988

Convening Playbook

Lifeline Contact Centers

NASMHPD

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988 Convening Playbook Lifeline Contact Centers

Overview

Goal: The document sets out to help:
- Articulate the need for operational readiness for 988
- Help Lifeline contact centers prepare for the 988 transition (not a specific mandate for them)
- Explain how to make progress on the criteria that are central to 988 readiness
- Identify best practices and examples seen in the field today

Audience: This document is intended for the directors and leaders of Lifeline contact centers

Structure: The document has three sections:
  I.   Operational readiness self-assessment
  II. Playbook
  III. Additional resources

Notes:
- *Equity:* The playbook aims to highlight equity considerations across topics, including how equity needs to be considered across all areas of readiness
- *Case studies and examples:* The playbook includes many case studies and examples from individual lifeline contact centers. Examples will not be applicable to all Lifeline contact centers
- *Resources:* The playbook includes links to the National Suicide Prevention Lifeline's Network Resource Center (NRC), a resource specifically for Lifeline contact centers (https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fhomepage.action).[1]

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[1] Access to the NRC is for Lifeline contact centers and can be set up by the Lifeline administrator.

Table of Contents

I. 988 operational readiness self-assessment for Lifeline contact centers

Introduction and purpose of the operational readiness self-assessment

The self-assessment tool is intended to assist Lifeline contact centers ("centers") in assessing their readiness for the July 2022 transition to 988 and prioritizing areas of focus moving forward.

The tool is <u>not</u> intended to be evaluative, and no responses will be collected or aggregated. There is neither a *perfect score* nor a *right answer*. The intent is solely to help Lifeline contact centers determine where they might focus efforts both ahead of July 2022 and beyond as the country moves toward integrated crisis care.

In addition, there is no time expectation associated with the self-assessment tool. Lifeline contact centers are working in different contexts and all have different priorities and needs related to 988 and integrated crisis care. The goal of this self-assessment tool is to help Lifeline contact centers define an aspiration unique to their locality, not prescribe any activities on a specific timeline.

Self-assessment levels

The self-assessment tool lays out a series of criteria within specific readiness categories that are aimed at holistically capturing components of readiness to realize the full potential of 988. For each criterion, centers can select from three distinct levels. Lifeline contact centers are asked to select the level that best approximates their current state.

- Beginning: Work in this area has not yet started
- Emerging: Work in this area is underway but not yet complete
- Solidified: Objectives in this area are fully or almost fully met

Some criteria reference specific services that may not be applicable to every organization. Each organization can choose to focus on the criteria that are most relevant for it.

Link to playbooks

The self-assessment categories match categories of information contained in the rest of the playbook document. The results of the self-assessment can be used to determine on which areas of the playbook centers should consider focusing in the immediate term.

For example, Lifeline contact centers who are "beginning" work within specific categories that they believe are important can use information from the playbook to chart a path to initiate activities aimed at achieving "emerging" readiness. Centers that are already "emerging" in certain categories can use the playbook to fully solidify their readiness in those categories.

Criteria

Criteria	Beginning	Emerging	Solidified
UNIVERSAL AND CONVENIENT ACCESS			
Reliable and timely response: All persons contacting 988 will be connected to professionally trained individuals reliably, efficiently, and in a timely manner.			
How **timely and efficient is the response** to Lifeline calls?	80 percent answered in 60 seconds or lower service level (e.g., <80 percent, >60 seconds)	90 percent answered in 60 seconds	90 percent answered in 15 seconds
What share (%) of Lifeline calls are **currently answered**?	Less than 70 percent of Lifeline calls are answered	70-90 percent of Lifeline calls are answered	More than 90 percent of Lifeline calls are answered
How does the center's **timeliness and efficiency of response on the Lifeline compare to its other lines of business** (LOBs), particularly those that are well-funded, if applicable?	Less timely and efficient response compared to other lines of business	Equally timely and efficient response compared to other lines of business	More timely and efficient response compared to other lines of business
Multi-channel availability: 988 will be accessible through various modalities based on individuals' needs and routed to network centers via a central administrator			
To what extent does the center provide **coverage for Lifeline calls**?	Does not provide coverage for Lifeline calls	Provides some, but not 24/7 coverage for Lifeline calls	Provides 24/7 coverage for Lifeline calls
To what extent does the center provide any **coverage for non-Lifeline texts**?	Does not provide coverage for texts	Provides some, but not 24/7 coverage for texts	Provides 24/7 coverage for texts
To what extent does the contact center provide any **coverage for non-Lifeline chats**?	Does not provide coverage for chats	Provides some, but not 24/7 coverage for chats	Provides 24/7 coverage for chats

Criteria	Beginning	Emerging	Solidified
HIGH QUALITY AND PERSONALIZED EXPERIENCE			
Tailored support: 988 will be a source of personalized, trusted support (e.g., tailored support for familiar callers, specialized services to meet functional, linguistic, or cultural needs)			
To what extent does the center provide and link individuals to **services** that are **person-centered** (culturally appropriate, linguistically appropriate, inclusive of support systems, etc.)?	No person-centered services or links to person-centered services are provided	Some person-centered services and/or links to person-centered partners are provided, but it is not 24/7 and/or only for a limited set of populations	Person-centered services and links to person-centered partners (including specialized services, warmlines, and peer-run resources) are provided 24/7 for a comprehensive set of populations
To what extent does the contact center have **training** to provide services that are **person-centered** (culturally appropriate, linguistically appropriate, inclusive of support systems, etc.) for groups with unique needs and/or at higher risk for suicide?[2]	No training to provide person-centered services or on how to identify links to specialty partners	Some training to provide person-centered services and/or identify links to specialty partners but only for a limited set of populations	Training to provide person-centered services and links to specialty partners (including warmlines and peer-run resources) are provided 24/7 for a comprehensive set of populations
How are **familiar contacts** identified and effectively served (e.g., ensuring that counselors are providing connections to long-term support when appropriate)?	No process in place to identify and provide specific assistance to familiar contacts	Familiar contacts are identified informally and plans for assisting and care coordination are prepared on an ad-hoc basis	Familiar contacts are identified through a formal process, and there is a standard procedure in place to review their needs and alert crisis counselors on how to best assist them, including collaborating on care coordination plans
How are counselors **trained to identify and effectively serve familiar contacts** (e.g., ensuring that counselors are providing connections to long-term support when appropriate)?	Crisis counselors do not receive training on best practices in working with familiar contacts	Crisis counselors receive informal training on best practices in working with familiar contacts	All crisis counselors receive formal training on best practices in working with familiar contacts

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[2] SAMHSA notes people at greater risk for suicide include but are not limited to: adults over the age of 45, American Indians, Alaskan Natives, veterans, LGBTQ+, youth and young adults, attempt survivors, loss survivors, and disaster survivors. Source: "People at greater risk of suicide," Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/suicide/at-risk; The National Suicide Hotline Designation Act of 2020 describes this group as "LGBTQ youth, minorities, rural individuals, and other high-risk populations," Source: "Text – S.2661 – 116th Congress (2019-2020): National suicide hotline designation act of 2020," Congress.gov, October 17, 2020, https://www.congress.gov/bill/116th-congress/senate-bill/2661/text.

Criteria	Beginning	Emerging	Solidified
To what extent does the center have a relationship with **Tribal reservation(s)** in the catchment area, as relevant?	Does not have any formal relationship or processes in place to identify and respond to Tribal needs	Has informal relationships and some processes in place to respond to Tribal needs (e.g., identifying individuals living on Tribal reservations, ability to connect individuals to Tribal resources for further support)	Has formal relationships and processes in place to identify Tribal contacts and route individuals to the appropriate Tribe's systems / services (e.g., Bureau of Indian Affairs vs. law enforcement, Tribe vs. State-run medical facility)
Consistency in line with best practices: All persons contacting 988 should receive care in line with best practices.			
How is the **risk of suicide assessed**?	Center uses suicide assessment tool that no longer meets Lifeline 2007 assessment standards or does not consistently use a compliant tool	Center uses suicide assessment tool that meets Lifeline 2007 assessment standards	Center uses suicide assessment tool that has been updated to reflect the Lifeline Safety Assessment (2018)
How does the center address **safety planning**?	Center does not use a safety planning process with callers / chatters / texters or provide training to crisis counselors on effective de-escalation and safety planning	Center uses an informal safety planning process with callers / chatters / texters and provides some training to crisis counselors on effective de-escalation and safety planning	Center uses a formal safety planning process with callers / chatters / texters and provides extensive training to crisis counselors on effective de-escalation and safety planning
Does the center have required policies in place addressing Lifeline contacts at **imminent risk of suicide**?	Center has policies in place that no longer meet Lifeline imminent risk requirements or does not consistently train in or use these policies	Center has policies in place that meet some but not all Lifeline imminent risk requirements and consistently trains in and uses these policies	Center has policies in place that meet all of the Lifeline imminent risk requirements and consistently trains in and uses these policies

Criteria	Beginning	Emerging	Solidified
How is **workforce** (e.g., crisis counselors, volunteers) **training** conducted to ensure best quality service? Lifeline-endorsed training includes the Safety Assessment site, simulation trainings, the QI monitoring instrument, ASIST, Lifeline training modules, and NRC tools.	No formal training in place OR Some formal crisis counselor training occurs, but does not incorporate any Lifeline-endorsed or developed training tools for staff responding to Lifeline contacts	Some formal crisis counselor training occurs. Training incorporates some Lifeline-endorsed or developed training tools for staff responding to Lifeline contacts	Extensive curriculum-based crisis counselor training occurs. Training consistently incorporates Lifeline-endorsed or developed training tools for staff responding to Lifeline contacts
How is **workforce** (e.g., crisis counselors, volunteers) **supervision** conducted to ensure best quality service?	No formal supervision is in place for workforce, and/or there is inconsistent access to a supervisor during all crisis counselor shifts	Supervision is accessible as needed for all team members, and a supervisor can be consulted at all times of center operation	Formal and consistent supervision meetings are in place for all team members, and a supervisor can be consulted at all times of center operation. Team members have real-time supervision and guidance for text / chat, as relevant
How are **dispatch or referral decisions** (e.g., facilitating real time connections to crisis care) determined (e.g., whether to dispatch a crisis mobile team (CMT) or rescue, to coordinate facility-based care or outpatient follow-up care)?	There is no consistent guidance on dispatch or referral decisions for contacts	Some staff may use an assessment protocol to determine dispatch or make referral decisions, but the assessment is not standardized or is not consistently used	Centers use an accepted assessment protocol to determine dispatch and make referral decisions
To what extent is there a **defined performance management strategy** (e.g., key performance indicators defined, data collected, data reported, frequency with which data is reviewed and acted on)?	No central performance management strategy	Data is collected and/or reported, but does not fit into a performance management strategy	Data is collected and reported against a defined set of key performance indicators (KPIs) and discussed and acted on consistently and at a regular schedule. A Continuous Quality Improvement (CQI) plan incorporates insights from data

Criteria	Beginning	Emerging	Solidified
To what extent does the center use the **performance management strategy** to implement continuous improvement and ongoing training programs guided by data (e.g., silent monitoring)?	No continuous improvement or ongoing training programs in place	Some data-driven continuous improvement and ongoing training programs in place	Data-driven continuous improvement and ongoing training programs are in place
How are **local collaborators** (e.g., government, public safety, providers) **included in regular performance management reviews** to improve systems efficiencies and effectiveness?	No arrangements nor regular meetings in place to develop / refine performance criteria and review potential systems improvements	Informal arrangements in place to develop / refine performance criteria and review potential systems improvements, but meetings and engagement with essential collaborators are not consistent or inclusive of key stakeholders	Formal arrangements in place to regularly develop / refine performance criteria to review potential systems improvements, and meetings and engagements with essential stakeholders are consistent and appropriately inclusive
CONNECTION TO LOCAL RESOURCES AND FOLLOW-UP			
Localized response: All persons contacting 988 will be connected to helpline support and additional local community resources as needed.			
What is the center's **relationship with local mobile crisis teams** (MCTs), if available?	Does not have a relationship with local MCTs	Has an informal relationship with local MCTs which enables it to make referrals to their services, but no formal agreement	Has a memo of understanding (or contract) with local MCTs or directly operates a CMT, enabling efficient referrals and exchange of information between services
What is the contact center's relationship with **CSRFs**, if available?	Does not have a relationship with local CSRFs	Has an informal relationship with local CSRFs and can make referrals, but no formal agreement	Has a memo of understanding with local CSRFs or directly operates a crisis receiving and stabilization facility, enabling efficient referrals and exchange of information between services

Criteria	Beginning	Emerging	Solidified
What is the process to coordinate **facility-based crisis care**?	No process in place to connect individuals to facility-based crisis care	A database or list of local facility-based crisis care referrals exists, but coordination is limited to referral (e.g., no warm handoff or coordination with facility)	A database or list of local facility-based crisis care referrals exists and coordination with facilities occurs through warm handoffs and/or direct coordination with facilities
Connection to local public health and safety services: 988 can connect to local public health and safety services to provide appropriate support while avoiding unnecessary law enforcement involvement, emergency department use, and hospitalization.			
What is the contact center's relationship with local **911 / Public Safety Answering Points (PSAPs)**, potentially including local ambulance and emergency medical services (EMS)?	Does not have a relationship with local 911 / PSAPs and local ambulances / EMS	Has an informal relationship with local 911 / PSAPs and local ambulances / EMS but no formal agreement	Has a memo of understanding with local 911 / PSAPs or works directly within 911 / PSAPs as well as local ambulances / EMS for relevant services, enabling efficient referrals and exchange of information between services
What is the process to **receive contacts from local 911 / PSAPs**?	No process in place given lack of formal agreement and/or technology capabilities	No process in place, but both PSAP entities and the center are interested in transferring 911 mental health (MH) contacts; however, they lack resources, technologies, or other capabilities	Process in place to receive MH crisis calls from 911
What is the contact center's relationship with **local emergency departments**?	Does not have a relationship with local emergency departments	Has an informal relationship with local emergency departments but no formal agreement that enables exchange of information between services	Has a memo of understanding with local emergency departments or works directly within local emergency departments, enabling efficient exchange of information between services

Criteria	Beginning	Emerging	Solidified
What is the contact center's relationship with **local information and referral services** (e.g., 211)?	Does not have a relationship with local information and referral services	Has an informal relationship with local information and referral services but no formal agreement	Has a memo of understanding with local information and referral services or works directly with information and referral services (e.g., co-located with or runs 211) Defined process in place to receive MH crisis contacts from local information and referral services (e.g., warm transfer services, information sharing, follow up contacts)

Follow-up as needed: As appropriate, persons contacting 988 may be offered follow-up services to facilitate on-going support and safety.

