined this issue and offers recommendations to strengthen technology and data standards for 911 that may also be considered for 988.

Call Transfer Technology

While some 911 and 988 systems have technology in place to transfer callers from 911 to 988 or vice versa, others require callers to hang up and redial the other hotline. Once the call is transferred, however, many call takers do not have the capacity to remain on the line to ensure the caller's needs or concerns are addressed.

Some communications centers have identified creative solutions to improve the transfer process. In Tucson, Arizona, fire, police, and 988 agencies are co-located within the city Emergency Communications Center. Call takers have a speed dial button they can press to smoothly initiate a warm transfer to other in-center staff. The ease of this system, supported by the trust that has been built up across agencies through many years of productive partnerships and their co-location, facilitates more seamless warm transfers. In other Arizona communities, the agencies are not

co-located, but onsite staff support 911 professionals and can transfer to off-site communications centers when necessary.

In Colorado, Rocky Mountain Crisis Partners (RMCP), the former provider of 988 services, had a similar solution. A one-touch button was incorporated at the ECC side, so when a call came into RMCP the 988 professional could easily determine that a 911 center was calling. Then, call takers were prepared to pick up a warm transfer, which allowed them to reduce duplication of questions. The center had also implemented a call-prioritization queue which allowed call takers to prioritize these warm transfer calls. Since the call diversion program began, administrators will determine whether processes used for call transfers could also be used for prioritizing incoming texts to 988.

In Douglas County, Kansas, the region's version of a "quick button" is supported by 911 geolocation technology to ensure that the call is being transferred to the Kansas Suicide Prevention Headquarters for all call takers in the area the center serves, even if their area code is from somewhere else.

To promote more seamless transfers between 911 and 988, technology and policy must work together. The examples in this section show how technology can be leveraged to ensure that call takers can pass calls between each other and their respective centers seamlessly, rather than having to conduct these transfers more manually. These technological advancements are most beneficial when supported by partnerships between agencies, by working to build trust, and by intentional guidance about how and when to transfer a call. Once a call taker determines that a call should be transferred, the technical ability to transfer a call should not be the barrier to connecting a caller with needed services and care.

Data Sharing

911 and 988 communications centers are covered by different data collection and sharing guidelines through the Criminal Justice Information Services (CJIS) and Health Information Portability and Accountability Act (HIPAA). See Table 2 below for an overview of how these guidelines apply. This is a very simplified approach primarily for illustrative purposes only – please visit these resources for more details on CJIS and HIPAA.

Table 2: CJIS and HIPAA Overview

	CJIS	HIPAA
Who's covered?	Certain ECCs – all law enforcement agencies fall under CJIS, but not every 911 communications center is classified as a law enforcement agency.	**988:** some but not all call centers are covered **911:** whether a call center falls under HIPAA depends on a variety of factors including location, local laws, funding sources, and the center's purpose.
When is data sharing allowed?	Data can only be shared with a "Non-Criminal Justice Agency" with an approved user agreement.	Healthcare providers can share data with emergency responders in the case of an emergency.

There are often additional layers of guidelines that limit data sharing. In some places, such as Chicago, 911 and 988 communications centers as well as crisis response programs must also ensure they don't violate the Illinois Mental Health and Developmental Disabilities Confidentiality Act in their data practices. As 911 and 988 communications centers develop plans to gather or share data across agencies, they must ensure their practices align with the multiplicity of different restrictions imposed by these varying levels of regulation.

California's Efforts to Manage Technology Infrastructure and Interoperability for 911/988

In the first year of 988 implementation, California received twice the number of 988 calls than any other state in the US (336,000 calls). In the context of needing to manage this high volume efficiently and effectively, California legislators mandated the formation of a **"988 Technical Advisory Board"** to guide the creation of their own systems. The legislation called for the board to advise the Office of Emergency Services on:

- *Recommendations on the feasibility and plan for sustainable interoperability between 988, 911, and behavioral health crisis services, including the identification of any legal or regulatory barriers to the transfer of 911 calls.*
- *The development of technical and operational standards for the 988 system that allow for coordination with California's 911 system.*
- *The creation of standards and protocols for when 988 centers will transfer 988 calls into the "911" public safety answering points or points (PSAP) [Emergency Communications Centers (ECCs)], and vice versa.*

On December 31, 2024, CalHHS released a report to the State Legislature which detailed its five-year implementation plan. CalHHS developed the plan in consultation with community voices (detailed in this report) and several workgroups, including the **988 Technical Advisory Board**. One of the plan's four goals is focused on technology and infrastructure:

Goal B: Statewide Infrastructure and Technology: Establish the systems, inclusive of technology, policies, and practices, to connect help seekers to the appropriate call/chat/text takers.

- *B.1. Support the technology to route 988 contacts safely and efficiently anywhere in California, including to mobile crisis dispatch.*
- *B.2 Promote coordination and communications across state technology implementation partners to ensure alignment of technology, policy, and practice.*

In pursuit of these goals, the **988 Technical Advisory Board** developed a draft "911/988 Transfer/Handling Criteria" document to aid California ECCs in providing the best service possible to address the needs of callers experiencing a mental health crisis. The criteria address policy and procedures related to: ECC transfer criteria, 988 center transfer/emergency services notification criteria, transfer process from 911 to 988, information to be provided when a transfer or notification occurs, and other items to consider addressing.

