Building California's Comprehensive 988-Crisis System:

A Strategic Blueprint

AB 988 Five-Year Implementation Plan to the State Legislature

December 31, 2024

Table of Contents

Acknowledgments

The 988-Crisis Policy Advisory Group (PAG) devoted substantial time and attention to supporting the development of this Five-Year Implementation Plan. PAG members and delegates[i] participated in seven in-person public meetings and many virtual public workgroup sessions. PAG members represent a cross-section of state, county, and local government, behavioral health providers, advocates, and community representatives. PAG members are:

Amanda Levy, California Department of Managed Health Care (DMHC)

Anete Millers, California Association of Health Plans (CAHP)

Ashley Mills, California Department of Public Health (CDPH)

Brenda Grealish, Council on Criminal Justice and Behavioral Health (CCJBH)

Jessica Sodhi, California Governor's Office of Emergency Services (Cal OES)

Chad Costello, California Association of Social Rehabilitation Agencies (CASRA)

Christine Stoner-Mertz, CA Alliance of Child and Family Services

Doug Subers, California Professional Firefighters

Elizabeth Basnett, California Emergency Medical Services Authority (EMSA)

Erika Cristo, California Department of Health Care Services (DHCS)

Jana Lord, Sycamores

Jeff Hebert, San Diego Sheriff's 9-1-1

Jennifer Oliphant, Two Feathers Native American Family Services

Jessica Cruz, National Alliance on Mental Illness (NAMI) California

John Boyd, Kaiser Permanente Northern California

Kasey Suffredini, The Trevor Project (Joined August 2024 for Peggy Rajski)

Kenna Chic, Project Lighthouse (formerly)

Keris Jän Myrick, Inseparable

Kirsten Barlow, California Hospital Association (CHA)

Lan Nguyen, County of Santa Clara Behavioral Health Services Department

Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies (CBHA)

Lee Ann Magoski, Monterey County Emergency Communications 9-1-1

Lei Portugal Calloway, Telecare Orange County

Melissa Lawton, Seneca Family of Agencies

Michael Tabak, San Mateo County Sheriff's Office

Michelle Doty Cabrera, County Behavioral Health Directors Association (CBHDA)

Miguel Serricchio, LSQ Funding Group

Nancy Bargmann, California Department of Developmental Services (DDS)

Phebe Bell, Nevada County

Rayshell Chambers, Mental Health Services Oversight and Accountability Commission (MHSOAC)

Rebecca Bauer-Kahan, CA State Assembly Member, AD 16

Rhyan Miller, Riverside County Department of Mental Health Substance Abuse Prevention and Treatment Programs

Robb Layne, California Association of Alcohol and Drug Program Executives, Inc. (CAADPE)

Robert Smith, Pala Band of Mission Indians

Roberto Herrera, California Department of Veterans Affairs (CalVet)

Ryan Banks, Turning Point of Central Valley, Inc.

Shari Sinwelski, Didi Hirsch Mental Health Services

Sohil Sud, California Health and Human Services Agency (CalHHS)

Stephanie Welch, California Health and Human Services Agency (CalHHS)

Stephen Sparling, CalYouth

Susan DeMarois, California Department of Aging (CDA)

Tara Gamboa-Eastman, Steinberg Institute

Taun Hall, The Miles Hall Foundation

Executive Summary

Following the passage of the **Miles Hall Lifeline and Suicide Prevention Act (AB 988)** in September 2022, the California Health and Human Services Agency (CalHHS) launched a year-long process to develop a Five-Year Implementation Plan (the Plan) that would help build a comprehensive 988-crisis system in the state.

AB 988 requires the establishment of an advisory group, subsequently named the **988-Crisis Policy Advisory Group (PAG)**, comprised of state and county representatives, service providers, advocates, and community representatives. The PAG, supported by seven interrelated Workgroups, met to develop recommendations for consideration by the state. The recommendations included in the Plan are intended to enhance existing programs and build a comprehensive 988-crisis system that addresses community needs and aligns with current and emerging federal requirements and national best practices.

AB 988 created the 988 State Suicide and Behavioral Health Crisis Services Fund, consisting of revenues generated by a telecom surcharge to support 988 Crisis Centers and related mobile crisis teams. The California Governor's Office of Emergency Services (Cal OES) administers this fund, managing the surcharge fee and overseeing state technology for 9-1-1-988 interoperability, with advice from the State 988 Technical Advisory Board (TAB). The fee, initially capped at $0.08 per access line per month, can be increased to a maximum of $0.30, based on a specified formula. AB 988 underwent further modifications in AB 118, the trailer bill that incorporates the implementing language of the California State Budget.

Strengthening crisis services in California is critical. In 2022, 4,312 Californians died by suicide[2] and 11,002 died due to drug overdose.[3] California, like most other states, has also experienced a significant rise in overdose deaths from the Opioid/Fentanyl crisis.[4] Across the state, more than 2.1 million Californian's visited an emergency department (ED) with a behavioral health concern in 2021.[5] In 2023, one in four Californians (25%) reported that they or someone close to them needed treatment for a serious mental illness (SMI), and one in five (21%) indicated that either they or someone close to them needed treatment for substance use or addiction issues.[6]

California's Comprehensive 988-Crisis System in Context

California's behavioral health crisis systems strive to serve everyone in California along a continuum of services that prevent, respond to, and stabilize crisis. The long-term aim of a comprehensive 988-crisis system is to connect individuals who call, text, or chat with

community-based providers capable of delivering a full spectrum of crisis care services while also providing help seekers with tools and resources to help prevent future crises.[7]

Central to these efforts is the implementation of the 988 Suicide and Crisis Lifeline (previously known as the National Suicide Prevention Lifeline) as a statewide service and its connection to 9-1-1, community-based crisis response, and stabilization services. The 988 Suicide and Crisis Lifeline is a national network that offers 24/7 call, text, and chat access for help seekers experiencing a behavioral health crisis.[8] As of December 2024, 12 California 988 Crisis Centers belong to this national 988 network, which is operated and administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) and its contracted national administrator.

Calls to California's 9-1-1 system are answered by 450 locally governed Public Safety Answering Points (PSAPs).[9] Connectivity between 9-1-1 and 988 is variable in terms of both technology and available resources. California is working toward establishing and verifying interoperability between 9-1-1 and 988, as required by AB 988.[10]

California is also investing in local mobile crisis response capacity. As of September 2024, the State had funded more than 450 Crisis Care Mobile Units (CCMU) through the Behavioral Health Continuum Infrastructure Program (BHCIP).[11] As of December 2024, 48 counties were approved to provide mobile crisis services under the Medi-Cal Mobile Crisis benefit, covering 98% of Medi-Cal members statewide.[12] The benefit helps to support county-based mobile crisis response teams that can provide rapid response, assessment, and stabilization to people experiencing a behavioral health crisis.[13] Additional community-based crisis response teams and innovative local models – funded at the local level – are also available across the state.

California's behavioral health efforts include significant investments in building the physical infrastructure necessary for individuals in crisis to access care. These investments aim to ensure that care is delivered in the least restrictive settings and within the community through a broad range of options.

Building a comprehensive 988-crisis system represents one of the state's strategies to transform the mental health and substance use disorder (SUD) system under the banner of "Mental Health for All". Mental Health for All is predicated on improved delivery of mental health care and substance use treatment; nation-leading behavioral health (BH) investments in services, facilities, housing, and workforce; accountability for results; and

cross-sector partnerships (including city/county, public/private, local/state, Tribal/county, and Tribal/state).[14]

The inclusion of populations that require tailored services and those disproportionately affected by challenges in crisis care delivery is critical in building a comprehensive 988-crisis system. The goal is to support the development of a high-quality, equitable behavioral healthcare system that serves **ALL** Californians.

Future Vision and Foundational Principles of a Comprehensive 988-Crisis System

In May 2023, CalHHS, in partnership with the Behavioral Health Task Force (BHTF), released the **Behavioral Health Crisis Care Continuum Plan (CCC-P)**. The CCC-P sets forth a vision of an equitable, accessible, high-quality behavioral health crisis system – spanning a full continuum of prevention, response, and stabilization services – for all Californians.