Criteria	Beginning	Emerging	Solidified
How is **crisis follow-up conducted**?	Does not provide crisis follow-up services	Sometimes provides crisis follow-up services on an ad-hoc basis but lacks standard protocols	Crisis follow-up services are provided according to standard protocols
What is the **process to coordinate outpatient follow-up care**?	No process in place to connect individuals to outpatient follow-up care	A database or list of local outpatient care exists, but coordination is limited to referrals (e.g., no warm handoff or appointment scheduling)	A database or list of local outpatient care referrals exists, and care coordination occurs through warm handoffs and/or appointment scheduling

FUNCTIONAL ENABLERS

WORKFORCE

Criteria	Beginning	Emerging	Solidified
What is the ability to **monitor and optimize efficiencies in staffing needs** to meet 988 demand?	Center does not currently have a workforce management system that can efficiently determine trends in service demands per shift	Center has a workforce management system (automated or manual) that helps determine trends in service demands per shift, though it still has gaps in staffing optimization	Center has an automated workforce management system that can efficiently determine service demands per shift

Criteria	Beginning	Emerging	Solidified
If hiring is identified as a challenge, what capability does the center **have to hire staff for in person, telework, or remote** (non-geographically limited) **roles**?	Center hires staff only or mostly only from the immediate community for in-person work. No significant telework / virtual roles available	Center hires staff mostly from the immediate community, but offers some limited telework and virtual roles	Center hires staff from the immediate community and is able to hire people across the state and country. Center supports virtual and teleworking roles as appropriate
How does **the center staffing (i.e., both paid and volunteer team members) align to service demand** / response needs?	Center frequently struggles to identify and hire the staff needed to respond to demand	Center generally has sufficient staffing but may have trouble identifying and hiring new staff as demand increases	Center continuously has sufficient staffing and can easily identify and hire new staff as demand increases
FINANCIAL SUSTAINABILITY			
To what extent has the **cost of 988 implementation** at the center (e.g., facilities costs, technology, staffing, administrative costs) been estimated and budgeted for?	The cost of 988 implementation has not been estimated or budgeted for	The cost of 988 implementation has been estimated but not budgeted for	The cost of 988 implementation has been estimated and budgeted for
To what degree is the **current funding strategy sufficient** for ongoing center operating costs?	Ongoing funding is insufficient to cover all center operating costs	Funding is in place to support short-term operations (<2 years), and considers Vibrant's expectations for the cost of 988 implementation (start-up costs)	Funding is in place to support longer-term operations (>2 years) and considers Vibrant's expectations for the cost of 988 implementation (start-up costs)
How does the center **receive ongoing funding**?	Ongoing funding is currently received from a single source	Ongoing funding is currently received through several sources, but is not predictable in the long-term	Ongoing funding is currently received from multiple, sustainable sources with recurring availability
TECHNOLOGY & DATA			
To what extent is the center's **local 988 contact documentation system coordinated** with the national 988 data-reporting needs?	Local contact documentation system is not readily capable of collecting and reporting the minimally required 988 data to the Lifeline (as per the Network Agreement)	Local contact documentation system is readily capable of collecting and reporting the minimally required 988 data to the Lifeline, but it does not use standardized data elements for Lifeline contacts	Local contact documentation system for 988 uses standardized data elements for Lifeline contacts

Criteria	Beginning	Emerging	Solidified
To what extent is **Automatic Call Distribution (ACD**) functionality implemented?	No ACD functionality incorporated	Limited functionality and/or plan to develop ACD functionality	ACD functionality incorporated
To what extent is **Caller ID functionality** implemented?	No Caller ID functionality incorporated	Limited functionality and/or plan to develop Caller ID functionality	Ability to ID every call received by call center
How are **contact summary data (**e.g., user inputs) **shared** with partners (e.g., 911 or other transport service, MCT, emergency departments or other receiving facilities, treatment facilities)?	Staff cannot send summary data to all partners, and there is not a plan to create this capability	Staff cannot send summary data to all partners, and there is a plan to create this capability	Staff can send summary data to all partners
How are **contact metadata** (e.g., caller ID, address, IP address) **shared** with partners (e.g., 911, MCT, treatment facilities, other transport services)?	Staff cannot send metadata to all partners, and there is not a plan to create this capability	Staff cannot send metadata to all partners, and there is a plan to create this capability	Staff can send metadata to all partners
How does the center **track and project contact volumes and performance metrics**?	No or limited ability to project or track contact volumes consistently across all channels (e.g., call, text, chat)	Contact volumes are projected and tracked across all channels (e.g., call, text, chat) through manual processes such as spreadsheets	Contact volumes are projected and tracked across all channels (e.g., call, text, chat) with forecasting software

II. Playbook for Lifeline contact centers

1. Workforce

Lifeline contact centers already face unique challenges related to workforce hiring, management, and retention. Optimizing the workforce will become even more critical with the expected volume increases associated with the 988 transition. The following section highlights potential approaches for contact centers to (1) accurately determine their staffing needs by using workforce management, and (2) address these needs through both hiring and retention.

Before implementing a workforce management strategy to determine how to optimize their use of their workforce, it is important for centers to accurately determine their staffing needs. To best determine these, a center can consider its staffing model (both the number of individuals needed and their distribution across functions) in the context of its service level goals. Centers can then evaluate their staffing model by looking at the number of team members per function to determine if the current distribution of team members supports the service level goals. For instance, they could assess the current balance between team members that answer contacts (e.g., counselors) and other team members (e.g., support, scheduling, training).

Embedding cultural and linguistic competencies is also critical in building and modifying a center's staffing model so it can best serve the community.

Additional information: Cultural and linguistic competency, including information about the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and free accredited online educational programs, is provided by the Office of Minority Health (https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6).[3]

Workforce management strategy and systems

Workforce management strategy

Lifeline contact centers can implement a workforce management strategy that efficiently identifies trends in service demands at a per-shift level.

Key steps in workforce management are described by Vibrant Emotional Health, the current operator of the National Suicide Prevention Lifeline (NSPL). They include:[4]
- Forecast call volume (or "traffic load") for multiple 15- to 30-minute intervals
- Determine staffing levels for each interval (number and types of agents)

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[3] "Cultural and linguistic competency: National CLAS standards," U.S. Department of Health and Human Services, Office of Minority Health, last modified December 30, 2021, accessed February 7, 2022, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6.

[4] National Suicide Prevention Lifeline, Vibrant Emotional Health, and Substance Abuse and Mental Health Services Administration, "Crisis call center metrics: Part 1. Service and efficiency," accessed Feb. 7, 2022, https://suicidepreventionlifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf.

- Schedule call center agents
- Monitor and manage performance in real time, as needs fluctuate
- Evaluate strategy by asking questions such as:
    - Is the software functionality adequate?
    - Were shifts covered?
    - Were performance measures met?
    - Are there any interesting trends in call volume data?

Workforce management (WFM) systems[5]

Workforce management systems support the effective implementation of workforce management strategies. Workforce management systems generally:
- Support forecasting, monitor performance, and manage day-to-day assignments and scheduling
- Operate in an automated way
- Work with existing call center systems
- Support the handling of surge capacity

An ideal workforce management system would include scheduling, real-time adherence, reporting, and data collection, and would communicate in a clear, concise manner. Real-time monitoring is an important part of any workforce management system, as it will ensure coverage is maintained and key performance indicators are being met within each center. Additionally, it helps maintain schedule adherence and efficiently monitors operational issues.

The process of setting up a new workforce management system is often initiated by the product team in the beginning of the process and completed by the call center team, which uses their specific data, goals, and needs. To set up a system, the teams would enter the call center's metric goals, employee data, schedules, hours of operation, and site locations if needed. Setup would also include entering the forecasts, average handle times, and shrinkage data; this will help facilitate the system's forecasting ability going forward.

Example workforce management systems include but are not limited to:

- Verint Monet WFM: Capable of handling day-to-day basic workforce management (https://www.verint.com/grow-my-smb-business/)
- Alvaria workforce management: Has additional, optional capabilities (https://www.alvaria.com/landing-pages-2021/call-center-wfm-software-2022?gclid=EAIaIQobChMIzvrEhoGK9gIVFmxvBB32oADxEAAYASAAEgLd2vD_BwE)

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[5] Bart Andrews, Vice President of Clinical Practice / Evaluation at Behavioral Health Response, February 2022.

Case study: Behavioral Health Response (BHR) (Missouri)[6]

BHR uses the Verint Monet WFM system, which includes a real-time monitoring dashboard and scheduling views. The monitoring dashboard shows information at the center and employee activity levels, including each employee's status (e.g., answering calls, wrapping, taking a break) and upcoming schedule, while the scheduling views enable the user to see shift coverage at the daily level. The system allows the center to see customized reports and statuses as well.

BHR's real-time monitoring dashboard:
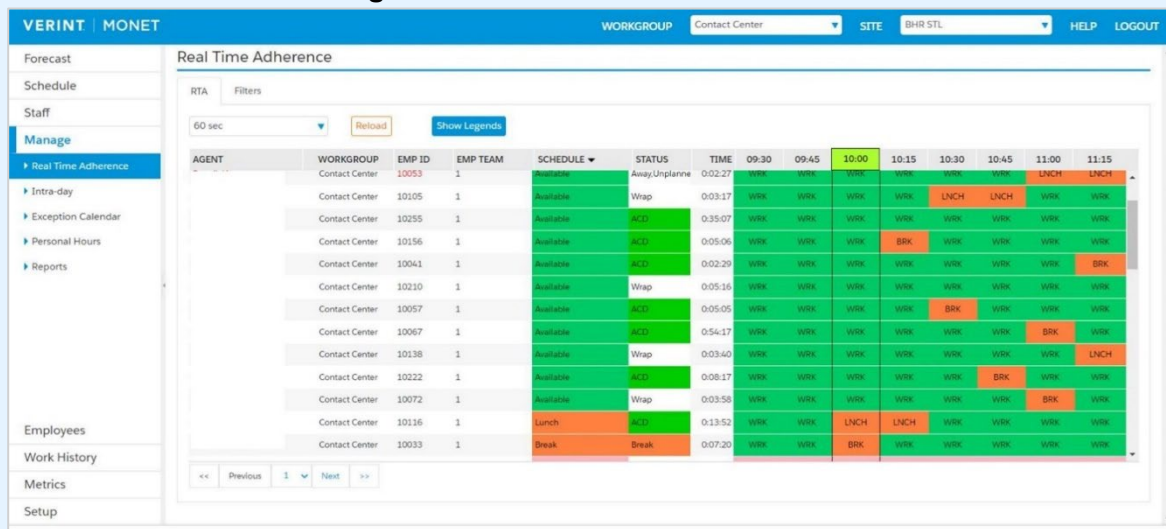
BHR's schedule dashboard:

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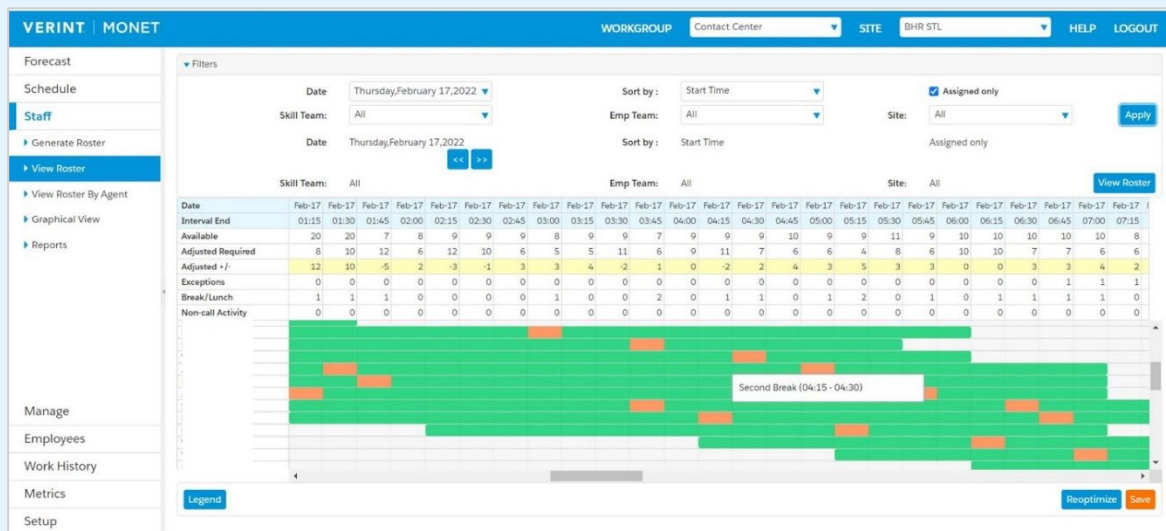
[6] Bart Andrews, Vice President of Clinical Practice / Evaluation at Behavioral Health Response, February 2022.

Center-specific information:

Surge Capacity: BHR created and maintains a detailed surge plan to address both planned and unplanned call volume increases, which it is able to monitor real-time using Verint Monet WFM. BHR receives automated alerts based on wait times and pushes notifications to staff when call volume exceeds certain parameters. Centers hold regular meetings with key staff to review performance metrics, staffing levels, call volume levels and projections of volume levels based on new information or planned events. Teamwork and agreed-upon expectations are key to managing call volume and supporting staff during call surges.

If BHR anticipates call volume surges (for example, due to site closure, agency phone problems), it can request extra staffing in advance.

BHR's Operations Analyst sends out a reminder on days where additional coverage for the agency's phones is necessary and reminds the center's staff when to be especially conscious of their Do Not Disturb (DND) use. BHR's Active Surge Management protocol is detailed in the Appendix.