Inform988 COPE members shared that when collecting and providing information during a call transfer, the primary focus is on what is necessary at the moment. On the 911 side, call takers are primarily concerned with learning about the safety of the scene and if there are any weapons present in order to safely deploy first responders. In contrast, 988 professionals are generally expected to share information they gather about the crisis "only as needed" for the situation at hand. This information is primarily collected and shared verbally via conversation during the transfer process, rather than retained in a centralized database.

Communications centers responding to mental health-related calls generally do not have unified guidelines on how to share data. In similar call-taking spaces, such as with domestic violence hotlines, there is a more universal philosophy for how to deal with callers' data – work with callers and always ensure consent. Although 911 callers do not have the same rights to consent once they have reported an emergency in process, these models can provide an example of how to approach these situations in a way that maintains callers' dignity. To better understand the rights and responsibilities of callers and professionals, see the Callers' Bill of Rights.

Many 911 communications centers retain information on calls for a certain period afterward, but often do not have the capacity or technological feasibility to keep recording calls once they are transferred to 988. Similarly, 988 centers are unable to get information about the outcomes of many situations once they have transferred a call to 911. Most 988 centers operate their own internal databases, but sometimes their capability to obtain data for calls transferred to 911 is limited to simply calling back and requesting updates.

The primary technological barriers to maintaining data for quality assurance come from disjointed technical systems. The lack of unity between 911 and 988 infrastructure means that there is rarely a streamlined, automated process for data sharing. Additionally, some 911 and 988 centers lack the capability to record calls or collect data during transfers. Perhaps most importantly, collecting and sharing data poses a risk to callers, including privacy and safety; technology advancements in data sharing and collection across the two entities should ensure that there is oversight.

CONCLUSION

988 is increasingly serving a unique and important role in the crisis response landscape. It operates as a dedicated hotline that provides callers with appropriate care and relief from distress. It also has the potential to reduce unnecessary law enforcement involvement, which can promote trust in accessing help in communities with strained relationships with law enforcement. The majority of 988 contacts are resolved over the phone, offering a less expensive model that promotes safety, could potentially be applied to future 911 virtual response or telehealth options. Public awareness of 988 is low, but utilization is growing. In pursuit of the commitment to providing relief from distress, it is important to acknowledge current challenges facing 988 and pursue strategies to mitigate them.

This report highlights insights provided by the Inform988 COPE, which included 988 and 911 practitioners, government representatives, researchers, and advocates from geographically diverse areas. The COPE focused on examining needs and gaps at the intersection of 988 and 911, particularly related to connecting 911 and 988, staffing 988, and achieving the right response at the right time. Drawing on insights offered by COPE members, this report outlines several challenges to successful interoperability at the human-level, system-level, and technology-level. It also presents several case studies, strategies, and solutions to address challenges and gaps associated with 988's rollout and continual operations.

The national landscape has shifted considerably since this work initially began in 2023, as have federal resources. Recent cuts to SAMHSA and 988's federal infrastructure, as well as to the LGBTQ+ youth suicide lifeline, introduces new challenges for which both 911 and 988 must now contend. While the national landscape has changed, this report still serves as a meaningful guide for 911 and 988 professionals—particularly those at the local level—and other interested parties committed to providing relief from distress and improving coordination across crisis care systems.

We hope this report can be used in a myriad of ways by ECCs, 988 centers, and the professionals who run these centers. Firstly, the report can be used to understand challenges and opportunities at the intersection of 911 and 988 as identified by a diverse national cohort of its practitioners and experts. Secondly, the report allows ECCs and 988 centers to reflect on their current system designs and guide their interoperability policies and practices. Lastly, we hope the report will be used to inform future policy making in this space, across local, state, regional, and national levels. Drawing on best practices from 988 centers across the country, we believe the report provides a comprehensive overview of 988 systems nationwide and offers valuable lessons for every professional engaged in this impactful work.

CONCLUSION

Research Questions for Future Study

Over the course of the Inform988 COPE discussions, it became clear that more information was needed to advance the field. The broad coalition of COPE members identified the following future directions of work:

1. What strategies are most effective in promoting call transfers from 911 to 988?

2. What are the most effective ways for communications centers (911 and 988) to share data to monitor progress in transferring calls and identify ways to increase transfers where appropriate?

3. What is the impact on call volume when 911 Emergency Communications Centers transfer calls to 988? How many calls come back from 988 that are originally transferred to 988 by 911?

4. What strategies and training modules are most effective in supporting both the long-standing 911 and the emerging 988 workforces to ensure that they are both prepared for their roles, able to interface with each respective hotline and their respective operations, and that their occupational wellness is supported?

5. What capacity are 911 and 988 communications centers typically staffed at, and how can we ensure full coverage?

6. What strategies are most effective in promoting trust in community members to contact 988 or to feel comfortable in being transferred to 988 from 911?

7. What are the facilitators and barriers to effective service delivery between 911 and 988?

As an outgrowth of this work, Health Lab is working in partnership with the members of both the Inform988 and Transform911 communities to advance research and practice that will specifically examine some of these operational and evaluative questions for the first time. We are excited to continue this important work with our invaluable partners. Understanding the answers to these questions will foster a richer understanding of the landscape, and how to best provide relief from distress to all who seek crisis care and services and professionals responsible for providing such access. Please continue to check the Transform911 website to learn about new projects and updates as this body of work continues.

APPENDIX A. INFORM 988 COMMUNITY OF PRACTICE AND ENGAGEMENT (COPE) MEMBERS

Below is a list of members of the Community of Practice, as well as their titles and affiliations.