Building on that vision, over the course of 11 months, the 43-member PAG and seven interrelated Workgroups provided input into the state of California's current crisis system and what the state can do to improve the system and address challenges within it. Additional input was gained through a community outreach and information gathering process that included:

> (1) facilitated focus groups with persons with lived experience and identified populations of focus across the state; and
>
> (2) semi-structured interviews with state and local implementation partners such as county behavioral health departments, 988 Crisis Centers and other help and access lines, community advocates, and providers serving county and tribal communities

Findings from these efforts are included in the Plan as well as in two associated documents: the *AB 988 Chart Book: An Inventory of Needs, Services and Gaps of the Behavioral Health Crisis System* and the *AB 988 Community Engagement Report*.

PAG discussions included the development of near-term recommendations and a long-term vision for a comprehensive 988-crisis system. Members of the PAG recognize that reaching this vision will take time to implement. Similar to the way 9-1-1 and emergency medical services have grown over the past 50 years, 988 services will also evolve over a longer time period than is stipulated in the Plan.

To support the long-term vision, the PAG and Workgroups helped to establish a set of Foundational Principles for a comprehensive 988-crisis system. These principles were shaped by the experiences of members, the legislative aims of AB 988, and the strategic priorities identified in the CCC-P. They are:

1. All Californians, regardless of insurance coverage, location, or other factors (including but not limited to age, race, ethnicity, gender, gender identity, disability status, sexual orientation), should have timely access to quality crisis care.

2. Californians should have timely access to 988 through phone, text, and chat 24/7 with contacts answered, whenever possible, in-state by 988 Crisis Centers with knowledge of how to connect with local resources.

3. Individuals in crisis should have access to timely therapeutic and appropriate care (and reduce unnecessary law enforcement involvement where possible).

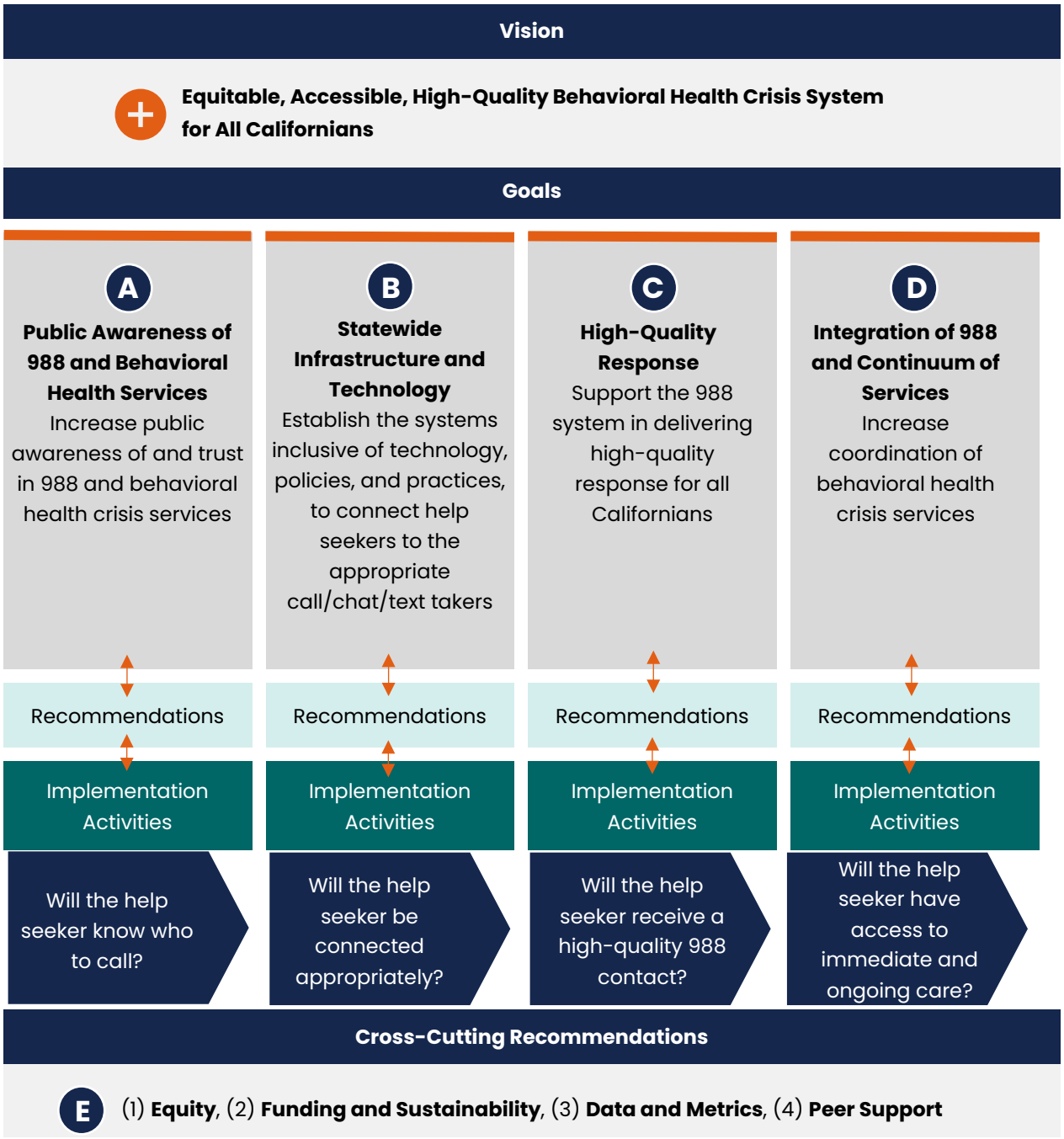
4. Individuals seeking help should be connected to a crisis care continuum that prioritizes community-based support and focuses on preventing further crises and trauma.

Organizing Framework

The Plan organizes the 14 required recommendation areas identified in AB 988 into four **Goals**, four cross-cutting recommendations, and potential implementation activities. Each **Recommendation** represents statements developed by the PAG about potential state action relevant to AB 988 and the crisis care continuum. **Implementation activities** – as detailed in the Plan – are potential actions for consideration that may be necessary to operationalize the recommendations. These implementation activities, which are recommended to begin in July 2025, are included in the Plan with the understanding that they will depend on securing the necessary resources, staffing, and approval processes.

In addition to CalHHS, state entities that may lead in select implementation activities include Cal OES, the California Department of Public Health (CDPH), the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), and the Emergency Medical Services Authority (EMSA). Additional state departments have contributed to and reviewed the Plan, among them: the California Department of Insurance (CDI), the California Department of Aging (CDA), the California Department of Developmental Services (DDS), the California Department of Social Services (CDSS), and the California Department of Rehabilitation (DOR).

Part of the work of implementation is to get to a next level of understanding with federal partners around data ownership, data sharing, and training curriculum so that the state can determine whether additional standards or training are needed to meet the needs of the state.



Goal A: Increase public awareness of and trust in 988 and behavioral health crisis services.

This goal and the related recommendations and implementation activities focus on the question: ***Will the help seeker know who to call?***

A sizable portion of the population both in California and nationally are not aware of 988 services. As of September 2023, over half of Californians were unaware of 988.[15] Raising awareness of and building trust in 988 and behavioral health crisis services, particularly among populations and communities that may be at a higher risk for suicide, behavioral health, or substance use challenges, was viewed as critical to building an effective 988-crisis system.

The PAG made three recommendations for the Plan:

A.1. Coordinate statewide behavioral health crisis communications strategies, informed by the 988 Suicide and Crisis Lifeline and the Substance Abuse and Mental Health Services Administration (SAMHSA).

A.2. Engage key partners in developing and disseminating statewide and regional communications strategies regarding behavioral health crisis services including 988 and other support lines (e.g., 211, County Access Lines, CalHOPE Red Line, and other warmlines).

A.3. Monitor the success and impact of communications strategies.

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

This goal and the related recommendations and implementation activities focus on the question: ***Will the help seeker be connected appropriately?***

Ensuring California's 988 system has the necessary infrastructure and technology to meet the needs of a large and diverse population was viewed as critical to the PAG. The PAG recognized the existence of an array of resources that a help seeker in California might contact before, during, or after a crisis, including specialized warm lines, county access lines,

mobile crisis dispatch lines, 9-1-1, and state and local hotlines other than 988. A core recommendation area of AB 988 relates to issues of interoperability between 9-1-1 and 988 and connecting help seekers to the most appropriate resource.