Case study: Lines for Life (LFL) (Oregon)[7]

According to LFL, an ideal workforce management system:
- Allows staff to clock in and out through the phone system so that supervisors can see when colleagues are present
- Contains in-house training and emergency contact information
- Houses the call-takers' schedules and PTO calendars
- Keeps track of how much time off staff are taking
- Includes its own texting platform
- Offers an internal chat system to enable communications
- Includes an agent status dashboard, scheduling database, and center workforce overview

Agent status board: The agent status boards allow supervisors to see the real-time status of each crisis intervention specialist

Scheduling database: LFL uses Better Impact as its scheduling database. It contains the profiles of all call-taking staff. It also houses the training modules, surveys, contact information, and allows LFL to send texts to all staff.

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[7] Dwight Holton, CEO of Lines for Life.

Telephony dashboard: The telephony dashboard allows LFL to see how much of the workforce is available at the moment. It also shows how many callers are waiting and daily performance.

Surge Capacity: LFL crisis workers who have met high standards for quality, attendance, and reliability are invited to become part of a back-up team. As a back-up team member, they agree to receive text notifications when there is need for additional coverage on the crisis lines. Back-up members who sign up to cover a back-up team shift receive a higher hourly wage for those shifts, with an additional differential added for swing shifts, overnight shifts, and weekend shifts. LFL sends out a group text to the back-up team when it is alerted to the possibility of a sudden / temporary spike in call volume.

With the Veterans Crisis Line (VCL) contract, LFL has had good success with offering pay incentives for staff to cover the lines for an anticipated or unexpected surge in call volume. For example, in 2021, VCL gave LFL advance notice of a four- to six-hour shut-down for maintenance on seven occasions. For the most recent shutdown in 2021, LFL was able to recruit a team of 30 crisis intervention specialists, supervisors, team leads and directors who worked from 8:30 PM until midnight to cover the shutdown. This team successfully answered 122 calls in three hours—79 on the VCL and 43 on the other line—compared with typical volumes of 70-100 calls over a 12-hour period on VCL.

Case study: Solari (Arizona)[8]

Solari has taken multiple steps to adopt the following practices to build surge capacity into workforce planning. Solari found that maintaining adequate staffing on 24/7 lines required the ability to manage sudden or prolonged increases in overall call volume. The four components of surge capacity Solari identified are structure, staff, stuff, and systems. During the pandemic, needs across all four of these areas were determined to be critical to manage surge capacity:

1. Ability to socially distance (structure)
2. Contact center and dispatch team members (staff)
3. Sanitizing and cleaning supplies (stuff)
4. Efficient, nimble electronic health records (EHR) that can be utilized regardless of location / system

Solari has procedures to accommodate call surges and regularly receives communications from NSPL about certain television interviews, tragedies, social media, and other events that may increase call volume. Solari also answers the Tragedy Support Line, which frequently experiences increased volume after a local distressing event. It has a blended workforce of on-site and remote staff, with on-call staff that can assist during a surge and be activated quickly.

To address the issues surrounding structure, Solari made the decision to offer and/or transition staff members to remote / home-based response and create a small onsite team for both continuity planning and supervisory oversight. This allowed it to place team members in their own offices, which lessened contact and maximized social distancing. It also ensured that engagement with staff was frequent, and that leadership was present 24/7 for the first few months. This allowed flexible coverage when staff members had to call out. The facilities team was very proactive in securing sanitization supplies from vendors and the EHR was configured so location was not a barrier to access. Solari did have to provide additional IT support to team members when they initially went remote,

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[8] Justin Chase, President and CEO of Solari Crisis and Human Services.

but it was able to quickly dial back the amount of support needed. This was mostly due to the high level of technical training that had been provided to center leadership.

Additional information: How to forecast volume and determining staffing needs using Erlang modeling can be found in Vibrant's Crisis Call Center Metrics guide (https://suicidepreventionlifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf).[9]

Addressing staffing needs through hiring and retention

Ensuring appropriate staffing levels requires focusing on talent recruitment, retention, and organizational health, as well as tools and standards for learning and development. The following section outlines potential levers to support both hiring and retention.

The first step will be to define goals for talent recruitment, retention, and organizational health along with timelines and acceptable staff. Each organization will want to adapt industry best practices to its unique markets and context, as ideal hiring and retention plans address the unique needs of the organization (e.g., focusing on being able to hire from new locations or new candidate profiles, focusing on increasing the number of applicants by raising awareness).

This section describes:
1. Levers to support recruitment
2. Levers to support retention

1. Levers to support recruitment

This section includes resources and information about:
- Job boards and postings
- Compensation
- Job requirements
- Expanding geographic areas for recruitment
- Working models
- Operations
- Identifying partnership opportunities to identify new sources of talent

Expanding use of job boards / websites: Assess how and where jobs are posted and advertised:

- Identify the standard list of places the positions are posted; lists of job boards / websites can be found on the web including this resource from Better Team (https://www.betterteam.com/free-job-posting-sites)[10]
- Ask employees where they heard about the organization and make sure the opportunities are posted there
- Reach out to partner health care organizations to identify potential new channels to advertise positions
- Identify ways to make the position stand out: Why should people choose this organization? What makes working at this organization different?

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[9] National Suicide Prevention Lifeline, "Call center metrics," pgs. 54-64, accessed February 7, 2022.
[10] "21 free job posting sites that are high traffic and 100% free," Betterteam. accessed February 24, 2022, https://www.betterteam.com/free-job-posting-sites.

- Consider adding a resume bank to a career's page to allow utilization of an applicant management system feature to match applicants from previous positions or resume bank to open employment opportunities, as appropriate

Case study: Behavioral Health Response (BHR) (Missouri)[11]

BHR uses a variety of tools to recruit top candidates, including:
- *Indeed*: https://www.indeed.com/ - Indeed is a very broad recruiting website that a vast majority of job seekers use to find positions—regardless of the industry
- *Ziprecruiter:* https://www.ziprecruiter.com/ - ZipRecruiter is another very broad recruiting website that a lot of job seekers use
- *LinkedIn Careers*: https://careers.linkedin.com/ - LinkedIn Careers is a tool used to hire more professional-level roles (i.e., management or hyper-specialized professional roles). Many clinicians in non-management roles have also used LinkedIn to find employment
- *The Rome Group:* https://www.theromegroup.com/ - The Rome Group is a recruiting tool for non-profit jobs but is area specific
- *Academic institutions* as well as professional networking organizations such as area chambers can provide sources of local talent
- *Chambers:* Chambers of Commerce, including those representing individuals from diverse backgrounds, can serve as potential sources of talent

Case study: Lines for Life (LFL) (Oregon)[12]

LFL considers many job boards / websites for job posting, including Indeed Career Builder, Handshake, ZipRecruiter, and LinkedIn. To successfully source a candidate on a platform, it is important to identify the candidate's priorities.

- *Boolean search:* if a center wants to hire a Crisis Call taker, it might type "crisis AND call taker" into the search bar and include the location. This is called a Boolean search term and it filters through candidates to reach out to them directly. Another example is "MH AND nonprofit." Indeed allows a search to be narrowed down to include only people that have recently updated their profiles, level of experience, level of education, and any assessments taken
- *Templates:* Most sourcing platforms will have an option to save a template, so job descriptions do not have to be recreated. The most important elements should be at the top of the template (e.g., job title, status (full time / part time / temporary / permanent), location, and compensation)
- *Title:* When posting a job, it is important to include the title of the job throughout the posting. For example: Crisis Call Taker Position Summary, Crisis Call Taker Responsibilities, Crisis Call Taker Requirements, Crisis Call Taker Physical Requirements, and so on. This is so the title and key words are more frequent and match the algorithms so that the job is more likely to be found by someone seeking it out. If a job posting is not getting enough applicants, consider whether the title would be attractive to job seekers

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[11] Bart Andrews, Vice President of Clinical Practice / Evaluation at Behavioral Health Response, February 2022.
[12] Dwight Holton, CEO of Lines for Life, February 2022.

- *Personalization:* LFL found that candidates are more likely to be interested in outreach if a name is included in the email. Candidates can tell the difference between generic and personalized outreach and are less likely to look at generic outreach
- *Review for bias:* Review the post to ensure there are no gendered phrases or biased speech in the post, e.g., "workmanship" and "manpower"

Case study: Solari (Arizona)[13]

Like most contact centers, Solari is also feeling the effects of the recent applicant shortage and the reverberation of what is being referred to as the "Great Resignation." In response to the COVID-19 pandemic in 2020, Solari remotely hired and trained more than 250 staff in four months to meet the needs of the community through center services.

Solari applies a continuous recruitment strategy to center positions. Its talent acquisition team is open to receiving and reviewing applications regardless of position vacancy. This creates a bench of qualified applicants and allows the team to stay in touch with local job markets, positively impacting time-to-fill metrics. Positions are posted on the Solari website, which are captured by Indeed, Glassdoor, and Diversity.com web scrapers. These sites serve as placeholders and information passthroughs, increasing visibility and reach. The agency also collaborates regularly with local universities on projects to maintain its expertise in the crisis space.

Solari's headquarters are in the fifth largest city in the country, which provides a robust pipeline of candidates. Its recruitment process is streamlined and includes an initial review by a seasoned member of the center team. This assistance with resume review and initial phone interviews helps identify appropriate candidates for the role.

Compensation: Compensation can generally be aligned with mean / median wages and adjusted for location, when possible. Before beginning any compensation assessment, Centers would start with a clear organizational chart with accurate job descriptions for each position and determine how broad the benchmark should be.

Centers could utilize a cost per contact of $82 to calibrate their center-level costs, according to the SAMHSA 988 appropriations report (https://www.samhsa.gov/sites/default/files/988-appropriations-report.pdf)[14] This estimate of cost per contact accounts for:

- "Dedicated resources (i.e., crisis workers and their supervisors)
- Shared resources (i.e., center director, HR manager) that support other programs in addition to 988
- Dedicated capital (assets employed for the sole use of 988)
- Shared capital (assets used by multiple programs administered by the network center)
- Dedicated expenses (expenses incurred to support 988, AAS conference)
- Shared expenses (expenses incurred to support the network center, e.g., rent)

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[13] Justin Chase, President and CEO of Solari Crisis and Human Services, January 2022.
[14] Substance Abuse and Mental Health Services Administration, "988 appropriations report," December 2021: pg. 10, https://www.samhsa.gov/sites/default/files/988-appropriations-report.pdf.

- Common center processes are also calculated in the model (refresher training, quality, debrief sessions, and attrition)" [15]

To conduct a compensation evaluation, centers can:

- Determine a benchmark for direct salary costs for crisis counselors by reviewing potential benchmarks and considering a market study. Potential benchmarks may include:
  - The Bureau of Labor Statistics (BLS), which breaks down wages (hourly and annual; percentile) by geography (state, metropolitan area) and includes related roles:

BLS roles
Psychiatric Technicians[16]
Psychiatric Aides[17]
Social and Human Service Assistants[18]
Substance Abuse, Behavioral Disorder, and MH Counselors[19]
and Substance Abuse Social Workers[20]
Customer Service Representatives[21]

  - Government entities such as state-level classification schedules

- Assess benefits packages for competitiveness (e.g., retention bonuses, paid time off, remote working options, childcare programs) and adjust as needed. Consider improving benefits packages as tenure increases
- Assess financial incentives such as offering hiring bonuses, referral bonuses, and/or tuition reimbursement

Case study: Integral Care (Austin, Texas) [22]

Integral Care recently standardized its compensation practices. Historically, compensation practices were somewhat but not fully standardized for all posts with a common benchmark. Integral Care's leadership and human resources decided to try to use one external benchmark and selected the Texas State Auditors' classification schedule because it is external, validated by government, and updated regularly (~every two years).

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[15] Ibid.

[16] "Occupational employment and wages: May 2020 29-2053 Psychiatric Technicians," Bureau of Labor Statistics, modified March 31, 2021, accessed February 7, 2022, https://www.bls.gov/oes/current/oes292053.htm.

[17] "Occupational employment and wages: May 2020 31-1133 Psychiatric Aides," Bureau of Labor Statistics, modified March 31, 2021, accessed February 7, 2022, https://www.bls.gov/oes/current/oes311133.htm.

[18] "Occupational employment and wages: May 2020 21-1093 Social and Human Service Assistants," Bureau of Labor Statistics, modified March 31, 2021, accessed February 7, 2022, https://www.bls.gov/oes/current/oes211093.htm

[19] "Occupational employment and wages: May 2020 21-1018 Substance Abuse, Behavioral Disorder, and Mental Health Counselors," Bureau of Labor Statistics, modified March 31, 2021, accessed February 7, 2022, https://www.bls.gov/oes/current/oes211018.htm.

[20] "Occupational employment and wages: May 2020 21-1023 Mental Health and Substance Abuse Social Workers," Bureau of Labor Statistics, modified March 31, 2021, accessed February 7, 2022, https://www.bls.gov/oes/current/oes211023.htm.

[21] "Occupational employment and wages: May 2020 43-4051 Customer Service Representatives," Bureau of Labor Statistics, modified March 31, 2021, accessed February 7, 2022, https://www.bls.gov/oes/current/oes434051.htm.

[22] Rodney Guinn, Director, Human Resources at Integral Care, February 2022.

Each role was evaluated and matched to the benchmark by multiple factors, including level, education, supervision, budget responsibilities, initiative, and risk. Integral Care determined that each job could be placed on a midpoint within the benchmark range, and that point varied based on the role and/or an individual's experience. Additionally, Integral Care contracted a vendor to evaluate market conditions, given the increasing cost of living in its location (Austin) and shifting compensation demands from potential candidates.