Amin Shariff
Former Law Enforcement and Public Safety Liaison, Rocky Mountain Crisis Partners (RMCP)
Denver, CO
Amin's law enforcement career spanned twenty-six years, all with the Arapahoe County Sheriff's Office. During his time there, Amin had the opportunity to become trained in CIT (Crisis Intervention Team). He has continued to maintain his connection to law enforcement as a CIT coach and continues to help bring this valuable training to members of the public safety community across the state. In his recent role as a Law Enforcement and Public Safety Liaison at Rocky Mountain Crisis Partners, Amin worked to foster partnerships and build trust between the public safety and crisis systems.

Amy Watson
Professor, Wayne State University School of Social Work
Detroit, MI
Amy Watson, PhD is a professor in the School of Social Work at Wayne State University. Trained as a social worker and mental health services researcher, she has focused on the experiences of people with serious mental illnesses and interventions to reduce their involvement in the criminal legal system. This has included research on police response to mental health crises, the Crisis Intervention Team model, mental health courts and re-entry programs. Her current work is focused on developing crisis response services that do not require law enforcement involvement.

Watson recently served as president of the CIT International Board of Directors and is currently president of the board of Crisis Intervention Programs and Training. She has authored over 100 publications. Earlier in her career, she worked as a probation officer on a team serving clients with serious mental illnesses.

Annette Love
Chief Clinical Officer, Community Counseling Centers of Chicago (C4)
Chicago, IL
Dr. Annette Love has served in many capacities of behavioral health, community mental health, and private practice over the last twenty years. With an emphasis in program development, Dr. Love has spearheaded a variety of programs for agencies such as intensive outpatient, mobile crisis, assertive community treatment, and other critical mental health programs. Trained and licensed as a Clinical Professional Counselor since 2007, Dr. Love has also had the experience of providing direct services while licensed in multiple states. Dr. Love continues to offer sustainability and growth strategies through program and organizational development. Dr. Love's last fifteen years of experience consist of multiple supervisory and directorial roles, ultimately leading to her service today as Chief Clinical Officer at C4.

Ashley-Laren Smalls
Former Program Manager of 911 Engagement, 988 Suicide and Crisis Lifeline, Vibrant Health
Charlotte, NC
Ashley-Laren Smalls is an independently Licensed Clinical Mental Health Counselor and a National Certified Counselor in the state of North Carolina. She worked at Vibrant Emotional Health, the administrator of 988, as a Program Manager for 911 Engagement. In that role, she focused on supporting 988 Lifeline Centers in building relationships with their local ECC to ensure those in crisis have equitable and appropriate crisis response. Ashley has worked in the crisis intervention world for a decade and has experience working at National Suicide Prevention Lifeline (NSPL) Centers (now known as 988 Lifeline Centers) where she served in multiple roles such as a crisis counselor, clinical risk specialist, and a manager. Beyond the professional realm, Ashley enjoys traveling and volunteering. Some of her favorite travel places include Belize and Thailand, where she was able to learn more about community mental health agencies and spend time bathing elephants.

Belinda McGhie
Director, City of Tulsa 911 Public Safety Communications
Tulsa, OK
Belinda McGhie holds over 30 years of experience as a business professional in the fields of information technology (IT), project management, and public safety. She has served the City of Tulsa since 2000 and was promoted to the position of Public Safety Communications (PSC) director in 2021. She previously held the positions of PSC systems manager (2014 to 2021) and IT project manager (2000 to 2014). Belinda sits on the Oklahoma 911 Management Authority Board and served as Vice Chair from January 2023 to December 2023. She also serves on the 9-1-1 Regional Board for the Tulsa area.

Belinda holds a Bachelor of Science in computer science and is a certified Project Management Professional (PMP). She is the recipient of the City of Tulsa's Michael P. Kier Blue Award for excellence in customer service. She is a graduate of Leadership Tulsa class 51 and a graduate of the City of Tulsa's Leadership U. Prior to joining the City of Tulsa, Belinda was the senior network/technology analyst for Parker Drilling Company and systems analyst for Mid America Pipeline Company (MAPCO).

Budge Currier
Public Safety Communications Consultant, Emergency Technology Consulting
Greater Sacramento, CA
Since 2011, Budge has served with the California Office of Emergency Services (Cal OES). In his most recent role as Assistant Director of Public Safety Communications, Budge was responsible for the statewide public safety radio systems and microwave network that support state agencies, the 9-1-1 system that supports 438 Public Safety Answering Points in California that respond to over 27 million 9-1-1 calls per year, and the Emergency Communications Division. Budge also served as the California Statewide Interoperability Coordinator (SWIC). Budge has over 30 years of communications experience, a Bachelor of Science in Computer Science from University of Michigan, and a Master's degree in Electrical Engineering from the Naval Postgraduate School in Monterey, CA. Budge is a member of NENA, APCO, and NCSWIC. Budge also served as the President of the National Association of State 9-1-1 Administrators (NASNA).

Candace Coleman
Community Strategy Specialist, Access Living
Chicago, IL
Candace Coleman is a black disabled woman from the South Side of Chicago. She works closely with disabled people affected by the justice system to organize around racial justice and disability. This work includes anti-bullying, the school-to-prison pipeline, restorative justice, police brutality, and deinstitutionalization. She is dedicated to teaching disabled people of color to take pride in all aspects of their identities so they can become leaders themselves.

Coleman's most notable work involves organizing around mental and behavioral health emergency response. She played an integral role in passing the Community Emergency Services and Supports Act (CESSA) in 2021. She continues to work diligently to implement non-police alternatives to emergency response in mental and behavioral health crises.