The PAG also recognized that new features – like chat and text – and new federal rules continue to place staffing and technology demands on 988 Crisis Centers. For instance, new rules regarding geo-routing, determined by the Federal Communications Commission (FCC), will now require that all calls to the 988 Suicide and Crisis Lifeline be routed by wireless carriers to local call centers using the caller's approximate physical location, rather than the area code of the caller's phone.[16]

The PAG made two recommendations for the Plan:

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

Goal C: Support the 988 system in delivering a high-quality response.

This goal and the related recommendations and implementation activities focus on the question: ***Will the help seeker receive a high-quality 988 contact?***

Today, California's 12 988 Crisis Centers, in alignment with SAMHSA's standards, provide empathetic listening, emotional support, crisis de-escalation, and referrals to local resources to support individuals experiencing suicidal thoughts and other mental health crises. Studies have shown that 95 to 98 percent of 988 calls are resolved over the phone, and that most 988 help seekers report feeling less depressed or suicidal after calling.[17] The PAG highlighted the need to bolster support for California 988 Crisis Centers, assess current federal standards, and, where necessary, augment standards and scopes of service to meet California's needs.

The PAG made three recommendations for the Plan:

> **C.1.** Support 988 Crisis Centers in meeting current national standards in preparation for meeting future statewide standards and California's vision for a comprehensive crisis care continuum.

C.2. Building on national standards and best practices to ensure trauma-informed, person-centered, and culturally responsive care, establish state-specific standards for staffing and training to equip 988 Crisis Centers to respond to suicide, mental health, and substance use-related 988 contacts.

C.3. Establish a process to review, designate, and re-designate California 988 Crisis Centers.

Goal D: Increase coordination of behavioral health crisis services.

This goal and the related recommendations and implementation activities focus on the question: ***Will the help seeker have access to immediate and ongoing care?***

Behavioral health crises encompass a wide range of situations, with many different potential points of entry into the continuum of care and possible transitions in care. The PAG recognized that properly connected and coordinated crisis services can offer timely services in the least restrictive setting, reduce inappropriate use of emergency departments and hospitals and reduce unnecessary law enforcement involvement in mental health and substance use crises. They also recognized the importance of integration with a range of state investments, policies, and reforms across the crisis care continuum focused on prevention, response, and stabilization.

The PAG made four recommendations for the Plan:

D.1. Coordinate state, Tribal, county, and regional behavioral health along with payers, providers, and cross-sector partners to connect individuals in behavioral health crises to immediate and ongoing care.

D.2. Support connection, coordination, and referrals of 988 help seekers to timely and effective community-based, culturally responsive crisis response, including mobile crisis dispatch, when appropriate.

D.3. Continue to assist communities in expanding the range of facilities and services to individuals before, during, and after a behavioral health crisis.

D.4. Develop more options or expand existing options for transporting individuals in crisis to a safe place to be.

Four cross-cutting recommendations – equity, funding and sustainability, data and metrics, and peer supports – represent areas that impact the design and implementation of activities within each of the four goal areas.

E.1. Equity: Prioritize inclusion and equity in crisis care service delivery for populations that may be at elevated risk for behavioral health crisis, experience discrimination and prejudice, and/or need adaptive/tailored services for equitable access due to physical, intellectual/developmental disability, or unique cultural and/or linguistic needs.

California envisions an equitable behavioral health crisis system that can serve anyone, anywhere, anytime. Achieving equity in the behavioral health crisis system requires addressing complex issues that disproportionately affect populations at elevated risk for behavioral health crisis, experience discrimination and prejudice, and have unique cultural and/or linguistic needs.[18] Ensuring equitable access was raised repeatedly in the focus groups and interviews as well as in Workgroup and PAG discussions. Each goal and cross-cutting recommendation include approaches to embed equity into crisis care.

E.2 Funding and Sustainability: Continue to implement strategies to support sustainable crisis systems at the local level that are connected to broader behavioral health transformation efforts, including behavioral health parity.

Sustainable funding sources are essential to maintain an effective and high-quality crisis system. AB 988 provides a dedicated funding source for 988 Crisis Centers and for mobile crisis teams accessed through 988. Further efforts are needed to coordinate the process of securing and disbursing funds, including a process for mobile crisis teams to access these funds. In addition, more communication and education should be provided to 988 Crisis Centers and the public to explain the 988 surcharge fee, the funding procedures, and the types of support provided by the 988 State Suicide and Behavioral Health Crisis Services Fund.

The PAG made clear that reimbursing crisis services beyond the initial 988 contact is essential for the financial sustainability of California's crisis system. Since individuals with various insurance types rely on the crisis system, it is critical that all insurance types provide reimbursement of behavioral health crisis services.

E.3. Data and Metrics: Establish data systems and data standards to support monitoring of 988 and the behavioral health crisis care continuum's performance.

The PAG discussed a variety of data to inform 988-crisis system performance, including existing key performance indicators submitted by 988 Crisis Centers as part of their existing contract with the national administrator. The PAG recommends that the state develop and maintain a public-facing 988 data dashboard that would appropriately support monitoring and accountability of the 988-crisis system.

E.4. Peer Supports: Integrate peer support across the crisis care continuum to support person-centered, culturally responsive, and recovery-oriented care.

Peer Supporters are role models for recovery who are uniquely able to promote hope and bring a shared understanding to people who are experiencing crises at every access point across the crisis continuum. Operationalizing this recommendation includes increasing consumer and provider awareness of the availability of peer support in behavioral health crisis services, exploring opportunities for increased engagement and integration of peer roles in settings across the crisis care continuum, gathering county- and state-level data on the prevalence of peer supports, and promoting training and supervision resources to support the ongoing development and advancement of Peer Supporters.

Summary

California is in the process of transforming its approach to behavioral health. The goal is to take proactive, upstream action to prevent behavioral health challenges from the outset, while also delivering high-quality care to those who are the most vulnerable and high-risk.

Building a comprehensive 988-crisis system is a key component of California's broader behavioral health transformation efforts and aligns with CalHHS's strategic priority to "Build a Healthy California for All." California has invested billions in resources to strengthen the continuum of community-based care options for Californians living with the most significant mental health and substance use needs, including but not limited to:

- Proposition 1 (The Behavioral Health Services Act and Behavioral Health Bond)
- California Advancing and Innovating Medi-Cal (CalAIM) initiative
- California Behavioral Health Community-based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration
- Children and Youth Behavioral Health Initiative (CYBHI)
- Medi-Cal Mobile Crisis Services Benefit
- Community Assistance, Recovery and Empowerment (CARE) Act
- Behavioral Health Bridge Housing

- Behavioral Health Continuum Infrastructure Program (BHCIP)
- Compliance and enforcement of mental health parity

Equity is a cornerstone of CalHHS's work. The agency strives to embed equity throughout its programs, including those listed above, to address persistent and systemic inequities rooted in historical and structural factors. CalHHS prioritizes listening to the individuals and communities it serves to better understand their needs and aspirations for improving their communities. Doing so helps CalHHS formulate better policies, programs, and services.

CalHHS is committed to delivering programs and services that produce tangible and meaningful results. Through ongoing evaluation and adaptation, CalHHS aims to better address unmet needs while advancing its goal of achieving positive outcomes for all Californians.

The goals, recommendations, and potential implementation activities in the Plan mark a significant step toward this goal and achieving California's vision of a comprehensive crisis care continuum – a system that aims to provide Californians with consistent, high-quality, equitable, and accessible resources for preventing, responding to, and stabilizing behavioral health crises. Pending available resources, CalHHS will work toward implementing and improving the Plan, continuously identifying challenges, opportunities, and solutions to improve California's crisis care system. The implementation activities outlined in the Plan may require additional legislative action and may be subject to further deliberations.

Together these efforts and initiatives will help CalHHS fulfill its mission to create a healthy, vibrant, inclusive California where everyone can live, play, work, and learn.