Job requirements and working models: Centers can evaluate how different job requirements and working model expectations are impacting hiring and consider adjustments as appropriate, including:

- Assess current job description requirements and compare them to similar roles. Determine if any requirements can be adjusted to broaden the potential applicant pool including:
  - **Entry level:** Consider minimum requirements for entry-level jobs to allow substitutions for formal education and/or mandatory training to enable hiring from alternative pathways
  - **Licensing**: The Lifeline does not require specific licensing of crisis counseling team members at centers and team members may be volunteers, depending on other requirements (e.g., local, state, other funders)
  - **Experience:** Consider expanding historical education and experience requirements to include a broader group of potential applications (e.g., first responders, police, emergency management services, 911 responders)
  - **Other requirements:** Reassess job requirements that may be overly restrictive, based on best practices and state guidance

- Identify ways to expand the geographic area from which the center can hire (e.g., hiring across state and country, when possible). During COVID-19, many centers transitioned to virtual service provision and looked to hire beyond the county or state

- Explore non-traditional work models including remote, hybrid, and/or split models (two employees working partial hours that coordinate schedules to fulfill hours requirement of one FTE) that may be more broadly appealing. Also consider utilizing overtime / comp-time in calculating overall FTE organizational needs

New sources of talent: Centers could also expand the pool of talent from which they draw applicants by:

- **Identifying creative pathways in communities,** for instance by partnering with local universities and community colleges to raise awareness and by offering internships and work study programs

- **Expanding recruiting of and the roles of people with lived experience in the center across levels.** Reach out to organizations that train and identify people with lived experience at the local level as well as national organizations that offer peer support training programs and have trained thousands of peers (e.g., RI International and Mental Health America).[23] The National Association of Peer Supporters (NAPS) also has a job board (https://www.peersupportworks.org/) that can be used to share jobs with peers. Additional resources for organization's hiring Peer Workers can be

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[23] "MHA announces partnership on peer support with RI International," Mental Health America. accessed February. 7, 2022, https://mhanational.org/blog/mha-announces-partnership-peer-support-ri-international.

found on SAMHSA's [Peers](https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers) page (https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers)[24]

Hiring operations: Centers can also assess the speed to hire of recent hires and identify potential points in the process where they can shorten the recruitment timeline. If there is a part of the process (e.g., round of interviews with senior staff) that regularly takes longer than planned, evaluate whether that process can be accelerated or potentially replaced.

2. Levers to support retention

This section includes resources and information about:
- Career development
- Supervision / licensure hours
- Workforce protection and staff well-being

Career development: Building a culture of investment in team members' career development can help support retention. This can involve:

- Holding senior team members accountable for prioritizing mentorship
- Building connections between team members and supervisors
- Building cohort or discipline-based activities or workshops to foster a sense of community among team members. For example, have all new hires start on the same day to build community and have a member of that group coordinate regular (e.g., monthly or quarterly) trainings, speaker sessions, and/or social events

Supervision / licensure hours: Offering supervision / licensure hours to team members, as allowed by the state, can help to retain employees who are simultaneously seeking licensure. Some states, including Georgia, allow crisis contact hours to count for licensure.

Workforce protection and staff well-being:[25] Center staff that answer the Lifeline are routinely exposed to traumatic material such as severe human distress and highly disturbing, graphic material including abuse, despair, hopelessness, and violent death. This continuous exposure has the potential to cause negative psychological effects such as compassion fatigue / secondary traumatic stress, sleep problems, a change in their view of the world as a good and safe place, and, less commonly, even mental illnesses such as depression and posttraumatic stress disorder (PTSD).[26]

These stressors can impact staff's decisions as to whether and how long they remain working in a particular center and also in the field in general. There is early research indicating centers experience a high turnover of volunteers and staff when the call volume increases in relation to suicide calls. Employees who are in good physical, mental, and emotional health are more likely to deliver optimal performance in the workplace than employees who are not, and ultimately healthy, well-prepared, and well-trained staff reduce turnover rates.[27] The ripple effects of reduced turnover rates are the positive effect of less

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[24] "Peers," Substance Abuse and Mental Health Services Administration, accessed February 7, 2022, https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.

[25] April Naturale, Assistant Vice President, National Programs, and Assistant Vice President, National Crisis & Wellness Programs at Vibrant Emotional Health, February 2022.

[26] C.R. Figley, (1999). "Compassion fatigue: Toward a new understanding of the costs of caring," in *Secondary traumatic stress: Self-care issues for clinicians, researchers & educators,* ed. B. H. Stamm, (Baltimore: Sidran Press, Second edition 1999), 3-29; Laurie Anne Pearlman and Paula A. Mac Ian, "Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists," *Professional Psychology: Research and Practice*, 26, no. 6, (1995): 558-565, https://www.nationalcac.org/wp-content/uploads/2016/10/Vicarious-traumatization-An-empirical-study-of-the-effects-of-trauma-work-on-trauma-therapists..pdf.

[27] Jerome M. Adams, "The value of worker wellbeing," *Public Health Reports* 134, no. 6 (November 2019): 583-586, https://doi.org/10.1177/0033354919878434.

strain on the staff, faster response rates, and the ability to keep these valuable resources answering lifesaving calls in the local community.[28]

Centers can take steps to improve staff wellbeing and engagement, including:[29]

Areas	Capabilities
Measure and track organization health and employee satisfaction	• Assess availability and adequacy of **current employee wellbeing program offerings**, and add capacity or new resources as needed • **Weekly pulse surveys** for center staff to voice concerns and suggest potential change to ways of working • Annual / bi-annual **employee engagement survey** to measure perceptions and experiences of center counselors (e.g., work environment, motivation, culture, likelihood to stay) • Annual / bi-annual **organizational health survey** to gain insights into organizational culture, management practice, and the effectiveness of operational processes
Introduce programs and/or benefits to promote staff well-being	• **On-site wellness counselors** and quiet meditation rooms to promote staff resiliency • **Greater staff flexibility** through shorter shift times, frequent breaks, more paid vacation days, and alternative work schedules (e.g., part-time, staggered shift hours) • **Expand behavioral health (BH) benefits for all network staff** through employee assistance programs (EAP) and/or by partnering with existing wellness apps • **Staff engagement programs** (e.g., peer networks, buddy assignments) to build a culture of collaboration and teamwork • **Stress management trainings and coaching sessions** to share best practices, tips, and tricks among staff members (e.g., staying in balance workshop series for healthy solutions to workplace stress)
Build engagement and awareness around wellness programs	• **Regular and clear communications with center staff** through emails, newsletters, and local events on available resources and when / how to access them • Ensure **clear communications on the importance of employee wellbeing** at all levels and normalize team conversations regarding situational distress • **Quick and transparent process for sharing results** from employee engagement and organization health surveys with all network staff • **Network-wide workshops and facilitated team discussions** to check-in, surface distress, and share ideas to improve counselor wellbeing • Collection of **insights and learnings from other companies** that are experienced in implementing successful employee wellbeing programs

Resources for frontline workers and their families that will support the center workforce's resiliency can be found in the National Alliance on Mental Illness's (NAMI's) Frontline Wellness Initiative (https://www.nami.org/Your-Journey/Frontline-Professionals).[30]

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[28] Derek Rouch and Liz Barnes, "Crisis at CrisisLink: Increasing the retention rate for crisis workers answering a suicide crisis line," Leadership and Learning in Organizations Capstone Projects, Vanderbilt University Institutional Repository, April 4, 2021, http://hdl.handle.net/1803/16527.

[29] Interview with Vibrant, 2022

[30] "Frontline professionals," National Alliance on Mental Illness, accessed February 7, 2022, https://www.nami.org/Your-Journey/Frontline-Professionals.

Case study: Behavioral Health Response (BHR) (Missouri)[31]

BHR utilizes best practice models for workforce retention that include the following:

- *Exit interviews:* Conducts exit interviews with staff who are leaving the organization. This is a useful tool to understand what is going right and what is going wrong. Additionally, it helps to identify reasons why staff are leaving and helps to identify themes that organizations need to address. This information can be shared with decision-makers to make effective changes within the organization

- *Stay surveys:* Surveys the current workforce to identify issues that can be addressed quickly to retain existing staff and to determine which ongoing initiatives are most effective

- *Communications:* Holds regular, productive team meetings at all levels to ensure that everyone is on the same page. All-staff meetings allow colleagues to participate in discussions on the organization's direction and how they can be a part of that mission, vision, and strategy, which can be helpful in gaining and strengthening buy-in

- *Team engagement:* Engages staff throughout the year by celebrating holidays, having luncheons, and setting up meetings. These events allow team members to engage with each other in non-stressed, social settings

- *Employee committees:* Forms committees of employees across departments to offer real-time feedback on what can be done to better engage and retain team members

- *Compensation analysis:* Conducts a third-party compensation analysis to ensure positions are being compensated appropriately for the market*,* if compensation is a reason staff are leaving and the organization has a large enough budget

Case study: Lines for Life (LFL) (Oregon)[32]

LFL is working on employee retention, beginning with employee recruitment, hiring, and onboarding. Practices that have worked for LFL include:

- *Hiring process:* Using a hiring process that ensures employees understand the nature of the work
- *Interventions and surveys:* Utilizing exit interviews, stay interviews, and employee surveys to find out what is important to employees as a group and individually
  - This information helps LFL understand why people leave organizations. Management often thinks it is for pay, but this is only part of the picture and not the primary reason employees report for leaving
- *Culture:* Understanding the importance of culture and setting the tone for a positive, mission-driven culture from the top

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[31] Bart Andrews, Vice President of Clinical Practice / Evaluation at Behavioral Health Response, February 2022.
[32] Dwight Holton, CEO of Lines for Life, February 2022.

- *Benefit surveys:* Doing regular benefit surveys to ensure that the organization stacks up well. This is crucial because today's job market is an employee's market. LFL has found most comparable employers offer health, dental, vision, short- and long-term disability and life insurance. Paying for these in full or near full is the expectation of, not the exception for, many potential applicants
- *Professional development:* Developing a structured program for employees to learn and grow in their positions and in the organization. Employees have expressed interest in development and career growth
- *Leadership training:* Providing training for supervisors in how to coach and lead employees. Frequently people are advanced to higher roles in organizations because they are good at what they currently do, which does not automatically translate into being good at supervision
- *Flexibility and autonomy:* Developing opportunities to provide flexibility, such as part-time employment, four ten-hour shifts ("4/10's"), or other non-traditional schedules. Employees want flexibility and autonomy. This can be challenging with shift work

Case study: Solari (Arizona)[33]

Solari has a very active Social Employee Engagement Committee (SEEC) that is dedicated to engaging, encouraging, and exciting staff along their journey. It recognizes that when staff feel cared for and appreciated, their fulfillment will fuel the services they provide to crisis line callers, and they will more likely remain in their positions. SEEC regularly plans in-person and virtual events to keep staff connected and allow space to decompress and laugh with each other. Such sponsored events and activities include spirit weeks, book clubs, bingo nights, costume challenges, wellness challenges, quarterly lunches, self-care challenges, guided meditations, fitness subscriptions, massage days, and more. Solari recognizes that self-care is individualized, and the organization aims to provide ample opportunities for employees to focus on their wellbeing.

In addition, Solari provides a comprehensive benefit package that includes a 401(k) with employer match, 13 annual paid holidays (which include two Solari Wellness days), paid-time off accrual with annual payout and rollover policies, public student loan forgiveness, tuition reimbursement, an on-site fitness room, and on-site fresh vending. It recognized early in the pandemic that staff members required additional self-care strategies and flexibility due to the stressful nature of their jobs and the increased stress and uncertainty of being in a global pandemic. Solari immediately implemented an updated staffing model that included work from home and more flexible schedules. It also offered an enhanced fiscal reward coupled with additional time off to provide much needed recognition and reprieve.

Finally, Solari's Chief Administrative Officer is an active participant on The Lifeline Cares Advisory Committee and works in partnership with the human resources team to continually advance Solari's investment in its people. The agency uses a 30-60-90-day check in process for new employees and has created a transparent exit interview system to ensure it is capturing the reasons staff are leaving the organization. It provides this information to both line-level leadership and the executive team to ensure full visibility.

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[33] Justin Chase, Solari, February 2022.

Solari is also pursuing a continuous quality-improvement (CQI) approach to engage, support, and motivate center staff to support themselves and each other.

Additional resources
- Vibrant's Crisis Center Metrics (https://suicidepreventionlifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf)[34]
- North American Quitline Consortium's (NAQC's) Fundamentals of Call Center Staffing and Technology (https://cdn.ymaws.com/www.naquitline.org/resource/resmgr/issue_papers/callcenter metricspaperstaffi.pdf)[35]
- Communities of practice (for best practices)
  - National Association of Crisis Organization Directors (https://www.nascod.org/about)
  - International Council for Helplines (https://councilforhelplines.org/)
  - American Association of Suicidology (suicidology.org)

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[34] National Suicide Prevention Lifeline, "Crisis call center metrics," accessed February 7, 2022.
[35] Penny Reynolds, (2010). "Fundamentals of call center staffing and technologies: Quality improvement initiative," North American Quitline Consortium, 2010, https://cdn.ymaws.com/www.naquitline.org/resource/resmgr/issue_papers/callcentermetricspaperstaffi.pdf.

2. Financial sustainability

In 2022, SAMHSA began providing funding to centers through the 988 State and Territory Grant program to provide workforce-related support. "The purpose of these cooperative agreements is to improve state and territory response to 988 contacts (including calls, chats, and texts) originating in the state / territory by:
1. Recruiting, hiring, and training BH workforce to staff local 988 / Lifeline centers to respond, intervene, and provide follow-up to individuals experiencing a BH crisis
2. Engaging Lifeline crisis centers to unify 988 responses across states / territories
3. Expanding the crisis center staffing and response structure needed for the successful implementation of 988

It is expected that these grants will:
1. Ensure all calls originating in a state / territory first route to a local, regional, and/or statewide Lifeline crisis call center
2. Improve state / territory response rates to meet minimum key performance indicators
3. Increase state / territory capacity to meet 988 crisis contact demand"[36]

To help ensure that the Lifeline crisis centers are able to recruit and respond to the 988 demand, no less than 85 percent of grant funds must be allocated to selected local, regional, and/or statewide Lifeline crisis centers and used for workforce capacity and related expenditures.[37]

As the Brookings Institute's "Building a Sustainable Behavioral Health Crisis Continuum" states: "ensuring adequate financing both for the initial call response and connecting people who need them to services will be a key determinant of the availability and effectiveness of crisis response services."[38] Federal law allows states to finance call center operations through a fee on cell carriers; however, only a handful of states have enacted legislation to date.[39] As of March 2022, enacted or proposed 988 legislation is tracked in this dashboard (https://www.quorum.us/dashboard/external/mgWzdPqJLWHohzOhdRWE/).

To ensure financial sustainability over time and the ability to meet the needs of individuals in crisis, it will be key for Lifeline contact centers to access diverse and long-term funding streams.

This section addresses opportunities for Lifeline contact centers to
- Identify additional sources of funding
- Improve insurance billing capabilities

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[36] Department of Health and Human Services and Substance Abuse and Mental Health Services Administration, "FY 2022 cooperative agreements for states and territories to build local 988 capacity," accessed February 2022, https://www.samhsa.gov/sites/default/files/grants/pdf/sm-22-015.pdf.