Chris Coleman-Sandwell, Steering Committee Member
Officer of Special Projects, Behavioral Health Response
St. Louis, MO
Chris Coleman-Sandwell is an experienced leader with a demonstrated history of working in the mental health care industry. She is a licensed professional skilled in Nonprofit Organizations, Crisis Intervention, Family Therapy, Training, Risk Management, HIPAA, and Case Management. Before taking on her role at Behavioral Health Response (BHR), she served as a coach and consultant for LivingWorks for 12 years and was the Director of Accreditation and Training at the American Association of Suicidology.

Dan Fichter
Founder, CrisisCrowd
Brooklyn, NY
Dan Fichter has created https://crisiscrowd.org and https://4amfund.org and served as head of engineering at The Trevor Project and on SAMHSA's 988 team, where his focus was on supporting a deeper understanding of the relationship between hotline policies and quality of care and on sustainable support for front-line crisis counselors. He is now conducting independent research that centers the experiences and ideas of crisis counselors. Previously, he was head of product and chief technology officer at Moat, growing a global team of 200 engineering, product, data science, and operations staff and helping lead the company from its earliest stage to its acquisition by Oracle.

Eric Rafla-Yuan, Steering Committee Member
Staff Psychiatrist, San Diego County Psychiatric Hospital; 988 Technical Advisor, California Governor's Office of Emergency Services
San Diego, CA
Eric Rafla-Yuan, M.D. is a board-certified physician, award-winning researcher and educator, and a nationally recognized policy expert. He is a voluntary assistant clinical professor in the Department of Psychiatry at the University of California (UC) San Diego, where he founded and led the psychiatry residency diversity committee. In this role, he teaches physicians and medical students, as well as social workers, nurses, and other professional students. He graduated medical school and completed additional training in bioethics at the Vanderbilt University School of Medicine. He completed residency training at the UC San Diego Community Psychiatry Program.

Jackie Seitz
Deputy Director of Health Privacy, Legal Action Center
New York, NY
Jackie advocates for privacy rights for people who use drugs and people living with HIV. In leading the Legal Action Center's (LAC) health privacy legal work, she provides legal counsel, training, and technical assistance on federal and state health privacy laws. She has also advised and represented individuals following a breach of their health privacy. Jackie supports LAC's legislative and policy work to strengthen privacy protections for criminalized and stigmatized health information. She co-edits Legal Action Center's book on privacy protections for substance use disorder treatment, Confidentiality and Communication (8th edition).

Jeanne Milstein
Director of Human Services, City of New London, CT
New London, CT
Jeanne is currently the Director for Human Services in the City of New London. Prior to this position, Jeanne was Director of Special Projects and Staff Researcher at the Tow Youth Justice Institute, University of New Haven. She served at Connecticut's Office of the Child Advocate from 2000 until 2012, an independent state agency responsible for overseeing the care and protection of children. Jeanne has led efforts to reform the foster care, juvenile justice, and mental health systems for children and youth. In addition, Jeanne served as the Deputy Commissioner of Strategic Planning and Policy Development for the Office of Children and Family Services in New York State. Jeanne has also served as the Director of Government and Community Relations at the Department of Children and Families; Legislative Director at the Connecticut Commission on Children; Director of Government Relations at the Permanent Commission on the Status of Women; and Director of the Women's Center of Southeastern Connecticut.

Jessica Gimeno
Mental Health Policy Analyst, Access Living
Chicago, IL
Jessica Gimeno, MPPA, has devoted her life to the causes of mental health and health equity through writing, keynote speaking, and nonprofit work. She started her blog, Fashionably ill ®, in 2012 where she writes and vlogs about surviving pain with style and humor. Previously, Jessica wrote for The Huffington Post. She is most known for her award-winning TEDx Talk, "How to Get Stuff Done When You Are Depressed." Jessica has been featured on various national media outlets including NBC News, PBS, and MSNBC. Jessica's policy interests include mental health parity, child and adolescent mental health, and advancing the implementation of Access Living's legislation CESSA—the Community Emergency Services and Supports Act.

Previously, Jessica worked on HYPE, Helping Youth on the Path to Employment—a program from UMass Chan Medical School that helps young adults with serious mental illness find meaningful employment and become self-sufficient. Jessica also used to work for the Child & Adolescent Bipolar Foundation (now part of Depression and Bipolar Support Alliance, DBSA). For her advocacy, Jessica won Second Prize in Achievement in the National Council of Community Behavioral Health's Awards of Excellence. Jessica earned a B.S. in Communications and a Master of Arts in Public Policy & Administration from Northwestern University. Jessica is currently earning a post-baccalaureate certificate in counseling & psychology from The University of California, Berkeley.

Julie Phillips
Shared Services Program Director, Mid-America Regional Council
Kansas City, MO
Julie Phillips is the Shared Services Program Director at the Mid-America Regional Council in Kansas City, Missouri. She currently serves as project director for a SAMHSA-funded Community Crisis Response Partnerships Grant, facilitating collaboration of mobile crisis response across five behavioral health clinics in the Kansas City metropolitan region. The collaboration is focused on consistent delivery of mobile crisis services across the four counties served by the five CCBHOs in partnership with CommCare, the regional 988 call center. In addition, the collaboration is building partnerships with local law enforcement and fire/EMS districts to work towards diversion of 911 calls to 988, when appropriate.