Introduction

California's Vision for a Comprehensive Behavioral Health Crisis Care Continuum

In May 2023, the California Health and Human Services Agency (CalHHS), in collaboration with the Behavioral Health Task Force (BHTF), released the Behavioral Health Crisis Care Continuum Plan (CCC-P). The CCC-P envisions a future in which **person-centered behavioral health crisis services** are seamlessly **connected** to provide an **equitable and accessible** continuum of care for all Californians.[19] The CCC-P articulates three broad strategic priorities to meet this vision: 1) build toward consistent access statewide, 2) enhance coordination across and outside the continuum, and 3) design and deliver a high-quality and equitable system for *all* Californians.

As **Figure 1** demonstrates, California's approach to comprehensive behavioral health crisis care spans a continuum that includes preventing, responding, and stabilizing crisis:

- **Preventing crisis** involves interventions for individuals at risk for suicide or mental health/substance use crisis. It includes an array of services like warmlines, digital self-help tools, harm reduction programs, recovery support services, and campaigns and initiatives that address stigma and reduce suicide attempts and death (e.g., Striving for Zero: California's Strategic Plan for Suicide Prevention). It also requires access to an array of community-based outpatient services for all Californians.[20]

- **Responding to crisis** requires adequate and accessible services to telephonic/remote response, including hotlines like 988 (formerly the National Suicide Prevention Lifeline) and community-based crisis response, such as mobile crisis teams, community co-response, and first responder models.[21] These services respond to acute behavioral health crisis[22] and connect help seekers in crisis to additional services as appropriate.[23]

- **Stabilizing crisis** includes community-based crisis stabilization services, in-home crisis stabilization services, crisis receiving facilities (such as sobering centers, peer respite centers, and crisis residential treatment programs), and other services that help transition individuals to care.[24]

Figure 1. Components of California Crisis Systems[25]

Preventing Crisis >>>  **Responding to Crisis** >>>  **Stabilizing Crisis**

Community-based preventive interventions for individuals at risk for suicide or mental health / substance use crises (e.g., Zero Suicide, harm reduction programs, warmlines, peer support, digital-self-help, recovery, support services, addressing stigma)	**Acute crisis response services,** including hotlines, 9-1-1 / 988 coordination, mobile crisis teams, social services response, and co-response models	**Community-based crisis stabilization services,** including in-home crisis stabilization, crisis receiving facilities, peer respite, crisis residential services, sobering centers, and transitioning individuals to care

Though California recognizes the importance and interrelationship of preventing and stabilizing crisis as part of its larger crisis care continuum, **building an effective, equitable, and accessible crisis response system is the priority of the Miles Hall Lifeline and Suicide Prevention Act (AB 988).**

Individuals experiencing behavioral health crises[26] often face barriers to timely and effective care, including access to care and appropriate services, insurance coverage limitations, and systemic inequities.[27] The CCC-P envisions a behavioral health crisis system that can serve anyone, anywhere, anytime. It further articulates that behavioral health and crisis care should be addressed in a cultural context, especially for populations that may have greater need or have been historically underserved, recognizing that each population will have its own needs due to different underlying drivers.

Populations of focus identified in the CCC-P and based on state and national research include:

- Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+) youth
- People with intellectual and/or developmental disabilities (IDD)
- Individuals who are d/Deaf or hard of hearing
- Veterans
- Native Americans
- Individuals with specific language needs
- Older adults
- System-impacted youth
- Individuals who are Black/African American, Latino/Latina/Hispanic, and Asian American and Pacific Islander (AAPI) (particularly youth)[28]

Additional populations and communities determined to be at-risk of behavioral health crises and/or who may require specialized services to ensure equitable access were identified as part of the planning process by members of the BHTF and members of the 988-planning process.[1] These included the following additions:

- Justice-impacted youths
- Reentering justice-involved population
- Rural communities
- Unhoused population
- College-aged students
- Middle-aged white males
- Law enforcement
- Medical professionals
- Active military (not just veterans)
- Individuals in transition from active to veteran status
- Undocumented individuals
- Perinatal populations
- Individuals who use drugs[29]

The CCC-P identifies some initial approaches to embed equity into crisis care, including:

- Understanding the historical trauma and cultural divide that has created distrust in current systems, particularly for Native American, Black/African American, Latino/Latina/Hispanic, and AAPI communities
- Assessing crisis intervention outcomes and variation between groups across and within regions
- Assessing social and economic conditions of populations that impact physical and behavioral health
- Incorporating equity into ongoing measurement and accountability measures[30]

Despite California's efforts to strengthen parity for behavioral health crisis services through legislation and regulations, coverage gaps continue to limit access to a comprehensive crisis care continuum for all.[31]

[1] For purposes of this Plan, all groups identified in the CCC-P and as part of the 988-planning process are referred to as "Populations of Focus." Notably, this is not an exhaustive list but seeks to lift up certain groups in the context of the Plan timeframe. Additional information about the populations of focus and ensuring equity in the 988-Crisis system is described in the cross-cutting recommendation on Equity (page 65).

AB 988: The Miles Hall Lifeline and Suicide Prevention Act

The National Suicide Hotline Designation Act of 2020 (NSHD) designates 988 as the three-digit national suicide prevention and mental health crisis hotline number. This legislation replaces the National Suicide Prevention Lifeline (NSPL), in operation since 2005, with the 988 Suicide and Crisis Lifeline. Subsequent federal grants and related Substance Abuse and Mental Health Services Administration (SAMHSA) efforts have supported state-based implementation of 988, mobile crisis, and other crisis services. The national launch of 988 and these other federal efforts have created a timely opportunity to bolster behavioral health (BH) crisis systems at the state and local levels.[32]

Following the launch of 988, and in parallel with the CCC-P's development, the Miles Hall Lifeline and Suicide Prevention Act (AB 988) was enacted in September 2022[33] and underwent further modifications in AB 118, the trailer bill that incorporates the implementing language of the California State Budget. AB 988 introduces pivotal provisions to increase the capacity of California's 988-crisis system, supports related crisis service partners and programs, and aims to help reduce unnecessary law enforcement involvement in behavioral health crises.[34]

AB 988 requires CalHHS to establish an advisory body, now known as the 988-Crisis Policy Advisory Group (PAG), which must be comprised of a diverse array of state, county, and local government representatives, service providers, advocates, and community representatives.[35] In accordance with AB 988, the PAG is charged with advising CalHHS on the development of recommendations to support a Five-Year Implementation Plan (the Plan) for a comprehensive 988-crisis system. The resulting Plan must include recommendations related to 14 areas outlined in the legislation (see Appendix, page 102).[36] As further described on page 20 (Process for Developing Recommendations to Support the Five-Year Implementation Plan), the PAG met seven times between December 2023 and November 2024 to discuss, deliberate, and review the Plan's recommendations and associated implementation activities. Seven interrelated workgroups (Workgroups) met a total of 21 times over the course of eight months (January to September 2024) to provide input for the PAG on specific areas of the Plan.

AB 988 also establishes the 988 State Suicide and Behavioral Health Crisis Services Fund, financed through a surcharge fee on telecom access lines.[37] This fund may be used to support the operations of 988 Crisis Centers and mobile crisis teams.[38] Fees are capped at $0.08 per access line per month in the first two calendar years of enactment (2023 and 2024); in state fiscal year (SFY) 2022-2023, the $0.08 surcharge fee generated $44.3 million.[39] Beginning January 1, 2025, the surcharge fee may be changed based on a specified formula,

but cannot exceed $0.30 per access line per month. The California Governor's Office of Emergency Services (Cal OES) oversees the Fund and the process to calculate the surcharge fee (see Appendix page 130 for more information on the surcharge fee).

AB 988 also mandates Cal OES to appoint a 988 system director and to convene a State 988 Technical Advisory Board (TAB) to guide technical and operational standards and interoperability requirements between 988, 9-1-1, and other emergency and behavioral health crisis services.