[37] Ibid.

[38] Richard G. Frank and Vikki Wachino, "Building a sustainable behavioral health crisis continuum," USC-Brookings Schaeffer on Health Policy, January 6, 2022, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2022/01/06/building-a-sustainable-behavioral-health-crisis-continuum/.

[39] "Text – S.2661 – 116th Congress (2019-2020)," October 17, 2020.

Resources to identify potential sources of ongoing funding and build diverse funding sources

HHS resources that support 988 and crisis services include: [40]

SAMHSA
- 988 State and Territory Cooperative Agreement (12/2022)
- Community Mental Health Services Block Grant — 5 percent Crisis Services set-aside
- Certified Community Behavioral Health Center (CCBHC) grant
- Zero Suicide Grant
- Garrett Lee Smith Youth Suicide Prevention (GLS) Grant
- Rural Emergency Medical Services Grant
- State Opioid Response (SOR) Grant & Tribal Opioid Response (TOR) Grant
- Tribal Behavioral Health Grant (Native Connections)
- State Transformational Technology Initiative Grants (Transformation Transfer Initiative – National Association of State Mental Health Program Directors (TI-NASMHPD))
- Governors' Challenges to Prevent Suicide Among Service Members, Veterans, and their Families

SAMHSA Technical Assistance
- Suicide Prevention Resource Center
- Center of Excellence for Integrated Health Solutions
- National and Regional Mental Health Technology Transfer centers
- GAINS Center for Behavioral Health and Justice Transformation
- National Child Traumatic Stress Network

CMS
- Medicaid / Child's Health Insurance Program (CHIP) Waivers - 1915 and 1115
- Medicaid / CHIP State Plan Amendments
- CMS State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services ($15M for 20 states)

In addition to information from SAMHSA, the NSPL NRC includes a section on Funding resources (https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fpages%2Fviewpage.action%3FspaceKey%3Dpracticeguide%26title%3DTip%2BSheets).[41] The NRC outlines current and previous funding opportunities, and describes a mix of funding sources that can be considered, including fees for service structure, funding opportunities to join specific sub-networks, and new Lifeline grants.

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[40] Input from SAMHSA, 2022.
[41] Network Resource Center, National Suicide Prevention Lifeline, accessed Feb. 25, 2022, https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fpages%2Fviewpage.action%3FspaceKey%3Dincalltools%26title%3DIn-Call%2BTools.

Improving insurance billing capabilities and related considerations

Insurance billing capabilities

Setting up and expanding insurance capabilities is an investment of time and resources, but can be worthwhile, particularly in states with a federal match. Variation exists among states in the extent to which Medicaid is currently used to cover crisis services, including crisis hotline calls and mobile crisis services.

Providers could utilize Medicaid reimbursement from a state, if available.[42] It will be necessary to coordinate with the State Medicaid authority to identify the current status of Medicaid reimbursement for crisis contact services, which varies by state.[43] If unclear, it is possible to ask the Medicaid authority if / what billing code(s) are active in the state, including the BH hotline services (H0030).[44]

Example: Arizona[45]

In September 2001, the Arizona Department of Health Services Division of Behavioral Health Services released their Covered Behavioral Health Services Guide. It included specific billing procedures for Telephonic Crisis Intervention Services and used the Case Management Healthcare Common Procedure Coding System (HCPCS) procedure code T1016. Contact centers collaborated with the State of Arizona and local entities on setting up the program.

As a result of the program, 58 percent of crisis call volume was Medicaid-reimbursed in 2021.

Reimbursement and billing considerations[46]

The Insurance Reimbursement Guidance (https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fpages%2Fviewp age.action%3FspaceKey%3Dpracticeguide%26title%3DTip%2BSheets
) in the NRC outlines several considerations related to reimbursement, including the importance of:
- Ensuring consent and transparency
- Following clear policies / procedures to explain information sharing
- Focusing on the crisis intervention and the safety assessment model

Specifically, "Centers must be careful about assuming that callers / chatters / texters will endorse the understanding that the service is 'free' if only their insurance is charged. Centers

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[42] "Guide to Medicaid billing," Crisis Response Network, 2021.
[43] The Federal government allows states to offer Medicaid reimbursement for certain community-based behavioral health services like crisis contact services, but not all states offer crisis call reimbursement. This is generally done through 1115 Medicaid Demonstration Waivers.
[44] The behavioral health hotline is a telephone service that provides crisis intervention and emergency management such as mental health referrals, treatment information, and other verbal assistance.
[45] Interview with RI International, January 2022.
[46] "Vibrant and 988," Vibrant Emotional Health, July 13, 2020, accessed March 8, 2022, https://www.vibrant.org/988/.

must offer a clear understanding of their center policies and practices to contacts so that they may make an informed choice about using the service."[47]

Consent and transparency: According to Vibrant, billing practices must include consent and transparency. Individuals have a right to know when and how their information is going to be shared. Centers may not collect information without clearly explaining what it will be used for and gaining explicit consent.[48]

Policies and procedures: If a center will be seeking insurance reimbursement for crisis conversations, there must be a policy / procedure in place to clearly explain to the individual what information will be shared, who it will be shared with, and how it will be used. The center should explain that the individual has the right to refuse consent, and they will still receive the same services from Lifeline / 988. For example, consent to share / bill must be opt-in and indicated in the documentation for each individual conversation that is billed.[49]

Focus: Crisis intervention and the safety assessment model must remain the primary focus. Centers cannot screen out individuals based on their decision to consent / not consent to insurance reimbursement. Any identifying information that will be used for billing / reimbursement purposes should not be collected at the beginning of the crisis conversation prior to establishing rapport. Centers cannot refuse services or end conversations prematurely if an interaction is reaching the time or service limit of what can be billed / reimbursed.[50]

Additional information: Consult the Gathering Demographics While Maintaining Rapport tip sheet on the NRC
(https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fdashboard.action).

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[47] Vibrant Emotional Health, " 988 serviceable populations and content volume projections," December 20, 2021, accessed February 7, 2022, https://www.vibrant.org/wp-content/uploads/2020/12/Vibrant-988-Projections-Report.pdf?_ga=2.62739180.1718066263.1611784352-1951259024.1604696443.

[48] "988 insurance reimbursement guidance from the Network Resource Center," Vibrant Emotional Health, 2021 accessed February 7, 2022.

[49] "988 insurance reimbursement guidance from the Network Resource Center," Vibrant Emotional Health, 2021 accessed February 7, 2022.

[50] "988 insurance reimbursement guidance from the Network Resource Center," Vibrant Emotional Health, 2021 accessed February 7, 2022.

3. Connection to 911 / PSAPs

Strong relationships between PSAPs—call centers responsible for answering calls to 911—and Lifeline contact centers are essential to realize the full potential of 988 and better serve individuals in crisis. 988 and 911 are designed to be complementary. As articulated by the National Emergency Number Association (NENA), "988 counselors are trained to utilize the least invasive interventions whenever possible, and ongoing collaboration between 988 and 911 will help individuals in crisis get the appropriate support, providing options like MCTs in place of police or EMS responders when needed and where available."[51]

The ultimate goal of collaborative relationships between crisis centers and PSAPs is increased safety for those at imminent risk of suicide in the community." [52] This includes:
- "Better and more compassionate care for individuals at risk of suicide that utilizes best and recommended practices
- Improved workflows that decrease staff frustration and burnout
- Community support through the partnership and 911's championing of the crisis center services is crucial, as well as the PSAPs' ability to provide timely and safe responses to all callers" [53]

Material tailored specifically to PSAPs is available in the PSAPs 988 Convening Playbook.

Process to develop relationships with PSAPs

Relationships between Lifeline contact centers and PSAPs often begin with informal engagement and processes and then evolve to formal relationships created via Memorandums of Understanding (MOUs) or Business Associate Agreements (BAAs). Steps for engaging PSAPs include:

- Identify and reach out to your local PSAPs in the community, use the Lifelines NRC.[54] Begin with PSAPs that are geographically closest and then expand to PSAPs that are located farther away (https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fdashboard.action)
- Focus on building and/or improving processes related to: (a) transferring calls from the PSAP to the contact center, and (b) transferring calls from the contact center to the PSAP. The NENA Suicide/Crisis Line Interoperability Standard may be a helpful starting off point for relationship building (https://cdn.ymaws.com/www.nena.org/resource/resmgr/standards/nena-sta-001.2-2022_suicide-.pdf)
- Codify processes in a formal arrangement such as a MOU or BAA. Two sample MOUs are included in the Appendix, one a simple template and another specific for centers that are blended crisis / information and referral lines

Informal understandings or formal agreements can contain approaches to address:

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[51] National Action Alliance for Suicide Prevention, "988 messaging framework–Draft" (unpublished manuscript, January 21, 2022).

[52] Caitlyn Peterson and Shye Louis, "Addressing imminent risk via collaborative 911 relationships and the NENA Suicide Prevention Standard" (PowerPoint presentation, National Crisis Center Conference, St. Louis, MO, October 18, 2018), https://www.crisiscon.org.

[53] Caitlyn Peterson, "Addressing imminent risk," October 18, 2018.

[54] "PSAP (911) locator," Vibrant Emotional Health, n.d., https://networkresourcecenter.org/display/incalltools/In-Call+Tools.

- Specific processes to transfer calls from a PSAP to a contact center
- Specific process to transfer calls from a center to a PSAP, including potentially a direct line between the crisis call center and the PSAP so those calls are labeled as crisis calls
- Data sharing approach (e.g., what data is shared)
- Systems and interoperability

Transfer of calls from 911 to 988

Protocols for transfer of calls from 911 to 988 are unique to specific PSAPs and Lifeline contact centers. In general, protocols will need to address multiple topics, including but not limited to:
- Situations that can be considered for transfer
- Times of day that calls can be transferred (if relevant)
- Approach to warm transfer and example script for PSAP operators
- Approach to transferring caller data
- How Lifeline contact center operators should handle the call

An example "911 dispatch protocol for diverting calls involving persons experiencing a MH crisis to a crisis center" from Didi Hirsch can be found in the Appendix.

Centers can share additional information about setting up and/or improving existing protocols.

Transfer of calls from 988 to 911

Lifeline centers will not generally transfer 988 callers who are currently in progress of suicide or at imminent risk to 911 to handle directly. Rather, a supervisor or colleague at the center will contact the PSAP for assistance on behalf of the person needing intervention while the crisis counselor continues to interact with the person needing intervention as long as they can be kept on the line (until intervention arrives).[55] As laid out in the NENA 911-988 workgroup's 988 to 911 Transfer draft, transfers from 988 to 911 may occur in the following cases:

- **Ability to share location information:** "If the person needing intervention is willing and able to provide clarification on their location to receive help. (The 988-crisis counselor may stay on the line in these cases, but will inform the 911 telecommunicator if they intend not to disconnect after transfer)

- **Third-party callers:** A third-party caller is someone who is seeking help for someone else. If a third party is reporting imminent risk / attempt in progress of someone they know, 988 may warm transfer the third-party caller to 911 so they can give more direct information about the person needing intervention to the PSAP. (The 988-crisis counselor would opt for transfer when it is unclear whether the third-party caller will follow through with calling 911 themselves to provide this information)

- **Emergencies not related to suicide:** Sometimes in the course of a 988 interaction about mental health or emotional distress, another emergency situation may be

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[55] Shye Louis, Director of Clinical Best Practices at Vibrant Emotional Health, February 2022.

disclosed outside of suicide but that requires life-saving intervention, such as a medical emergency or a violent crime in progress / imminent:

- o When assessed as safe to do so, a 988 center can direct those callers to hang up and dial 911 for assistance, so the 911 center can get correct location information
- o There may be times where it does not seem safe to have the person call 911; the 988-crisis counselor may then warm transfer the person to 911 to ensure that they contact emergency assistance." [56]

For more information on this process please refer to the Suicide / Crisis Line Interoperability Standard (currently in Stable Form Notice 30-day period).[57]

An example "LAPD 911 diversion guide for SPC counselors and supervisors" from Didi Hirsch can be found in the Appendix.

Data-sharing approach

As stated in the NENA Suicide / Crisis Line Interoperability Standard: "Sharing of data between 911 and other entities within the crisis ecosystem can be critical for enabling the right response at the right time for individuals in crisis. Both critical incident data and caller information (e.g., caller ID, address, IP address) would ideally be able to be shared with partners, including Lifeline contact centers and first responder agencies.

Regulations currently do <u>not</u> limit data sharing between PSAPs and 988. PSAPs are legally permitted to obtain or request that a mobile carrier obtain the geolocation of a subscriber at imminent risk of death during exigent circumstances threatening death or serious bodily harm. (See, e.g., 47 U.S.C. § 222(d)(4)(A); see also 402 Michigan v. Fisher, 558 U.S. 45 (2009)).

PSAPs therefore may request that a carrier ping the location of an individual at imminent risk of death or serious bodily harm when alerted to same from a crisis line. Subscriber information can also be requested to obtain name and sometimes address or alternate phone number.

There is no reasonably foreseeable legal risk (including with regard to HIPAA) to a PSAP for requesting that a carrier ping the imminent risk user's location during exigent circumstances that threaten the user's life or that of a third party. Nor is there a reasonably foreseeable legal risk (including with regard to HIPAA) for the PSAP to provide the crisis line with disposition information relating to the attempted rescue of such user."[58]

More information can be found in the OCR / HIPAA Privacy / Security Enforcement Regulation Text, 45 CFR 414 164.512(j).

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[56] NENA 911-988 workgroup, "988 to 911 transfer draft" (unpublished manuscript, February 11, 2022).
[57] NENA 911-988 workgroup. "988 to 911," 2022.
[58] National Emergency Number Association, "NENA Suicide/Crisis Line Interoperability Standard," March 4, 2022, https://cdn.ymaws.com/www.nena.org/resource/resmgr/standards/nena-sta-001.2-2022_suicide-.pdf

Case study: Arizona Complete Health[59]

Arizona Complete Health, a provider of crisis services including a crisis line, shares reports with system partners (e.g., PSAPs, other first responder partner agencies), which can be tailored to specific county and time segment (month, quarter, or year). Data is shared bi-monthly and monthly, and organizations can request information as needed.