Prior to moving to Kansas City, Julie led a coalition in Longmont, Colorado focused on community mental health education and awareness. She also served as the chair of the Boulder County Voluntary Organizations Active in Disaster, a collaboration of local government, disaster response agencies, and local nonprofits focused on disaster preparedness, recovery, and resilience. She has a Bachelor of Arts in Social Science from Westmont College and a Master of Arts in Public Administration from St. Mary's University of Minnesota.

Keris Jän Myrick, Steering Committee Member
Senior Vice President of Partnerships, Inseparable
Los Angeles, LA
Keris Jän Myrick is the Vice President of Partnerships at Inseparable, policy liaison for the National Association of Peer Supporters, and on the Board of Mental Health American. Recently, she was Co-Director of S2i, The Mental Health Strategic Impact Initiative. Prior to this, she was a Peer and Allied Health professional for the County of Los Angeles' Department of Mental Health and a Director of Consumer Affairs for the Substance Abuse and Mental Health Services Administration (SAMHSA). She has received a B.B.A at the Fox School of Business at Temple University, an MBA at the Weatherhead School of Management at Case Western Reserve University, and a PhD at Alliant International University.

Kristin Bronson
Executive Director, Colorado Lawyers Committee
Denver, CO
Kristin M. Bronson is a civic leader, community advocate and civil litigator with over twenty-five years of experience. She joined the Colorado Lawyers Committee in May 2023 after serving as Denver's City Attorney for six years. As the City's Chief Legal Officer, she provided legal and policy advice to elected officials, appointees, and senior managers while managing a large legal department. Ms. Bronson also led a number of key initiatives including the formation of the Denver Immigrant Legal Services Fund, the development of a comprehensive citywide youth violence prevention plan, and two national non-partisan convenings of legal experts on voting rights and election integrity. Ms. Bronson practiced law at Lewis Roca Rothgerber Christie LLP for nearly twenty years and is a trained mediator and arbitrator.

Laura Kane
Chief Executive Director, Marshmallow's Hope
Rockford, IL
Laura Kane started Marshmallow's Hope in memory of her son Zachary Ryan Birkholz, a 14-year-old Harlem Freshman who died by suicide in 2018. Sadly, Laura was unaware that her child was suffering in silence. After Zachary's death, she began to post motivational messages on social media through her son's Snapchat Shadow313zc and on her personal Facebook. Her goal was to encourage kids in the community to reach out for help and stay alive. But to her surprise, kids began to open up to her about their own struggles with depression, anxiety, trauma from abuse, their battle with self harm, addiction, and suicidal ideations. Parents of hurting children also began to reach out to her for help.

She began to educate herself on these topics and quickly realized that her community has a huge need for resources to help kids who are struggling and need mental health-related services. She knew that she had to make a change for these kids and help in a big way, thus the birth of Marshmallow's HOPE. Her commitment is to help kids like her son Zachary stay alive and live out their purpose as no parent should ever have to go through this type of pain. She is committed to helping survivor families as well, as she knows that the journey is a difficult one, and offers them her support.

Leah Pope
Associate Professor, Columbia University; Research Scientist, NYS Office of Mental Health
New York, NY
Leah G. Pope, Ph.D., is a research scientist and associate professor of clinical behavioral medicine at the New York State Psychiatric Institute and Columbia University's Department of Psychiatry. As an anthropologist and mental health services researcher, her work is primarily focused on the intersection of the mental health and criminal justice systems and the development of police-based and alternative crisis response services for people with serious mental illnesses. Dr. Pope earned a Ph.D. in applied anthropology from Teachers College, Columbia University.

Lora Ueland, Steering Committee Member
Former Executive Director, Valley Communications Center 911 (retired)
Kent, WA
Lora Ueland is the former Executive Director of Valley Communications Center 911 in Kent, Washington. She began her career as a dispatcher at Valley Com and has held multiple roles, culminating in her position as Executive Director from 2011 to 2024. Lora is a past-president of the Washington APCO/NENA Chapter, charter board member of the Puget Sound Emergency Radio Network Operator, and actively worked to bring new ideas, technology, and practice to the 911 Industry. With nearly 40 years of experience in the 911 field, Lora has earned APCO certifications as a Registered Public-Safety Leader and Certified Public-Safety Executive. Continual improvement, growth mind-set and being of service are part of Lora's core values.

Lori Jump
Chief Executive Officer, Strong Hearts Native Helpline
Sault Saint Marie, MI
Lori Jump, a citizen of the Sault Ste. Marie Tribe of Chippewa Indians, is the Director of the StrongHearts Native Helpline. She brings a wealth of tribal advocacy experience to StrongHearts, having worked for 25+ years as the Program Manager of the Advocacy Resource Center (ARC).

The ARC is a comprehensive victim services program for the Sault Ste. Marie Tribe, providing advocacy, shelter and civil legal representation for victims of domestic and sexual violence. Lori is also a founding member and former Executive Director of Uniting Three Fires Against Violence (UTFAV), Michigan's tribal coalition. UTFAV provides training, technical assistance and resources to support tribal programs in responding to domestic and sexual violence. Lori now serves as a board member for UTFAV.

Madyson Ganeles
Former Law Enforcement & Public Safety Liaison, Rocky Mountain Crisis Partners
Denver, CO
Madyson spent 6 years as a Law Enforcement Officer, gaining experience as a jail deputy, a patrol officer, and as a parole officer. While working for the Colorado Department of Corrections (CDOC), Madyson had the opportunity to become CIT Certified and has since become a CIT Training Coach. In 2021, Madyson was recruited by Rocky Mountain Crisis Partners (RMCP), where she continues to spend her time providing support to individuals calling Colorado Crisis Services and 988. Madyson was later part of a two-person team at RMCP that developed a statewide call diversion program between 988 and 911, bridging the gap between mental health crisis and emergency services.