As of December 2024, 12 988 Crisis Centers were operating across California. These 988 Crisis Centers provide free and confidential services to people in emotional distress or suicidal crisis, answering calls, texts, and chats from help seekers with California area codes.[40] With geo-routing, help seekers are routed to the nearest 988 Crisis Center based on the caller's approximate physical location.[41]

A Comprehensive 988-Crisis System in the Context of "Mental Health for All"

Building a comprehensive 988-crisis system represents one of the state's many significant investments in transforming the mental health and substance use disorder (SUD) system under the banner of "Mental Health for All." Mental Health for All is predicated on increased mental health care and substance use treatment; nation-leading BH investments in services, facilities, housing, and workforce; accountability for results; and cross-sector partnerships including city/county, public/private, local/state, Tribal/county, and Tribal/state.[42]

Among the most significant investments and reforms are:

Proposition 1, the ballot initiative that California voters approved in 2024, which represents an opportunity to advance Mental Health for All. It encompasses the Behavioral Health Services Act (BHSA) (SB 326) and the Behavioral Health Infrastructure Bond Act (AB 531).[43]

The BHSA is the first major structural reform of the Mental Health Services Act since 2004 and is intended to improve and expand behavioral health services and housing interventions for people with severe mental illness/emotional disorders and/or SUDs. It also calls for the following:

(1) Updated allocations for local services and state directed funding categories, including housing supports

(2) Community-defined practices as a key strategy for reducing health disparities and increasing community representation

(3) Revised county processes for planning and reporting

(4) Improved transparency and accountability of BHSA funding[44]

The Behavioral Health Infrastructure Bond Act allocates $6.38 billion for ***treatment sites and housing to fund the construction of 11,150 new treatment beds and supportive housing units, along with 26,700 outpatient treatment slots***.[45]

This latest investment in behavioral health infrastructure through the Behavioral Health Infrastructure Bond Act adds to five prior rounds of funding provided through the Behavioral Health Continuum Infrastructure Program (BHCIP). Funding in the first round of BHCIP focused on mobile crisis response, providing more than $202 million to 54 behavioral health authorities for Crisis Care Mobile Units (CCMUs).[46] Subsequent rounds of BHCIP funding have included substantial investments in crisis stabilization and other facilities for individuals to receive behavioral health care services.

- Round 2 funding includes more than $7 million for planning grants for 18 tribes and 30 counties
- Round 3 funding includes $518.5 million for construction, acquisition, and rehabilitation of assets to expand the BH continuum of treatment and service resources
- Round 4 funding includes $480.5 million for facilities for children and youth
- Round 5 funding includes $430 million for projects that explicitly address infrastructure gaps in crisis services, which includes behavioral health inpatient and outpatient facilities for mental health and SUD treatment[47]

In total, as of August 2024, **BHCIP supported the construction, acquisition, or expansion of more than 95 residential facilities (adding 2,601 beds), and 128 outpatient facilities, adding 281,146 slots to the state's outpatient service capacity**.[48]

Additional reforms and investments to enhance the behavioral health crisis care continuum in recent years include:

- $55 million in funding to the state's 12 988 Crisis Centers for 988 services, which does not include funding from the 988 State Suicide and Behavioral Health Crisis Services Fund[49]
- Investments in mobile crisis response of more than $202 million to 54 behavioral health authorities' mobile units and $7.5 million to 23 Tribes/Tribal entities through Round 1 of the BHCIP[50]

- Training and technical assistance to support implementation of 24/7 mobile crisis response in all California counties through a State Plan Amendment that adds "mobile crisis services" as a Medi-Cal Benefit

Other critical efforts to improve behavioral health have focused on addressing the behavioral health of vulnerable populations. These include but are not limited to:

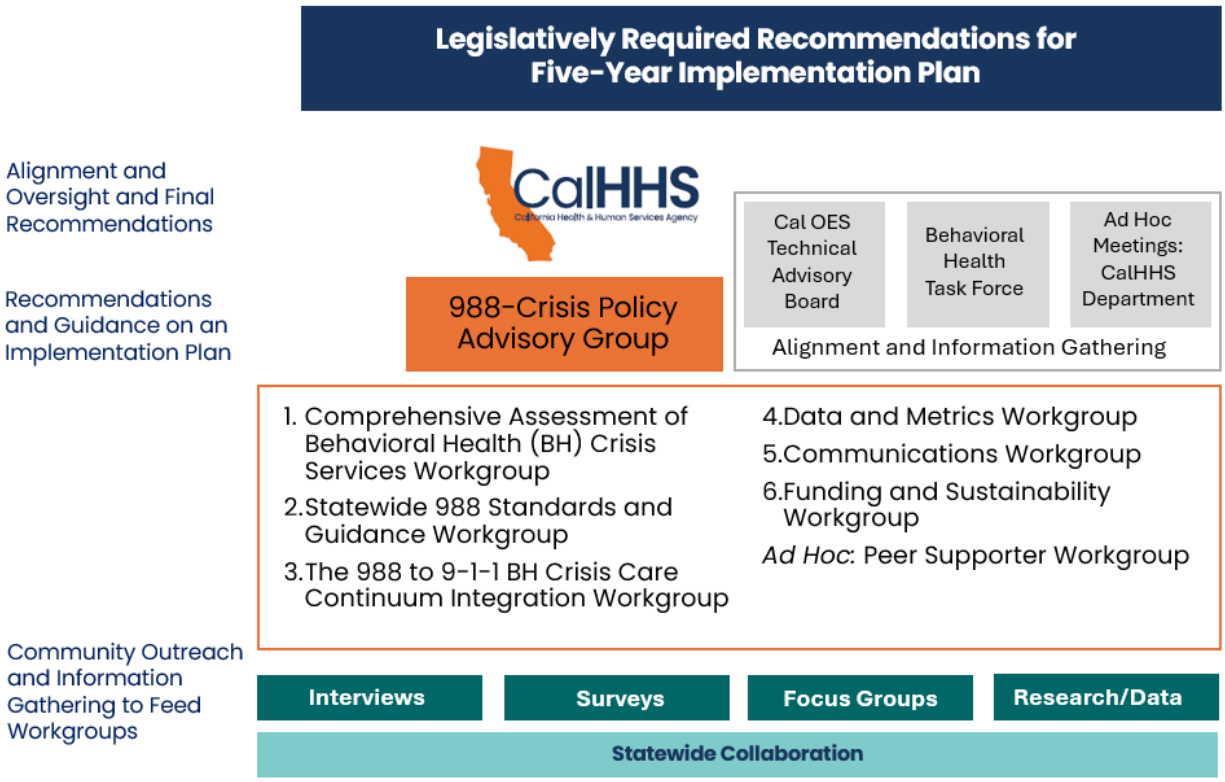
- Implementation of the Children and Youth Behavioral Health Initiative (CYBHI), a multi-billion-dollar, multi-disciplinary initiative to expand and redesign systems for children's mental health. Some of the activities supporting crisis response and suicide prevention include the Youth Suicide Reporting and Crisis Response Pilot Program; a statewide youth suicide prevention campaign ("Never a Bother"); Round 4 of BHCIP for children and youth, which funded the construction of various facilities, including residential treatment centers; Behavioral Health Virtual Service Platforms, which provides consultation and training support for primary care providers caring for youth with mental and behavioral health concerns, expanded behavioral health workforce, and other school-based behavioral health programs
- Efforts through California Advancing and Innovating Medi-Cal (CalAIM) to improve the administration of Medi-Cal behavioral health services and target key quality measures and behavioral health outcomes via policy and payment reform
- The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration, which focuses on enhancing community-based care and treatment for California's highest needs populations
- Implementation of the Community Assistance, Recovery, and Empowerment (CARE) Act, which provides community-based behavioral health services and supports to Californians living with untreated schizophrenia spectrum or other psychotic disorders through a new civil court process
- Ongoing efforts to create a comprehensive approach to the opioid crisis, including efforts to increase access to medication-assisted treatment (MAT) and reduce opioid overdose related deaths through prevention, treatment, and recovery services
- Investments in housing, including Behavioral Health Bridge Housing, to support county and Tribal development of housing for individuals experiencing homelessness who have serious behavioral health conditions

Process for Developing Recommendations to Support the Five-Year Implementation Plan

The advancements and investments made by the state and the federal government represent a historic effort to improve the behavioral health care continuum in California. With its dedicated funding for 988-crisis services and mobile crisis response, AB 988 (the Miles Hall Lifeline and Suicide Prevention Act), provides an important opportunity to advance the state's vision for a comprehensive crisis care continuum.