The items shared in the reports include:
- Crisis Line (CL) call volume and episode volume (adult and youth)
- CMT volume (adult and youth)
- CMT average response time (general calls and law enforcement calls)
- Primary Presentation–Crisis Line (adult and youth)
- Primary Presentation–CMT (adult and youth)

Information shared by PSAPs with Arizona Complete Health includes:
- BH call type volume by day of week and time of day
- Heat mapping of BH call type
- Forecasting data based on additional call type transfers
- 911 high-frequency callers identified by phone number

Systems and interoperability

The NENA Suicide / Crisis Line Interoperability Standard describes systems and interoperability principles.

Case study: The Harris Center for Mental Health and Intellectual and Developmental Disabilities (Houston, Texas)[60]

The Harris Center integrates BH call takers alongside 911 call takers at the Houston Office of Emergency Management from 6 am to 10 pm, seven days a week. This Crisis Call Diversion (CCD) program is designed to decrease reliance on preventable emergency and hospital services for people experiencing a MH crisis. Because crisis responders sit in the Harris County 911 call center and work on the same technology platform, they can rapidly respond to people's needs, resulting in faster response times.

Training: At the Harris Center, BH call takers undergo rigorous training to encourage confidence in the program and working alongside the emergency communications team. They have a bachelor's in psychology, sociology, or a related field. Each call taker receives training on crisis intervention theory, cultural awareness and trauma-informed care, rapport building and empathetic listening, privacy and confidentiality, an overview of adult and children's MH , substance use, and intellectual and developmental disabilities,

[59] Input from Arizona Complete Health, February 2022.
[60] Stephanie Hepburn, "Embedding crisis response in Harris County's 911 dispatch center," #CrisisTalk, December 14, 2021, https://talk.crisisnow.com/embedding-crisis-response-in-harris-countys-911-dispatch-center/; Input from Kristin Neylon, Project Manager and Senior Project Associate, National Association of State Mental Health Program Directors Research Institute, 2021.

how to assess for suicidal and homicidal ideation, safety planning and de-escalation, and mandatory reporting scenarios. In addition to classroom-based training, they also shadow crisis providers: Mobile Crisis Outreach Teams (MCOTs), psychiatric ER providers, 911, the fire department, and police department dispatchers, and even take part in ride-alongs with officers from the police department. The training may take up to three months.

First responder diversion: Between March 2016 and March 2021, the program diverted nearly 7,500 calls from law enforcement response, which the department estimated is equivalent to over 11,000 police hours and more than $2 million in resources saved for the police department. Between June 2017 and March 2021, it diverted more than 3,000 calls from fire department response, which the department estimates saved nearly $4.5 million over four years. Besides the time and resource savings the diversion program provides the police and fire departments, the program made over 3,000 community referrals and completed more than 2,500 safety plans with callers. Before its launch, any calls the Harris Fire Department responded to had to be cleared by law enforcement. With the implementation of the diversion program, counselors can sign off on MH crisis calls without the police department, saving both agencies significant time and resources.

Enhancing the crisis continuum: In March 2021, the Harris Center began a new collaboration with the police department to automatically dispatch MH clinicians through the Harris Center's MCOTs. The service offers an alternative to law enforcement response for non-violent, non-criminal 911 calls for service involving a MH issue the CCD program could not resolve over the phone. In the four months since the project launched, the teams have resolved 53 percent of calls they have received from the diversion program. In addition, only 31 percent of calls for MCOT were transported to a hospital for safety and stabilization, 13 percent required additional emergency response, and 3 percent could not be located upon arrival.

Relationships with PSAPs:[61] Harris Center PSAP partners noted, "if you've seen one PSAP, you've seen one PSAP." Some PSAPs have only a handful of staff while some, like the Harris Center, have hundreds of staff. Some PSAPs are designed where the dispatcher does everything from answer the initial call to making the dispatch and staying on the line with the caller until a law enforcement or EMS unit arrives on scene. Other PSAPs have each of these as specialized positions. In addition, some PSAPs use the same dispatch teams to handle calls for service for police, fire, and ambulance while others have multiple teams. All of these considerations make each contact with an individual PSAP center a unique experience which will require the crisis center to be prepared to understand the unique nature of that PSAP and how they can best benefit from a relationship. The Harris Center states it "is critical that a crisis center's first communication with their local PSAP is not to pitch the 911 / 988 collaborative." There needs to be some trust building and understanding about how both systems work and interact first. People from the crisis center, the PSAP, law enforcement, and EMS all need to be at the table to ensure all representatives' roles are fully understood.

It was very important to PSAP partners to understand training and quality assurance / performance improvement processes. It is also critical to understand the telecommunication licensure requirements for the state if part of the plan includes co-locating or working within computer-aided dispatch-software systems.

Once it has been determined that the crisis center and PSAP will work collaboratively on calls, it is key to start with the creation of a call flow to determine under what circumstances the PSAP will connect / transfer calls to the crisis center and what the

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[61] Jennifer Battle, Director of Access for The Harris Center for Mental Health and IDD Services, February 2022.

protocol for the crisis center is when the caller needs to be reconnected to the PSAP for emergency response.

It is also critical to determine what sort of data needs to be collected and/or mined from both entities so the center can ensure that it is seeing both the positive outcomes as well as areas for improvement. Decisions about who pulls what data and when, as well as what data can be shared across agencies, need to be discussed early in the written agreement process.

Just like crisis center new hires / volunteers do side-by-side shifts, there should be side-by-side shifts at the PSAP. The PSAP dispatchers and leaders should also be offered side-by-sides at the crisis center. This will help enhance both teams' understanding of work style and capability.

Case study: Didi Hirsch (Los Angeles, California)[62]

Didi Hirsch's Suicide Prevention Center (SPC) was the nation's first and is now its largest, fielding the NSPL, Disaster Distress Hotline, and local Teen Line with 24/7 bilingual coverage of calls, chats, and texts. The Los Angeles Police Department (LAPD) and Didi Hirsch partnered to build a program to divert 911 calls so those in suicidal crisis or severe emotional distress can receive appropriate MH assistance. The program began for eight hours a day and was later expanded to a 24-hour operation.

The program was shown to lessen the burden on police patrol resources, decrease violent, traumatic encounters between police and people suffering from MH crises, and save the local police department millions annually, with savings to healthcare and other systems being even larger.

Building relationships with PSAPs. Didi Hirsch found that the relationship starts with local law enforcement and the PSAP staff. About 35 years ago, she began building these relationships, coming in with the belief that law enforcement agencies are just as committed to MH crisis de-escalation as the crisis centers. The relationship is based on the idea that this is mutually beneficial, and that partnership can start with training. She asked law enforcement if they could provide training to the crisis center on their response, and also offered to provide MH de-escalation call training to law enforcement. In fact, law enforcement representatives listened in on crisis calls and vice-versa.

As part of this bi-directional learning and training, crisis counsellors and 911 operators understood that they both experienced difficult interactions. In fact, through collaboration, both crisis center and law enforcement team members began to understand each other at a human level. One particularly successful element was adding crisis response training, which included suicide prevention training, to law enforcement and PSAP standard trainings. Didi Hirsch also identified a team member that would be a dedicated point of contact and trainer for the local law enforcement and PSAP teams.

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[62] Sandri Kramer, Director of Community Relations and Special Projects, Didi Hirsch Mental Health Services, February 2022.

4. Additional categories

Universal and convenient access

A key tenet of 988 is "Universal and Convenient Access, including omnipresent public awareness and varying modalities for individuals to access 988 through their preferred method of communication." [63]

This section includes information about
1. Required answer rates
2. Projections of contact increases and answer speeds
3. Information about multichannel contacts (call, chat, text)

1. Required answer rates for coverage areas

Required answer rates for a coverage area are detailed in the table below from SAMHSA's Cooperative Agreements for States and Territories to Build Local 988 Capacity (https://www.samhsa.gov/grants/grant-announcements/sm-22-015). [64]

Key Performance Indicators (KPIs)**	Definition	Target
Calls, Chats, Texts Received	Total number of contacts received	n/a
Calls, Chats, Texts Answered	Total number of contacts answered	Greater than 90 percent
Phone, Chat, Text Average Speed to Answer**	Speed to answer contact	95 percent answered in 20 seconds, 90 percent answered in 15 seconds (network target)
Abandonment Rate	Percentage of contacts received vs. disconnected prior to answer	Less than 5 percent
Direct / Rollover calls to Backup centers	Total number of phone contacts sent to the Lifeline centers	Less than 10 percent

** Select KPIs are required for the services (phone, chat, or text) a state or territory is providing.

Commonly used metrics and their definitions include:
- *Handle time*: "the time it takes to take a call, including documentation time" [65]
- *Average speed of answer (ASA)*: "the amount of time it takes to answer a call (this does not include abandoned calls)" [66]
- *Service level*: "the proportion of calls a center answers in a certain amount of time (out of answered calls only)" [67]

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[63] "Vibrant and 988," Vibrant Emotional Health, July 13, 2020, accessed February 24, 2022, https://www.vibrant.org/988/.
[64] "Cooperative agreements for States and Territories to build local 988 capacity," Substance Abuse and Mental Health Services Administration, December 20, 2021, https://www.samhsa.gov/grants/grant-announcements/sm-22-015.
[65] "Operations and Service Levels in the Lifeline/988 Network," 2021, Vibrant Emotional Health.
[66] "Operations and Service Levels in the Lifeline/988 Network," 2021, Vibrant Emotional Health.
[67] "Operations and Service Levels in the Lifeline/988 Network," 2021, Vibrant Emotional Health.

Additional information: The Crisis Call Center Metrics guide (https://suicidepreventionlifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf).

In addition to ensuring an opportunity to respond to all contacts, centers should maintain focus on the human / therapeutic connection. [68] As Vibrant writes, "With grant requirements, it's easy to get completely caught up in the numbers. We look at these metrics for our planning, but do not fixate on it. There are intangibles that are the reason Lifeline exists. What is most important is how crisis center counselors handle callers in distress. It is easy to get caught up in call volume and cost and forget about the human connection piece. Crisis centers are a different kind of contact center, and we have to treat them as such." [69]

2. Overview of potential expectations for increases in contacts

"In order to support the development of appropriate infrastructure and operations for 988, Vibrant has compiled models to project the populations likely to utilize 988, and the potential volume of contacts via phone, SMS, and online chat for the first five years of 988's service".[70]

National projections can be found in 988 Serviceable Populations and Contact Volume Projections (https://www.vibrant.org/wp-content/uploads/2020/12/Vibrant-988-Projections-Report.pdf?_ga=2.62739180.1718066263.1611784352-1951259024.1604696443).[71]

3. Approaches to increasing share of contacts answered and multichannel availability (calls, texts, chats)

Resources to increase the share of contacts answered can be found in the Crisis Call Center Metrics (https://suicidepreventionlifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf).

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[68] James Wright, Public Health Advisor for SAMHSA.
[69] "Operations and Service Levels in the Lifeline/988 Network," 2021, Vibrant Emotional Health.
[70] Vibrant Emotional Health, "988 serviceable populations," December 2020.
[71] Vibrant Emotional Health, "988 serviceable populations," December 2020.

High quality and personalized experience

Another key tenet of 988 is "High Quality and Personalized Experience that is tailored to the unique needs of the individual while also in line with identified best practices." [72] This section includes information about best practices for contact center management and responding to contacts.

According to the NSPL: "The Lifeline provides MH professionals and crisis centers in the Lifeline network with innovative best practices and resources in the field of suicide prevention and MH (https://suicidepreventionlifeline.org/best-practices/)." [73] These best practices and resources include:

Imminent risk [74]
- Policy for Helping Callers at Imminent Risk of Suicide: This document outlines the research and rationale that led to the development of the Lifeline's policy for helping callers at imminent risk of suicide. It provides a definition for what constitutes a caller at imminent risk of suicide, informed by Lifeline's Suicide Risk Assessment Standards. In addition, it describes the process used to determine the core values, definitions, and components of the policy (https://drive.google.com/file/d/1MKdm9HC5F0LFpuLTmL0IGW0dhLZeGDT2/view)
- Checklist of Imminent Risk Requirements: This document contains all of the required elements of a center's Imminent Risk Policy; it outlines those requirements in a checklist format (https://drive.google.com/file/d/1aCxBfeaO4l9EJhADA21c175KKEtIKcS2/view)
- Lifeline Best Practices for Helping Callers (https://drive.google.com/file/d/1RuSEAlej-bUB-Kt8LlFxME0qK6BniFRG/view)

Risk/safety assessment [75]
- Establishing standards for the assessment of suicide risk among callers to the NSPL: This document provides the background on the need for these standards, describes the process that produced them, summarizes the research and rationale supporting the standards, and reviews how these standard assessment principles and their subcomponents can be weighted in relation to one another so as to effectively guide crisis counselors in their everyday assessments of callers to the Lifeline (https://drive.google.com/file/d/1R3_wRDSN0EKjcvk9Vd3AmQ9xGfAXdggn/view)
- Suicide Risk Assessment Standards chart: This document provides a reference chart outlining the core principles and subcomponents of assessment, including the required prompt questions (https://drive.google.com/file/d/1F1EQ7Qvgz2wWABNYr4wyliudkHiKFATz/view)
- Risk / Safety Assessment Checklist: This document contains all of the required elements of a center's Risk / Safety Assessment and outlines those requirements in a checklist format (https://drive.google.com/file/d/1-roj5zbLyqXI8FnMc5cbuTsJuhWUxZ8X/view)

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[72] "Vibrant and 988," July 13, 2020.
[73] "Best practices," National Suicide Prevention Lifeline, accessed February 26, 2022, https://suicidepreventionlifeline.org/best-practices/.
[74] National Suicide Prevention Lifeline, "Lifeline best practices and clinical resources," updated November 2020, https://988vibrant.grant.org.
[75] National Suicide Prevention Lifeline, "Lifeline best practices and clinical resources," 2020.