Margie Balfour
Executive Policy Advisor, Connections Health Solutions; Founder and Principal, MultiPass Consulting
Tucson, AZ
Dr. Margie Balfour is a psychiatrist and national leader in quality improvement and behavioral health crisis care. She is Chief of Quality and Clinical Innovation at Connections Health Solutions and an Associate Professor of Psychiatry at the University of Arizona. Dr. Balfour was named Doctor of the Year by the National Council for Behavioral Health for her work at the Crisis Response Center in Tucson and received the Tucson Police Department's medal of honor for helping law enforcement better serve people with mental illness. She contributes to expert panels for SAMHSA and the Department of Justice. Her pioneering work on crisis metrics has been adopted as a national standard, and she co-authored Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards, and Best Practices. Dr. Balfour is a Distinguished Fellow of the American Psychiatric Association and serves on the Quality-of-Care Council.

A native of Monroe, Louisiana, Dr. Balfour earned a BA in Biology at Johns Hopkins University followed by her MD and PhD in Neuroscience from the University of Cincinnati. She completed residency and fellowship in Community Psychiatry at the University of Texas Southwestern Medical Center in Dallas.

Matt Fishback
Public Policy Manager, Cook County Sheriff's Department
Cook County, IL
Matthew Fishback is a Public Policy Manager at the Cook County Sheriff's Department in Illinois. He received a Bachelor of Science in Criminology and a Master of Public Administration from the University of Illinois Chicago. In the past, he has worked on several 988 implementation committees in Illinois.

Melissa Beck
Executive Director, Sozosei Foundation
New York, NY
Melissa is the inaugural Executive Director of the Sozosei Foundation. She brings 20 years of experience in the nonprofit sector, managing and growing large-scale, nonprofit and philanthropic organizations. Prior to joining the Sozosei Foundation, she served as Executive Director of The Educational Foundation of America (EFA), a family foundation that supports a range of organizations through grantmaking and impact investing activities. Before joining EFA, Melissa was CEO of Legal Information for Families Today (LIFT), a nonprofit organization dedicated to enhancing access to justice for children and families throughout New York State. Prior to her role at LIFT, she championed criminal justice reform on a national and local scale with a focus on decriminalizing mental illness.

Monica Luke
Mental Health Advocate
Boston, MA
Monica Luke is a mental health advocate focusing on financial barriers to accessing mental health care. Activities include legislative advocacy, parity enforcement and creative approaches to expanding payment models and commercial insurance coverage. Monica is on the Steering Committee for CORE Mental Health, focused on racial equity and mental health and is a consultant with Massachusetts Association for Mental Health. She co-chairs the Massachusetts Mental Health Coalition. Monica works as a volunteer paralegal with Health Law Advocates supporting parity complaints and denial reversals.

Neil Olson
Former Senior Director of Strategic Initiatives, Crisis Connections
Seattle, WA
Neil Olson has a diverse work experience in the field of social work, with roles in various organizations. In their most recent position at Crisis Connections, they served as the Senior Director of Strategic Initiatives and previously held the role of Senior Director of Clinical Operations. Before that, they worked at Kitsap Mental Health Services as the Director of 24/7 Recovery Services and also served as a Program Manager for both Adult+Youth Inpatient Units and Adult Inpatient Unit. Prior to this, they worked at DESC (Downtown Emergency Service Center) as a Project Manager-Crisis Diversion Facility and as a Clinical Supervisor.

Richard Ray
Co-Chair, National Emergency Number Association (NENA) Accessibility Committee; Member, FCC Disability Advisory Committee
Los Angeles, CA
Richard Ray is currently serving as a co-chair of the National Emergency Number Association (NENA) Accessibility Committee and is a member of the Federal Communications Commission (FCC) Disability Advisory Committee. Prior to this work, he retired from the City of Los Angeles after serving over 35 years as an Americans with Disabilities Act Technology Access Coordinator while working in the field of Telecommunication Technologies, Emergency Services and advocating for civil rights of individuals who are deaf, deafblind, and hard of hearing in all levels of government. He has also served on the FCC Emergency Access Advisory Committee, North American Numbering Council - Interoperable Video Calling Working Group, Emergency Access Advisory Committee, Emergency Communications Subcommittee and Optimal Public Safety Answering Point Architecture Task Force. He is involved in projects such as Text to 9-1-1, Real-Time Text to 9-1-1, Next Generation 9-1-1, and Emergency Notification Systems.

Robert McClintock
Assistant to the General President for Technical Assistance and Information Resources, International Association of Fire Fighters
Washington, DC
Robert McClintock served as Director of Fire and EMS Operations for the IAFF from 2021 to 2025, previously serving as a fire-based EMS specialist since 2015. Prior to joining the IAFF, McClintock retired as a captain after a 25-year career with the City of Hackensack Fire Department. He served as vice president of Hackensack, NJ Local 2018 and as a trustee for Hackensack Fire Officers Local 3172. Robert also worked at MONOC, a paramedic agency in New Jersey, serving in multiple positions over a 17-year career, including EMT, paramedic, 9-1-1 dispatcher, communications coordinator and operations coordinator for the agency's South Division. McClintock has a baccalaureate degree in business administration from the University of Phoenix. In addition, he is a nationally registered paramedic and an emergency medical dispatch instructor for Priority Dispatch.