To support 988 implementation planning, CalHHS contracted with Health Management Associates, Inc. (HMA), a leading independent research and consulting firm. As shown in **Figure 2,** CalHHS convened the PAG and seven Workgroups to make recommendations and to guide the Plan's development.

Figure 2. Project Structure



Additional input was gathered through a community outreach and information gathering process that included: (1) facilitated focus groups with persons with lived experience and identified populations of focus across the state; (2) semi-structured interviews with state and

local implementation partners such as county behavioral health agencies, 988 Crisis Centers and other help and access lines, community advocates, and providers serving county and Tribal communities across the state. The resulting Plan includes a set of recommendations as put forth by the PAG as well as implementation activities as identified by CalHHS and its departments and other state agencies to operationalize the recommendations.

988-Crisis Policy Advisory Group and Workgroups

Given the breadth and complexity of the 14 recommendation areas in AB 988, CalHHS convened seven Workgroups to solicit professional expertise and community perspectives on specific topics and required areas of the legislation.[51] These Workgroups, totaling 140 members, are:

- Comprehensive Assessment of BH Crisis Services
- Statewide 988 Standards and Guidance
- 988-9-1-1 BH Crisis Care Continuum Integration
- Data and Metrics
- Communications
- Funding and Sustainability
- Peer Supporter (Ad Hoc)

Each Workgroup met in a virtual format two to four times to gather and discuss information relevant to the Workgroup's charge and to draft recommendations for PAG consideration. Workgroups were co-chaired by PAG members. All Workgroup meetings were open to the public and included a public comment period.

The 43-member PAG met seven times between December 2023 and November 2024 for a series of daylong, in-person, facilitated meetings. Each meeting was organized around one or more of the 14 required recommendation areas. Meetings included large and small group discussion to review and revise recommendations shared by Workgroup co-chairs. All PAG meetings were open to the public and included a public comment period.

CalHHS selected PAG and Workgroup participants based on the membership requirements in AB 988,[52] which sought to draw in the expertise of a cross-section of state, county, and local governments, Tribal government, behavioral health providers, advocates, and community-based organizations (CBOs). As outlined in the PAG Charter, selection of the PAG and Workgroups was further informed by:

- Professional expertise
- Knowledge of/experience with a particular community or population
- A collaborative mindset and ability to listen to and consider other perspectives, and find consensus where possible

- Diversity in race, ethnicity, gender identity, sexual orientation, age, disability status, geographic representation (urban/rural, northern/central/southern California), and representation from communities that have been historically underserved, including special consideration for Tribal community members
- Lived experience, inclusive of people who are suicide attempt survivors and loss survivors

Notably, more than a dozen of the 43 members on the PAG and many of the Workgroup members brought to the engagement both professional expertise as well as personal experience with the crisis system. A list of Workgroup members is in the Appendix. All PAG and Workgroup meeting materials, including presentation materials, summaries, and video recordings are available on the dedicated 988-Crisis Policy Advisory Group webpage.

Alignment and Information Gathering with CalHHS Departments and Other State Agencies

Throughout the 12-month planning period, CalHHS worked closely with its departments and other state agencies, including the California Department of Public Health (CDPH), the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), the Emergency Medical Services Authority (EMSA), and the California Governor's Office of Emergency Services (Cal OES). Regular conversations sought to identify where the state has or needs authority to coordinate behavioral health transformation statewide, as well as the distinct roles and responsibilities of different departments and agencies in advancing the recommendations and implementation activities described in the Plan. CalHHS also sought input from other state entities and initiatives, including but not limited to the California Department of Developmental Services (DDS), California Department of Social Services (CDSS), the California Department of Aging (CDA), the Center for Data Insights and Innovation (CDII), the California Department of Insurance (CDI), the CYBHI, and BHTF, which includes over 24 state representatives.

Community Outreach and Information Gathering

Throughout the development of the Plan, CalHHS sought input from potential end users and affected communities through key informant interviews and focus groups.

Interviews: Over 85 interviews were conducted to gather information throughout the Plan's development. This included interviews with PAG members as well as semi-structured interviews with various state and community partners. The interviews provided important insights into 988 Crisis Center and local/county behavioral health system operations with their related challenges and opportunities. Interviewees included:

- Representatives from each of the following 988 Crisis Centers: (1) Suicide Prevention Program (Buckelew); (2) Central Valley Suicide Prevention Hotline (Central Valley - Kings View); (3) Contra Costa Crisis Center (CCCC); (4) Crisis Support Services of Alameda County (CSS Alameda); (5) Didi Hirsch Mental Health Services - Suicide Prevention Crisis Line (Didi Hirsch); (6) Kern County Behavioral Health Recovery Services - Crisis Services (Kern County BHRS); (7) Optum - San Diego Access and Crisis Line (Optum); (8) San Francisco Suicide Prevention - Felton Institute (SFSP); (9) Santa Clara County Behavioral Health Services - Crisis and Suicide Prevention Lifeline (Santa Clara CSPL); (10) Star Vista Crisis Center (Star Vista); (11) Family Services Agency Central Coast 988 Center (FSA Central Coast 988 Center); and (12) WellSpace Health Suicide Prevention and Crisis Services (WellSpace Health).
- Representatives of five county behavioral health agencies (Los Angeles, Nevada, Riverside, Santa Clara, and San Luis Obispo). Each set of interviews included county leadership responsible for crisis response services as well as a sampling of key partners in the local/regional crisis care continuum. These included representatives of local/regional mobile crisis teams, law enforcement agencies, school-based partners, local emergency departments, a sobering center, a peer respite, and a Crisis Stabilization Unit (CSU). Input was also sought from the County Behavioral Health Directors Association (CBHDA) and the California State Association of Counties (CSAC)

Focus Groups: Facilitated focus groups were organized to gather the perspectives of individuals with lived experience and their family members, as well as populations of focus identified by the CCC-P, the PAG, and the BHTF. The 13 focus groups served to elevate and amplify the voices of those with lived experience in the development of the Plan. Focus group participants, totaling 90, included:

- Individuals with co-occurring disorders (COD)
- Family members who lost someone to suicide
- Formerly unhoused individuals
- LGBTQIA+ individuals
- Older adults
- Young adults
- Mothers with children

Participants also reflected a variety of systems involvement that often characterize the current and intended service users of the 988-crisis system, including those with lived experience with mental health and/or substance use challenges as well as people with lived experience with incarceration/justice system involvement and/or foster care system involvement. Focus group participants were recruited through different communication

channels, including outreach by PAG members and other advocacy organizations and community-based providers that serve diverse populations and communities across the state. Due to time constraints, participants were not explicitly solicited based on race/ethnicity/cultural backgrounds; however, many participants self-identified during the discussion. Most participants were people of color, with Black/African American, Latino/Latina/Hispanic, and Native American communities heavily represented.

Three focus groups organized by Kauffman and Associates and hosted by Native American communities represented multi-generational (i.e., youth, adults, and elders) perspectives of enrolled Tribal members from both rural and urban communities in Humboldt, Sacramento, and San Diego counties. Findings and themes from all the focus groups are integrated throughout this Plan and outlined further in the *Community Engagement Report.*

Engagement By the Numbers

Seven (7) public 988-Crisis PAG Meetings (43 members)

Twenty-one (21) public meetings of seven Workgroups (140 members)

Thirteen (13) virtual and in-person focus groups with populations with lived experience or otherwise impacted by crisis services (90 participants)

Over eighty-five (85) interviews with PAG members, community groups and advocacy organizations, county behavioral health agencies, Tribal community members, 988 Crisis Centers, and other crisis-related service partners

An informational webinar and two public/community comment periods on the draft plan

Comprehensive Assessment and Chart Book

The development of recommendations was informed by "[f]indings from a comprehensive assessment of the behavioral health crisis services system that takes into account infrastructure projects that are planned and funded."[53] To support this recommendation area, a Workgroup was established to collect and review information and to help CalHHS identify known and unknown gaps in the behavioral health crisis services system. Additional information was drawn from primary and secondary sources, including recent evaluations, studies, and analyses by state agencies and independent evaluators, public health data, and qualitative research (via interviews, surveys, and discussions with interested parties). Details from the comprehensive assessment are included in the *AB 988 Chart Book: An Inventory of Needs, Services, and Gaps of the Behavioral Health Crisis System*.