Other policies, documents, and training required in network agreements [76]
- [Network Agreement Provision of Resource Referrals requirement](https://docs.google.com/document/d/1fbJW-jzi1KZnNZv3X-eOZ0CjinMbOg2K8WAAdsN58hc/edit) (https://docs.google.com/document/d/1fbJW-jzi1KZnNZv3X-eOZ0CjinMbOg2K8WAAdsN58hc/edit)
- [Network Agreement Grievance / Complaint / Caller Action requirements](https://docs.google.com/document/d/136omXR96zIO0OPuVFoXOZG8p-FDzO9ohhjNWiKQbYDg/edit) (https://docs.google.com/document/d/136omXR96zIO0OPuVFoXOZG8p-FDzO9ohhjNWiKQbYDg/edit)
- [Network Agreement Training requirements](https://docs.google.com/document/d/1KFTemyGfvx2AaxlujqfTiab-vg5vgF4XxfaDTq2WUD8/edit) (https://docs.google.com/document/d/1KFTemyGfvx2AaxlujqfTiab-vg5vgF4XxfaDTq2WUD8/edit)

Information on related and additional topics can be found in the Practice Guidelines section of the NRC, including :
URL:
(https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fpages%2Fviewpage.action%3FspaceKey%3Dpracticeguide%26title%3DTip%2BSheets)

- **"Contact center management**: This page contains best practice guidelines for managing a contact center
- **Follow-up**: Follow-up has become an integral part of crisis center services. This page provides a wealth of information on providing follow-up services to both Lifeline callers and those recently discharged from inpatient or emergency department settings
- **Good contact**: This page contains information on good contacts and collaborative problem-solving
- **Imminent risk**: The Lifeline policy for helping callers at imminent risk of suicide was adopted throughout the network in 2012. Detailed information on this policy is included here as well as information on how to ensure center policies meet this network requirement. Crisis center examples of approved policies are provided
- **Lifeline crisis chat / text**: The Lifeline Crisis Chat (LCC) program was officially launched in February 2013. Information is provided on the value of chat service provision and the steps to take to join the LCC Network
- **Postvention**: This page contains information on postvention as well as supporting documentation
- **Quality practice**: In January 2014, the Lifeline distributed the best practices for helping callers to the Lifeline network of crisis centers. This page provides information on the development of this document and links to supporting documentation and resources to assist with quality programming
- **Safety assessment**: This page contains information on the Lifeline Safety Assessment as well as supporting documentation
- **Safety planning**: This page provides information on safety planning and links to training resources for safety plan development
- **Violence / threat management**: This page contains information about the violence assessment and threat management webinar series with links to the recordings and handouts as well as supporting documents with recent research and resources for those with further interest in the topics." [77]

Tip sheets for specialized interventions can also be found in the NRC, including on inclusive language, LGBTQ youth guidelines, maternal MH , psychotic symptoms, gambling disorders, working with American Indians / Alaska Natives, working with the deaf community, and

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[76] National Suicide Prevention Lifeline, "Lifeline best practices and clinical resources," 2020.
[77] "Practice guidelines," Lifeline Network Resource Center, n.d., https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fpages%2Fviewpage.action%3FspaceKey%3Dpracticeguide%26title%3DFollow-Up.

working with individuals with substance use concerns, among many others (https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fpages%2Fviewp age.action%3FspaceKey%3Dpracticeguide%26title%3DTip%2BSheets).

Connection to local resources and follow-up

Another key tenet of 988 is "connection to resources and follow-up to ensure all persons contacting 988 receive additional local community resources as needed."[78]

Follow-up

"Crisis centers are uniquely positioned to be a crucial resource for people in need of follow-up care and are a vital resource for linking patients to services and providing emotional support."[79] Most centers provide "some form of follow-up service. Programs ranged from follow-up services for familiar callers, monthly check-ins for high-risk callers, ED / inpatient discharges, high-risk callers, and third-party calls." [80]

Resources for follow-up care: SAMHSA has made significant investments to ensure follow-up care is integrated within crisis centers within the Lifeline. Funding opportunities for initiatives such as follow-up care can be found on SAMHSA's website, when / if listed (https://www.samhsa.gov/grants).[81]

SAMHSA has provided direct grant funding to expand follow-up services through the Lifeline's contact centers. This program was intended to create an integrated hub that: "(1) ensures systematic follow-up of suicidal persons who contact a NSPL Crisis Center; (2) provides enhanced coordination of crisis stabilization, crisis respite, and hospital emergency department services; and (3) enhances coordination with mobile on-site crisis response. In effect, with the resources provided, the hub should not lose track of a person in a suicidal crisis as they interface with crisis systems."[82] The goal is to ensure "continuity of care to safeguard the well-being of individuals who are at risk of suicide."[83]

Additional information:
About follow-up care and effectiveness: In 2016, the Lifeline created the Follow-Up Matters microsite
(https://followupmatters.suicidepreventionlifeline.org/?_ga=2.34605221.544625352.1646010 686-1989988634.1643164991) as a resource for contact centers, emergency departments, and other providers and stakeholders who are interested in creating and supporting follow-up partnerships. The microsite provides resources such as information on getting started with follow-up partnerships, access to research and statistics that support follow-up initiatives,

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[78] "Vibrant and 988," July 13, 2020.
[79] "Follow-up," Lifeline Network Resource Center, n.d., https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fpages%2Fviewpage.action%3FspaceKey%3Dprac ticeguide%26title%3DFollow-Up.
[80] "Follow-up," Lifeline Network Resource Center.
[81] "Grants," Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/grants.
[82] Note: "Eligibility is limited to NSPL Crisis Centers because they have been specifically trained in NSPL procedures pertaining to follow-up of persons at imminent risk of suicide and in risk assessment and are the only entities that can obtain the required consents from NSPL Crisis Center callers for follow-up activities. This eligibility limitation ensures that the infrastructure is in place to serve high-risk, high-priority, and/or underserved populations. Limiting eligibility also ensures that relationships with local and state mental health systems are in place for NSPL Crisis Center callers, and that individuals discharged from partnering agencies receive follow-up care and access to treatment." Source: "Suicide prevention lifeline crisis center follow-up expansion grant program," Substance Abuse and Mental Health Services Administration, January 9, 2019, https://www.samhsa.gov/grants/grant-announcements/sm-19-008.
[83] "Suicide prevention lifeline," 2019.

tools for use in assessment and follow-up, sample materials, examples and profiles of current follow-up partnerships under the current SAMHSA Follow-up grant, and more."[84] *Guidance for follow-up care:* This can be found on the NRC's Follow Up (https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fpages%2Fviewp age.action%3FspaceKey%3Dpracticeguide%26title%3DFollow-Up) page.

Collaborating with peer support / warmlines

"Peer support services are profoundly valuable and fill an important role in the continuum of care that supports individuals seeking crisis services. The Lifeline also fills an important and different role in that continuum of care. Callers having the option and ability to choose the type of support they feel works best for them, which is important when different modalities for support exist in the individual's area."[85]

"A warm line is an alternative to a crisis line that is run by 'peers,' generally those who have had their own experiences of trauma that they are willing to speak of and acknowledge. Most warm line operators have been through extreme challenges themselves and are there primarily to listen. A warm line has the purpose of reducing hospitalization and forced treatment, being a cost effective and non-intrusive, voluntary intervention."[86]

Additional information: How the Lifeline centers collaborate with peer support / warmlines is available in the NRC. Multiple organizations have lists of warmlines that they try to keep as up-to-date as possible:

- Warmline.org's Directory (https://warmline.org/warmdir.html)
- Mental Health America's (MHA's) list of available warmlines (https://screening.mhanational.org/content/need-talk-someone-warmlines/)
- NAMI's National Warmline Directory (https://nami.org/NAMI/media/NAMI-Media/Helpline/NAMI-National-HelpLine-WarmLine-Directory.pdf) and the NAMI HelpLine (an information and resource referral helpline that can connect help seekers with NAMI programs, NAMI support groups, and peer-informed national resources—https://www.nami.org/help)

Relationships with in-person care sites

To build a strong continuum of care, centers and in-person sites of care can establish linkages to other sites of care, including mobile crisis services, CSRFs, peer-run respites, and emergency departments.[87][88]

***Mobile crisis services, e.g., MCTs:*[89]** Connecting individuals in crisis to mobile crisis services, as appropriate, is an essential element of an integrated crisis system. Examples of MCTs in three communities can be found in the TAC report on Mobile Crisis Teams: A State planning guide for Medicaid-financed crisis response services

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[84] "Follow-up," Lifeline Network Resource Center.

[85] "Collaborating with peer support / warmlines," Lifeline Network Resource Center, https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fpages%2Fviewpage.action%3FspaceKey%3Dprac ticeguide%26title%3DTip%2BSheets.

[86] Daniel Fisher, President, National Coalition for Mental Health Recovery.

[87] SAMHSA. 2020. "National guidelines for behavioral health crisis care – best practice toolkit," Substance Abuse and Mental Health Services Administration, pg. 25, 2020, https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

[88] Daniel B. Fisher et al., "Peer-run respites: An effective crisis alternative," Substance Abuse and Mental Health Services Administration, n.d., https://www.nasmhpd.org/sites/default/files/Peer%20Run%20Respite%20slides.revised.pdf.

[89] Jordan Gulley et al., "Mobile crisis teams: A State planning guide for Medicaid-financed crisis response services," Technical Assistance Cooperative and California Health Care Foundation, January 2022, https://www.tacinc.org/resource/state-planning-guide-for-medicaid-financed-mobile-crisis-response/.

(https://www.tacinc.org/resource/state-planning-guide-for-medicaid-financed-mobile-crisis-response/). [90]

Crisis receiving and stabilization facilities (CSRFs): [91] CSRFs can take many forms; in many communities, CCBHCs provide access to these services. CCBHCs are involved across the crisis continuum, with prevention, crisis response (24/7 mobile teams, crisis stabilization, suicide prevention), detoxification, coordination with law enforcement and hospitals, and post-crisis care. 100 percent of CCBHCs provide crisis support and many operate crisis call lines.

To find nearby CCBHCs, visit the CCBHC Success Center or email ccbhc@thenationalcouncil.org.[92]

The chart below from the National Council for Mental Wellbeing describes some of the different names used for facility-based care.[93]

Many flavors of facility-based crisis stabilization

What's in a name? All of these things might be called a "CSU" depending on the state nomenclature and licensing.

Model	Description	Level of Care	Acuity	Locked	Police drops	Use of peers
23 hr. obs	Short-term (< 24 hrs.) assessment and stabilization with hospital level staffing and safety protocols	LOCUS 6 "Medically Managed" with 24/7 nursing and medical coverage	Can take both low and high acuity/violent patients	Yes	Yes	Yes
Subacute	Short-term (3-5 days) inpatient-like care. Can be reimbursed as crisis via MHBG/SABG.				Sometimes	Yes
Living Rooms	Short-term (< 24 hrs.) stabilization in a home-like environment with mostly peer staffing	LOCUS 5 "Medically Monitored" with medical/nursing staff available but not on-site 24/7	Lower acuity patients not at imminent risk of harm to self/other, not agitated or violent	No	Sometimes	Yes
Sobering Centers & "Social Detox"	Short-term (< 24 hrs.) stabilization for patients with substance use needs, typically not using meds			No	Sometimes	Yes
Crisis Residential	Intermediate term (days to a couple weeks) crisis stabilization in a residential setting			No	Usually not	Yes

An episode of care might start at one level of care then step-down to a lower acuity facility.

Peer-run respites:[94] Peer-run respites are another model of short-term facility-based care. A peer respite is a voluntary, short-term, overnight program that provides community-based, non-clinical crisis support to help people find new understanding and ways to move forward. It operates 24 hours per day in a homelike environment. As of March 2021, peer respites are currently operating in California, Florida, Georgia, Iowa, Massachusetts, Nebraska, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Vermont, and Wisconsin. Peer respites are staffed and operated by people with psychiatric histories or who have experienced trauma and/or extreme states. This means that: 1) 100 percent of staff have lived experience of extreme states and/or the BH system; 2) All individuals in program / house management positions have lived experience of extreme states and/or the MH system; 3) Job descriptions for program / house management positions require lived experience of extreme states and/or the MH system; and 4) The peer respite is either

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[90] Gulley, "Mobile crisis teams," 2022.
[91] "Crisis care continuum integration: Crisis stabilization units and in-patient psychiatric units," June 16, 2021, Vibrant Emotional Health
[92] Rebecca Farley David, "CCBHC and 911 / PSAP partnerships: Building comprehensive referral resources and strategies," Vibrant Emotional Health and Education Development Council,
[93] "Crisis care continuum integration: Crisis stabilization units and in-patient psychiatric units," June 16, 2021, Vibrant Emotional Health
[94] Daniel Fisher, President, National Coalition for Mental Health Recovery.

operated by a peer-run organization OR has an advisory group with 51 percent or more members having lived experience of extreme states and/or the BH system.

The National Empowerment Center (NEC) compiles a directory of peer respites (https://www.peerrespite.com/directory/).[95]

Emergency departments: Examples of different types of partnerships that contact centers have developed with Emergency Departments, as well as strategies of how to go about creating these relationships, can be found in the Emergency Department Partnership Toolkit (https://networkresourcecenter.org/plugins/servlet/samlsso?redirectTo=%2Fdownload%2Fatt achments%2F8421462%2FLifeline%2520Crisis%2520Center-Emergency%2520Department%2520Partnership%2520Toolkit.pdf%3Fversion%3D1%26mo dificationDate%3D1536862438957%26api%3Dv2).

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[95] "Peer respite directory," last updated 2018, https://www.peerrespite.com/directory/.

III. Additional resources

Compiled below are additional resources for Lifeline contact centers:

Substance Abuse and Mental Health Services Administration (SAMHSA)
National Guidelines for Behavioral Health Crisis Care
https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
Crisis care best practice toolkit

Substance Abuse and Mental Health Services Administration (SAMHSA)
988: America's Suicide Prevention and Mental Health Crisis Lifeline
https://www.samhsa.gov/find-help/suicide-prevention/988-lifeline
Preparing for 988, Frequently asked questions (FAQ)

Substance Abuse and Mental Health Services Administration (SAMHSA)
Crisis services for Child, Youth, and Family Guidelines
Forthcoming

Centers for Disease Control and Prevention (CDC)
Health Equity Guiding Principles for Inclusive Communication
https://www.cdc.gov/healthcommunication/Health_Equity_Lens.html
Inclusive communication principles

Lifeline Network Resource Center (NCR)
- **Call Specialist Resources**
    - https://networkresourcecenter.org/category/csr
    - Information about in-call tools, practice guidelines, specific populations, training, enrichment, and research and evaluation
- **Center Operations Resources**
    - https://networkresourcecenter.org/category/co
    - Information on data, media, 988, sustainability, funding, and zero suicide
- **Lifeline Operations Resources**
    - https://networkresourcecenter.org/category/lo
    - Information on committees, network information, partnerships, and policy

Vibrant Emotional Health / National Suicide Prevention Lifeline
- **Vibrant and 988**
    - https://www.vibrant.org/988/
    - Frequently asked questions (FAQ), documents for stakeholders, Vibrant statements on 988, press releases and statements
- **988 Serviceable Populations and Contact Volume Projections**
    - https://www.vibrant.org/wp-content/uploads/2020/12/Vibrant-988-Projections-Report.pdf?_ga=2.62739180.1718066263.1611784352-1951259024.1604696443
    - Projected contact volume
- **Crisis Call Center Metrics**
    - https://suicidepreventionlifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf

Note:
In addition to the sources noted above, this document incorporates information shared during the Lifeline Contact Centers Working Group meetings of partners of the SAMHSA / NASMHPD 988 co-sponsorship (December 2021 – March 2022).