Roberta "Toni" Meyers Douglas
Vice President of State Strategy and Reentry, Legal Action Center
Stockbridge, GA
As the Vice President of State Strategy and Reentry, Roberta "Toni," executes strategic state-based criminal justice and health advocacy goals and priorities for LAC. She also directs the National Helping Individuals with criminal records Reenter through Employment (H.I.R.E.) Network, LAC's national project to improve employment and other opportunities for people with arrest and conviction records. She has decades of experience training workforce development, corrections, and behavioral health practitioners on employment strategies that best serve job-seekers with arrest and conviction histories; authored dozens of guidebooks and policy briefs on criminal record policies that impact employment, housing, education, and other opportunities; testified before and served as a technical assistance provider to members of Congress, government agencies, and state legislators about effective reentry policies and practices that reduce recidivism; and more importantly, works closely with community and directly impacted leaders within communities to strengthen and support their ability to organize and mobilize around critical issues that impact Black, Brown, Indigenous and other people of color. She co-leads LAC's No Health=No Justice campaign to achieve racial equity in health care and criminal legal reform.

Shannon Scully
Director of Justice and Policy Initiatives, National Alliance on Mental Illness
Washington, DC
Shannon Scully is the Director of Justice and Policy Initiatives at the National Alliance on Mental Illness (NAMI), where she serves as a subject matter expert, providing strategic guidance across the organization regarding NAMI's criminal justice, diversion and crisis response policy. She works closely with key federal agencies and Congress to advance NAMI's priorities and supports leaders across the NAMI Alliance to increase their impact on local and state policies. Prior to joining NAMI, Ms. Scully worked for several other national non-profit organizations on various justice-related issues. She began her criminal justice career supporting victims of crime in the county courts in Cook County, IL. Ms. Scully holds a bachelor's degree from the College of St. Benedict and a Master of Public Policy from American University.

Tansy McNulty
Founder, 1 Million Madly Motivated Moms (1M4)
Washington, DC
1M4 empowers Black Moms to end police violence by the year 2038 through legislative policy education, financial assistance to impacted families, and encouraging the next generation of Black youth to pursue roles in the justice system & politics with integrity. This type of activism and organizing requires that Black Moms protect their greatest weapon in the fight… their mental health. 1M4 gives Moms a place to air their frustrations with recurring police violence, create solutions that have measurable impact, and prioritize their mental health to maintain peace of mind despite the chaos of inequality.

With a background in Corporate Supply Chain Management, emphasis on cost reduction and process improvement initiatives, Tansy is a problem solver who simply wants to save Black lives and create a more equitable justice system.

Tiffany Patton-Burnside
Senior Director of Crisis Services, Chicago Department of Public Health
Chicago, IL
Tiffany Patton-Burnside is a Senior Director of Crisis Services at the Chicago Department of Public Health, where she has been working since August of 2021. Prior to this, she served as the Director of Community Based Behavioral Services at Human Resources Development Institute, Inc. (HRDI) for seven years, a Clinical Program Manager at Assist Her, Inc. for over four years, and was a Behavioral Specialist at the UCP Seguin of Greater Chicago for eight years. Burnside holds a Master's Degree in Social Work from Dominican University.

Tiffany Russell
Chief Officer of Crisis and Justice Initiatives, SAMHSA
Washington, DC
Tiffany Russell is a Chief Officer of Crisis and Justice Initiatives at the Substance Abuse and Mental Health Services Administration (SAMHSA). Prior to this position, Russel worked as a Project Director for the Mental Health and Justice Partnerships Initiative at the Pew Charitable Trusts. Russel also served as a Director for the Planning and Development Division and as a Public Information Officer at the Superior Court of Fulton County. Russell received a Bachelor of Science in Organizational Leadership at Mercer University and an MBA at the Stetson School of Business and Economics.

Tina Orwall
State Representative, Washington State
Seattle, WA
Tina has represented the 33rd district of Washington State since 2009. She introduced HB 1477 to improve Washington state's suicide and behavioral health crisis response system by implementing the National Suicide Hotline Designation Act, which had designated 988 as the new national suicide prevention and mental health crisis hotline number. Tina has worked with all levels of government to help embrace best practices to better serve the community. Her 20 years of experience working in the public mental health system, as well as her expertise in strategic planning in workforce development and affordable housing, have established her as a valued legislator and community leader.

Vesper Moore
Chief Operating Officer, Kiva Center
Boston, MA
Vesper Moore currently serves as the Chief Operating Officer at Kiva Center. They also serve as a Board Member for the Bazelon Center for Mental Health Law, a Special Commission on State Institutions Member with the Commonwealth of Massachusetts, a Board member of the National Association for Rights Protection and Advocacy and a Board member of MindFreedom International. They received a Bachelor of Science in Health Science at the University of the People.

Victoria Palacio Carr
Deputy Director of State Strategy, Legal Action Center
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As the Deputy Director of State Strategy at the Legal Action Center (LAC), Victoria leads the development of partner engagement strategies and serves as project manager for the No Health = No Justice campaign and the Black Harm Reduction Network. In her role, she works to advance state-based health and criminal justice reform and policy solutions. Victoria first joined the LAC in 2018 as the State Advocacy Coordinator. Prior to working at the LAC, she was a research assistant at the Center for Law and Social Policy, where she supported advocacy efforts on improving access to work support programs for low-income communities and justice-involved populations.