The assessment revealed both assets and gaps in California's behavioral health crisis care continuum. Findings most relevant to implementing a comprehensive 988-crisis system include:

1. Many people are not aware of 988, and some people who know about it are apprehensive about using it
2. The numerous "places to contact" before, during, and after a crisis are difficult to track and monitor and vary by community
3. Services offered by California's 988 Crisis Centers vary and sometimes lack formal connection with or knowledge about County/Tribal BH systems and services
4. Population-level disparities exist among some groups and communities who may benefit from or need tailored services in order to equitably access BH crisis care
5. In-person community response services are fragmented, and 24/7 mobile crisis response teams that respond to people in crisis are still in development, particularly in rural, remote, and Tribal areas of the state
6. Availability and accessibility of crisis services and facilities that provide a safe place to be during and after an acute crisis vary widely across the state, particularly in rural, remote, and Tribal communities
7. Information on available local resources for 988 Crisis Centers and other crisis responders to connect help seekers with services in the community is inconsistent
8. Data collection and reporting on crisis services vary across the continuum, which makes it difficult to monitor system performance

These findings align with many of the broad challenges identified in the CCC-P, including:

- Workforce and facility capacity constraints across the BH crisis care continuum
- Fragmentation and coordination challenges inside and around BH systems
- Lack of knowledge about Tribal communities and/or jurisdictional confusion
- Gaps in crisis care insurance coverage, particularly for low-income Californians with high cost-sharing, and individuals with commercial health insurance
- Local data infrastructure limitations and varied approaches to data collection

- A lack of consistent standards of quality and oversight of crisis care[54]

Select Data Points on California's Crisis Care Continuum in 2024

Numerous state and local warmlines are available as are new digital tools and resources for individuals and families (as of December 2024)

12 California-based 988 Crisis Centers across the state, with 1,100+staff (the majority of whom are paid staff, a shift from previous staffing with volunteers) (as of December 2024)

Medi-Cal mobile crisis benefit implemented in 48 counties, covering 98% of Medi-Cal members, with corresponding dispatch centers (as of December 2024)

CCMU grant funded/enhanced 458 mobile crisis teams (MCTs) (as of September 2024)

92 CSUs in 33 of the 58 counties (as of October 2024)

289 licensed Social Rehabilitation Programs in 35 of 58 counties (as of April 2024)

33 licensed Mental Health Rehab Centers (as of August 2024)

7 Peer Respites (Listed by the National Empowerment Center, accessed December 2024)

24 Sobering Centers (as of October 2024)

536 Hospitals, including 40 acute psychiatric hospitals, 7 chemical dependency hospitals, and 33 psychiatric health facilities (as of April 2024)

See the *AB 988 Chart Book* for additional data and source information.

Findings also align with a January 2022 report from DHCS entitled, *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications*.[55] DHCS's assessment revealed that many California residents with behavioral health conditions across all payers and levels of acuity experience barriers to receiving treatment. It also identifies gaps across the behavioral health continuum of care, including access to outpatient services, inpatient services, peer recovery supports, intensive support services, community services and supports, and crisis services.[56]

Notably, findings from the CCC-P and DHCS's assessment were conducted prior to the national 988 designation, the expansion of mobile crisis services reimbursement, and other state and local efforts to enhance the behavioral health crisis system.

Organization of the Five-Year Implementation Plan

Developing a comprehensive 988-crisis system is a critical step toward the state's **vision of an equitable, accessible, high-quality behavioral health crisis system for all Californians**.

Building on the desired future state articulated in the CCC-P, the PAG and Workgroups expressed the following **Foundational Principles** for a comprehensive 988-crisis system:

1. All Californians, regardless of insurance coverage, location, or other factors (including but not limited to age, race, ethnicity, gender, gender identity, disability status, sexual orientation), should have timely access to quality crisis care.
2. Californians should have timely access to 988 through phone, text, and chat 24/7 with contacts answered, whenever possible, by in-state 988 Crisis Centers with knowledge of how to connect people with local resources.
3. Individuals in crisis should have timely access to therapeutic and appropriate care (without unnecessary law enforcement involvement where possible).
4. Individuals seeking help should be connected to a crisis care continuum that prioritizes community-based support and focuses on preventing further crises and trauma.

These principles were shaped by the experiences of PAG members, the legislative aims of AB 988 (the Miles Hall Lifeline and Suicide Prevention Act), and the strategic priorities identified in the CCC-P. As shown in **Figure 3,** the Plan organizes the 14 required areas in AB 988 into four interdependent goals (A, B, C, D) and four recommendations (E) that cut across all the goals.

- The **Goals** describe the components necessary to advance the state's vision of an equitable, accessible, high-quality 988-crisis system, answering key questions about the system from the help seeker's point of view:
    - Will the help seeker know who to call?
    - Will the help seeker be connected appropriately?
    - Will the help seeker receive a high-quality 988 contact?
    - Will the help seeker have access to immediate and ongoing care?
- Under each goal is a set of **Recommendations,** as identified by the PAG. The recommendations are broad statements centered around the opportunity of 988 to improve the crisis care continuum.
- Under each recommendation is a list of **Implementation Activities** that describe potential actions for consideration that may be necessary to operationalize the

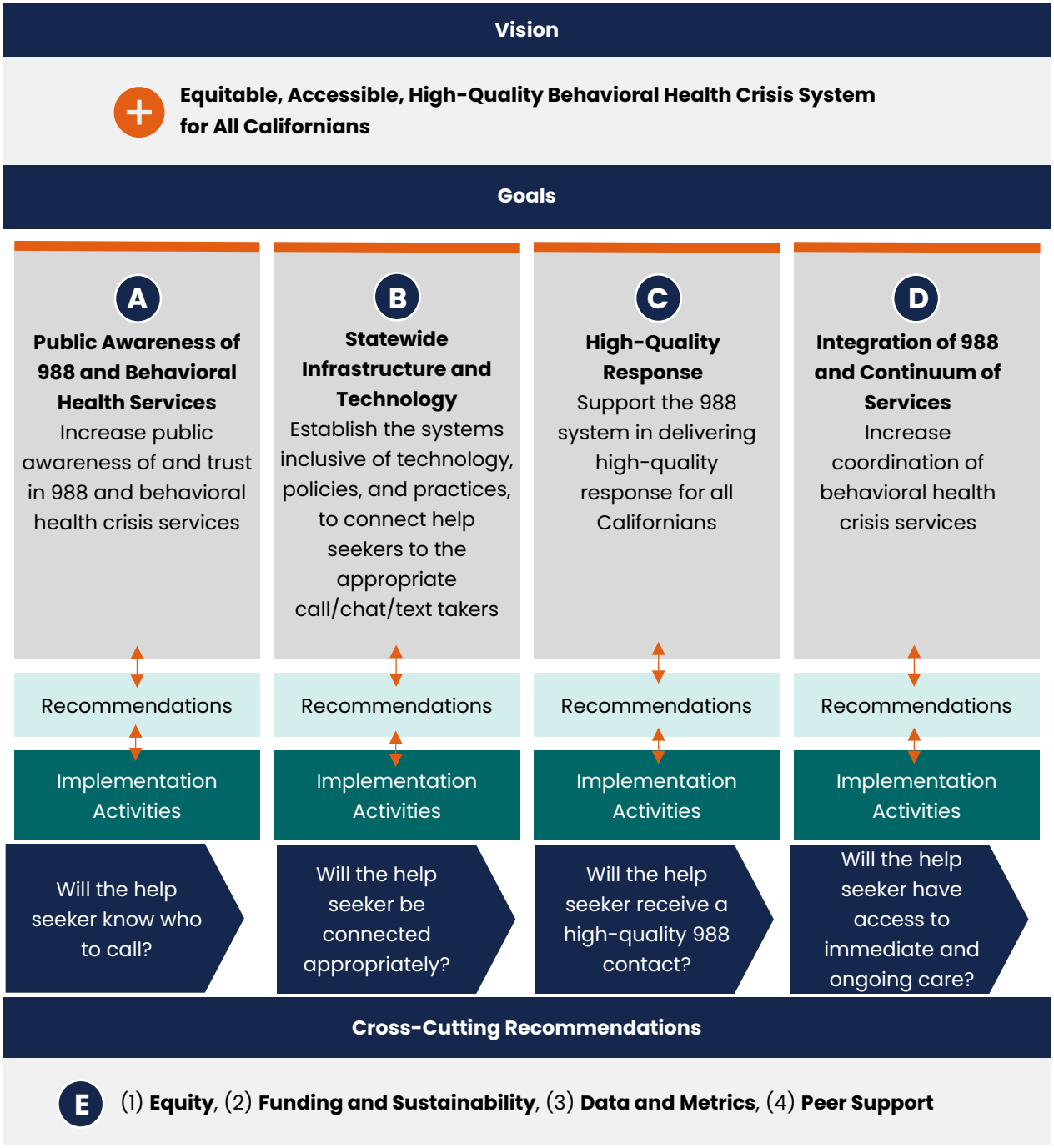
recommendations. Implementation activities are subject to change and will depend on available resources, staffing, and approval processes over upcoming state fiscal years.