IV. Appendix

Appendix A: Active surge management example protocol from BHR

Example protocol[96]
- If calls hold for two minutes:
  - An automated email notification will go out to all of the on-call management team
  - If the Operations Analyst is available, they will notify the contact center leads and managers that they are taking care of notifying CICs who need to get in queue via email and/or teams to individual/s
    - The Operations Analyst will also note any DND and call lasting longer than 10 minutes during the surge
    - A clinical staff member who supports the contact center leads and a manager (the person with the most seniority, who is on shift first) will stay out of queue to assist CICs by taking over their Telehealth / Mobile outreach team (MOT) dispatching and staffing during the surge
  - If Operations Analyst is not available, the staff with the most seniority, who is on shift first, will monitor the dashboard for calls waiting and will also stay out of the queue to assist with all staffing needed during the surge. They will keep the dashboard and teams open on their screen
- At two minutes, contact center staff who are <u>not</u> on lunch, break, actively working with IT, or in a scheduled meeting with their supervisor <u>must</u> become available
  - If sending a MOT, telehealth, or on-call email, leads and managers and the person with the most seniority (as noted above) will do it. Leads will stop making outbound SL calls at this mark
- At four minutes, all clinical staff need to log in (i.e., leads, CCC, managers) except for one identified person (as noted above) who handles staffing, contacting MOTs / Telehealth / or on-call resources

Ongoing Surge / Extended Surge

- Notice of emergency call coverage: Contact the Operations Analyst and the Clinical Director of the contact center
- If high surge volume continues, at 30 minutes maximum or earlier based on the managers / leads discretion, the Clinical Director will be contacted about the issue
- If the Clinical Director does not believe this will be resolved in less than an hour, they will contact the Chief Clinical Officer

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[96] Behavioral Health Response via National Council for Mental Wellbeing.

Appendix B: MOUs between contact centers and PSAPs

Example A – Simple MOU: between XYZ Crisis Center and ABC County 911 Services[97]

This Memorandum of Understanding (MOU) outlines the working relationship between XYZ Crisis Center and the ABC County 911 System.
- *Insert paragraph detailing programs and services of ABC County 911*
- *Insert paragraph detailing programs and services of XYZ Crisis Center*

The following information is provided to both parties for coordination purposes:

Responsibilities of the XYZ Crisis Center under this MOU:
- XYZ Center crisis counselors will accept calls referred by 911 operators from callers seeking non-emergent help with suicidal thoughts or emotional crises
- XYZ Center crisis counselors will instruct callers needing emergency services, such as fire, law enforcement, or medical services, to hang up and dial 911
- XYZ Center crisis counselors will attempt to collect appropriate information from callers unable or unwilling to dial 911 and transmit that information to the appropriate 911 PSAP (Public Safety Answering Point)
- XYZ Center crisis counselors will, when a caller or chat visitor is determined to be at imminent risk for suicide / suicide in progress, collect as much information as possible on the circumstances and notify the appropriate PSAP. This will include information on the suicide plan, potential weapons, and other known dangers to responding emergency personnel. The XYZ crisis counselor will remain on the line with the caller as long as possible. In these circumstances, the crisis counselor will share any caller ID information, address / location, IP address, or any other identifying information the caller has shared

Responsibilities of the ABC County 911 System under this MOU:
- ABC County 911 Operators will, at their discretion, refer or transfer callers in emotional crises to the XYZ Crisis Center. When possible, 911 Operators will inform crisis counselors that they have transferred a call and let the crisis counselor know whether they intend to monitor the call
- ABC County 911 Operators will use the identifying information provided by the crisis center for situations involving imminent risk of harm / harm in progress and assist with location and dispatch of emergency services to these callers / chat visitors 24 hours per day when requested by the XYZ Crisis Center
- This MOU shall take effect upon the date signed by both parties and shall be reviewed annually. Either party shall be allowed to terminate this MOU by submitting a written letter to the other party.

XYZ Crisis Center Name / title, Signature & Date
ABC County 911 Name / title, Signature & Date

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[97] Input from Vibrant Emotional Health, 2022

Example B – MOU centers that are blended crisis / information and referral lines:[98]

Memorandum of Understanding *between* **blended crisis center** *and* **sample PSAP**

Center Name is a non-profit organization in **City, State** that answers various hotlines including **xxx** and **xxx**, and local area calls for the NSPL. The hotlines provide callers with 24-hour telephone crisis / suicide prevention and community information and referrals.

Purpose:
This memorandum describes and documents the working relationship between **Center Name** and the **PSAP Name** (hereafter referred to as 911) in order to enhance delivery of Information & Referral, Crisis Intervention, and Suicide Prevention services to community residents and assist with the non-emergency calls to 911.

Center Name and other local nonprofits, community organizations, and government agencies share a common mission of serving their communities. They seek to improve access to community health and human services and to serve as community barometers to indicate insufficient resources and gaps in services. With that mission in mind, **Center Name** is proud to partner with 911 to provide the community with appropriate information and referral, crisis intervention, and suicide prevention services and to limit non-emergency calls to 911.

Each party to this memorandum is a separate and independent organization and nothing herein shall be constructed to create a joint venture or legal partnership. Each organization shall retain its own identity in providing services.

<u>**Center Name** and 911 agree to the following</u>:

Component I: Confidentiality

1. Client confidentiality is to be maintained by **Center Name** staff and volunteers **at all times**, except when the client gives the crisis counselor explicit verbal permission to share specific information with an agreed-upon entity for purposes of advocacy / referral or in cases where the crisis counselor learns of imminent danger to a person or persons, or in cases where the crisis counselor learns of abuse or neglect of a minor, disabled adult, or elder.

2. Every person contacting **Center Name** has the right to receive services without divulging his/her identity. Services provided to a client should in no way be affected by their choice to maintain anonymity. However, certain demographic and other information is requested and recorded for purposes of maintaining confidential client records and aggregated call reports.

3. **Center Name** and 911 will comply with all applicable federal, state, and local confidentiality laws.

4. **Center Name** will provide 911 with an aggregated data report of contacts referred to the 911 on a quarterly basis.

5. **Center Name** crisis counselors will consult with a supervisor prior to breaching a contact's confidentiality, except with suicide in progress contacts, violence in progress contacts, or contacts where the person has become unconscious.

Component II: Community Collaboration

1. **Center Name** and 911 will communicate, at least annually, to evaluate mutual processes and practices and make changes to this memorandum of agreement as needed.

Component III: Client Contacts

1. 911 may direct callers requesting non-emergency related information and referral services to **Center Name** through referral, call transfer, or call conferencing processes.

2. 911 may direct callers in crisis or those individuals wanting to speak with a crisis counselor and not have Emergency Medical Services (EMS) respond to their location to **Center Name** through referral or call transfer or call conferencing processes.

3. 911 may call conference **Center Name** for callers in crisis who have EMS responding to their current location.

4. **Center Name** crisis counselors will consult with a supervisor prior to calling 911 for callers who require emergency services due to imminent risk for suicide or violence.

5. **Center Name** can provide a presentation to 911 staff, as requested by 911 and the schedule availability of **Center Name**.

Component VI: Termination

Shall either **Center Name** or 911 decide to terminate this memorandum of agreement they shall send written notice of intent to the other party 30 days prior to termination, which shall conclude all activity detailed in this agreement. Each party shall remove references to this agreement from their website and other similar documents.

For **Center Name**.:

Center Representative Name / Title

For **PSAP Name**

PSAP Representative Name / Title

Appendix C: LAPD 911 dispatch protocol for diverting calls involving persons experiencing a mental health crisis to Didi Hirsch[99]

The following situations shall be considered for transfer to Didi Hirsch:
- Suicide attempt or suicidal thoughts
- Possible suicide attempt or suicidal thoughts
- Mental illness
- Possible mental illness

The operator receiving the call shall conduct a thorough interview and determine if the circumstances meet any of the following criteria:
- The caller is threatening to jump from a bridge or structure
- The caller needs medical attention
- A suicide attempt is in progress
- The caller has a weapon and is in public with others present
- The caller has a weapon, is inside a residence / building, and with others present

If any of the above criteria are met, the operator shall follow established policies, procedures, and guidelines and dispatch a patrol unit / SMART and/or transfer to the Los Angeles Fire Department (LAFD).

If none of the above criteria are met, the operator shall:

1. Create an incident in the PremierOne Computer Aided Dispatch system and attempt to obtain the caller's name, location, phone number, and any pertinent information. The incident shall be closed using the "CTR" disposition code and "transferred PR to Didi Hirsch" noted in the comments.

> **Note:** If the caller refuses to provide their location, the operator shall use the address of the Metropolitan or Valley Communications Dispatch Center. Location information provided by Automatic Location Information and/or RapidSOS shall be entered into the comments of the incident in the event it is needed later.

2. Advise the caller they are being connected to a crisis counselor and not to hang up. Tell the caller you are going to provide the counselor with some background information while the caller is on the line.

> **Example:** *"I am going to connect you with a crisis counselor that can help you, please don't hang up. When the counselor answers, you are going to hear me give them some background information on you and what you're experiencing today. After that, you will remain connected to the counselor, and I will drop off the line."*

3. Conference the caller with Didi Hirsch using the dedicated phone number **(424) xxx-xxxx**. This number is programmed into the Power 911 application in the "Quick Dial" section. Searching the key words "mental" or "suicide" will also display the Quick Dial entry.

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[99] Sandri Kramer, Suicide Prevention Program Director at Didi Hirsch Mental Services.

4. Announce to the counselor that you are from LAPD and have a caller on the line, introduce the caller by name, and provide a brief synopsis of the situation.

> **Example:** *"This is Operator 123 from LAPD. I have James on the line, and he's been depressed recently over the death of his spouse. He reached out for some help today."*

5. Provide the counselor with the incident number, caller's address, phone number, and any other pertinent information.

6. Indicate that you are dropping off the line then release the call.

Appendix D: LAPD 911 diversion guide for crisis counselors and supervisors[100]

How will I know it is an LAPD 911 Diversion call?
- Starting Feb. 1, you will see an additional queue / phone line called "LAPD 911 Diversion" added onto our system
- Staff and volunteers who have completed the apprenticeship will be the only ones who can see and receive calls from this line
- This line will not roll and must be answered (has been programmed as a priority line above all other lines)
- 'LAPD 911 Diversion' will also auto-populate into the iCarol report under 'Line Called'

What types of transfer calls we will receive:
- Calls transferred to us will be those in emotional distress, MH crisis, or suicidal crisis ***For exact criteria, please see LAPD Dispatch Protocol for 911 Diversion***
- Calls on this line will only be from **LAPD 911 Dispatch**, not CHP operators or other entities. Other law enforcement agencies may continue to cold or warm transfer calls to us on our other lines as they always have
- LAPD should not divert crime-related calls to us nor calls where a person is already in imminent danger or physically harmed and needs immediate medical attention
- Our role as crisis line counselors remains the same and we are expected to continue utilizing our crisis-line training to handle these calls. It is not expected for us to have any specialized training for this service. The diverted calls are from people who should have called us to begin with, not 911. Please handle all calls as you normally would on any of our lines
- If you receive calls outside of these parameters, please still take the call:
  - After the call, please notify your supervisor
  - Supervisors: Please add the call report in the on-call email and note this

All calls from LAPD 911 Diversion should be warm transfers (i.e., the LAPD 911 operator will provide you with information with the caller still on the line)
- If any call is cold transferred (you are immediately connected to the caller without being handed off by the operator first), please inform your supervisor
- Supervisors: Please add this to the call report and note what happened in the on-call email

You should receive the following information from the Operator:
- Caller's name
- Caller's phone number
- Caller's address or location (if exact address is not available)
- Reason for the transfer
- Incident number
- Operator Number
- *It is okay to ask background questions of the operator to ensure you get important information*

How to handle the call with the caller
- Start from the beginning like a regular call, do not assume all information from the operator is correct but use it as a prompt to start the interaction

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[100] Sandri Kramer, Suicide Prevention Program Director at Didi Hirsch Mental Services.

- Continue using your crisis line training to take the call as you would any call on the lines
- *ALWAYS OFFER A FOLLOW-UP CALL* to the caller, regardless of presence or level of suicidality / risk. This is a mandated part of our contract with LAPD 911 Dispatch
    - The only exception is if the caller is abusive. Please document why a follow up was not offered when this occurs
    - Depending on the risk of the caller, you can decide if a high risk or standard follow-up is needed
    - You will document the reason for follow-up as 'Contracted Follow-Up Service (911 Diversion, ELAC, EDFU). This check box has been added to the call report

If the call turns into a rescue and emergency services are needed:
- **SUPERVISORS ONLY:** CALL OUR LAPD DISPATCH SPECIFIC NUMBER**: (xxx)xxx-xxxx** and provide the incident number to let them know a rescue is needed
    - COUNSELOR WILL NOT TRANSFER CALLER BACK TO 911
        - The only exception would be if caller explicitly requests to be transferred back and the supervisor deems this to be appropriate
    - Dispatch will know who the caller is based on the incident number
- This Dispatch Specific Number is to be used by supervisors mainly for 911 Diversion callers needing rescue
    - Supervisors CAN also use this direct line for callers needing rescue from other lines if they are confirmed to be located within the Los Angeles city area
- This is considered a rescue and should be treated as any other rescue (counselor will stay on the line with caller while supervisor contacts dispatch and until emergency rescue arrives)