APPENDIX B. INFORM988 COPE PLANNING ARC

The following table provides an overview of COPE discussions, broken down by each meeting, its topic, the facilitator(s), and the related discussion questions. This discussion structure was created in partnership with our Steering Committee. The COPE used the Planning Arc to guide discussion and ensure that key questions were addressed.

Meeting	Questions
Introductions and project information	• Introductions • Discuss goals • Audience recommendations • Introduce format of meetings: What is the state of things? What are the problems/issues/barriers? Why are these occurring? How do trust, partnership and equity arise in this context? • Establish a recurring meeting time
Interoperability opportunities Facilitated by Tiffany Russell	• Define interoperability. • Are there regulations in 988 that govern how imminent threat calls will be handled? • What other call routing and triaging protocols in 988 centers determine which calls are transferred to 911? From 911 to 988? • What are the Issues/Problems/Barriers (the WHY) related to interoperability? (e.g., tech, trust in response offered by another system, different location information) • When might it be appropriate to transfer calls from 988 to 911? When might transfer be appropriate from 911 to 988? • When are these transfers not appropriate? • How do trust, partnership and equity arise in this context?
Data sharing and documentation Facilitated by Melissa Reuland	• When a call is transferred from 988 to 911, what data are/should be/should not be shared? • What data are/should be/should not be shared when a call is transferred from 911 to 988? • How are the data shared and how is it protected? What sort of data sharing agreements need to be in place given the requirements of the Criminal Justice Information System (CJIS) and Health Insurance Portability and Accountability Act (HIPAA) data protection guidelines for 911 and 988 data respectively? • How do 988 and 911 centers track and document data on calls transferred between them to enable reporting on outcomes and assess need for improvements (QA)? • How do trust, partnership and equity arise in this context?

Understanding the state of interoperability Facilitated by Budge Currier	• What barriers exist (policy, law, tech, trust, etc.) in interoperability between 911 and 988? • How can systems with different technologies—that were not designed for interoperability—work together? Or, what workarounds can be adapted to facilitate tech interoperability? • Do liability concerns affect how and when calls are transferred between 911 and 988? If so, how? • How do trust, partnership and equity arise in this context?
ECC/988 center capacities and relationships Facilitated by George Rice and Lora Ueland	• How does the number and size of 988 centers compare to the number and size of 911 centers in each state? Do these centers have capacity to handle need? • How is it determined which ECCs will transfer calls to which 988 centers? Do those same 988 centers transfer calls to those ECCs? • How do trust, partnership and equity arise in this context?
Call Transfer outcomes Facilitated by Amin Shariff and Madyson Ganeles	• Define warm hand off. • What happens on the 988 side when a call is transferred from 911? What could that response look like? Is there a protocol in place to guide this response? • How can we build trust between partners on what will happen with the call after it is transferred? • Are there instances where 911 and 988 are coordinating to respond (either in person or otherwise)? • How do trust, partnership and equity arise in this context?
Accessibility Facilitated by Howard Rosenblum	• How do 988 centers manage access for people who speak different languages or who would prefer to text? Are there differences between how 988 centers and ECCs manage language access, texting, and video content? • Do people know about 988 services (video remote service, onsite ASL interpreters)? • How is accessibility maintained when callers requiring these services are transferred to 911? • How do trust, partnership and equity arise in this context?
Interoperability with other services Facilitated by Eric Rafla-Yuan and Keris Myrick	• How does 988 interact with other existing mental health services, such as community crisis hotlines or service providers that do not have 988 accreditations? • How does 988 interact with other specialized services not related to mental or behavioral health? • Is 988 able to transfer calls to these other relevant service providers apart from 911? • How do trust, partnership and equity arise in this context?

Understanding the 988 workforce Facilitated by Dan Fichter	• What are the qualifications and experiences of the current 988 workforce? What kind of training do they get for their jobs? • Is there overlap in the qualifications and experience, and in recruitment methods, between the 988 and 911 pool of candidates? For example, are these two roles potentially pulling from the same candidate pool?
Sustainable employment Facilitated by Ashley-Laren Smalls	• What are the vacancy rates in 988 centers? What hiring strategies are 988 centers deploying to improve staffing? • What sustainable employment models exist, either within the 911 space or other hotlines, that can be borrowed by 988 centers? • Does 988 leverage a volunteer workforce? If so, what are the strengths and weaknesses of this model?
911/988 co-location Facilitated by Lora Ueland and Neil Olson	• What are the benefits and challenges of physical co-location of 988 and 911 workers? • How can we achieve physical co-location of 988 and 911 workers? What are the components of a sustainable co-location model? • How do trust, partnership and equity arise in this context?
In-Person response Facilitated by Annette Love	• The majority of 988 calls may be resolved over the phone, but what is happening with the remaining incidents? • What models exist for in-person responses? Who comprises the teams (training, roles, etc.)? Are these teams managed by 988 centers? Separate entities? • For those 988 centers that dispatch an in-person response, how do they determine the threshold for sending a response? What do those response teams consist of? • How do 988 in-person response teams track and manage data? What data are shared between 988 centers and in-person response teams? • Knowing that 988 does not capture precise location data, how could incident location be determined if a response is needed? • Who determines when a dispatchable location should be shared with 911?
Determining a response Facilitated by Tiffany Patton	• What kinds of 988-calls should have an in-person response? What calls can be handled virtually? • When is follow up appropriate? What information gets transferred from first to second responders? • Who should own the data?