- While the Plan focuses on areas where state entities may have authority (as **State Leads**), it also recognizes the role of **Implementation Partners** in advancing recommendations and related activities. These implementation partners include but are not limited to other state departments and offices, county behavioral health delivery systems (County/Tribal BH), 988 Crisis Centers, 9-1-1 Public Safety Answering Points (PSAPs), Local Emergency Medical Services Authorities (LEMSAs), and CBOs. (*Note that the list of implementation partners is non-exhaustive and may be augmented as the Plan is implemented. State leads will consult with appropriate state and county and local organizations to address the needs of specific populations; agency and/or department equity offices will also be engaged, as appropriate.)*
- **Potential timing of implementation** is listed in the tables by state fiscal year, each beginning on July 1 and ending on June 30. The first two time periods are listed as separate fiscal years: Year 1 (SFY 2025-2026) and Year 2 (SFY 2026-2027). The second two time periods are combined as Years 3-4 (SFY 2027-2028 and SFY 2028-2029) and the final period is listed as Year 5+ (SFY 2029-2030 and later). The Plan was developed to allow flexibility for future operationalization over the implementation timeline (beginning July 1, 2025). Flexibility is critical given changes in the landscape, including emerging federal guidance on 988, other state and local behavioral health initiatives, and existing staffing and resources. Activity periods are designated in the Plan with the following:

Potential Implementation Activity	No Potential Implementation Activity
●	○

- **Cross-Cutting Recommendations** are those that impact all four goal areas. Any implementation activities for these recommendations may have implications for how the state operationalizes other aspects of the Plan.

Figure 3. Organizing Framework



Recommendations for the Five-Year Implementation Plan

Plan Overview

The recommendations in the Plan include four primary goals (A, B, C, D) to realize the state's vision for an equitable, accessible, high-quality behavioral health system for all Californians. The Plan also includes four cross-cutting recommendations that impact all the goal areas.

The goal areas and recommendations are summarized below:

Goal Area	Policy Advisory Group Recommendations
A. Public Awareness of 988 and Behavioral Health Crisis Services: Increase public awareness of and trust in 988 and behavioral health crisis services	**A.1.** Coordinate statewide behavioral health crisis communications strategies, informed by the 988 Suicide and Crisis Lifeline and the Substance Abuse and Mental Health Services Administration (SAMHSA). **A.2.** Engage key partners in developing and disseminating statewide and regional communications strategies regarding behavioral health crisis services including 988 and other support lines (e.g., 211, County Access Lines, CalHOPE Red Line, and other warmlines). **A.3.** Monitor the success and impact of communications strategies.
B. Statewide Infrastructure and Technology Establish the systems, inclusive of technology, policies, and practices, to connect help seekers to the appropriate call/chat/text takers	**B.1.** Support the technology to route 988 contacts safely and efficiently anywhere in California, including to mobile crisis dispatch. **B.2** Promote coordination and communications across state technology implementation partners to ensure alignment of technology, policy, and practice.

Goal Area	Policy Advisory Group Recommendations
C. High-Quality 988 Response: Support the 988 system in delivering a high-quality response	**C.1.** Support 988 Crisis Centers in meeting current national standards in preparation for meeting future statewide standards and California's vision for a comprehensive crisis care continuum. **C.2.** Building on national standards and best practices to ensure trauma-informed, person-centered, and culturally responsive care, establish state-specific standards for staffing and training to equip 988 Crisis Centers to respond to suicide, mental health, and substance use-related 988 contacts. **C.3.** Establish a process to review, designate, and re-designate California 988 Crisis Centers.
D. Integration of 988 and the Continuum of Services: Increase coordination of behavioral health crisis services	**D.1.** Coordinate state, Tribal, county, and regional behavioral health along with payers, providers, and cross-sector partners to connect individuals in behavioral health crises to immediate and ongoing care. **D.2.** Support connection, coordination, and referrals of 988 help seekers to timely and effective community-based, culturally responsive crisis response, including mobile crisis dispatch when appropriate. **D.3.** Continue to assist communities in expanding the range of facilities and services to individuals before, during, and after a behavioral health crisis. **D.4.** Develop more options or expand existing options for transporting individuals in crisis to a safe place to be.

CROSS-CUTTING RECOMMENDATIONS

E.1. Equity: Prioritize inclusion and equity in crisis care service delivery for populations that may be at elevated risk for behavioral health crisis, experience discrimination and prejudice, and/or need adaptive/tailored services for equitable access due to physical, intellectual/developmental disability, or unique cultural and/or linguistic needs.

E2. Funding and Sustainability: Continue to implement strategies to support sustainable crisis systems at the local level that are connected to broader behavioral health transformation efforts, including behavioral health parity.

E.3. Data and Metrics: Establish data systems and data standards to support monitoring of 988 and the behavioral health crisis care continuum's performance.

E.4. Peer Support: Integrate peer support across the crisis care continuum to support person-centered, culturally responsive, and recovery-oriented care.

Plan Goals and Recommendations

Goal A: Public Awareness of 988 and Behavioral Health Crisis Services: Increase public awareness of and trust in 988 and behavioral health crisis services.

> AB 988 Required Area (8) GOV 53123.3. (b)(8): Statewide and regional public communications strategies informed by the National Suicide Prevention Lifeline and the Substance Abuse and Mental Health Services Administration to support public awareness and consistent messaging regarding 988 and behavioral health crisis services.

Rationale: A 2022 survey found that, among California adults who reported experiencing symptoms of anxiety and/or depressive disorder, more than one-quarter (28.5%) reported needing counseling or therapy but not receiving it in the past four weeks.[57] Marginalized groups in California, as in other states, are often at greater risk for behavioral health issues *and* are less likely to have access to services.[58]

Public awareness of available services is one key factor that influences access to behavioral health. In a statewide survey conducted in September 2023, 56 percent of Californian adults polled (n=1,671 adults) said they knew "nothing at all" about 988,[59] a level of awareness similar to national polling.[60] [61] The same poll found that Black/African American respondents were slightly more likely to know nothing at all about 988 (59%) than Latino/Latina/Hispanic (56%), White (57%), and Asian American (51%) respondents.[62] One cross-sectional study found that use and awareness of the 988 Suicide and Crisis Lifeline was significantly higher among adults with serious and moderate psychological distress.[63]

> "People simply do not know what to do [in a crisis]."
> – Focus Group Participant

In the September 2023 poll, younger California adults (ages 18-34) were slightly more likely to use and know about 988: 50 percent said they knew "nothing at all" about 988 (compared with 56% of all Californians) and a higher percentage (6%) knew "a lot" about it.[64] Another survey by Blue Shield of California in June 2023 found that a little more than one in four (28%) California youth (ages 14-25) said they knew someone who had used 988, and 8 percent said

they had used it themselves, higher percentages than adults 25 and older.[65] Such awareness among young people might be aided by a legal requirement in California to place 988 information on all public school student identification cards.[66]

After reading a summary description of 988, 63 percent of California adults said they would be "very" or "somewhat likely" to call if they or a loved one were experiencing a mental health crisis. This polling data aligns with input from focus groups that included individuals with lived experience. While only a handful of participants had previously heard of 988 or used the service, once it was described by the facilitator, many participants expressed that they thought 988 could have helped them (See the *Community Engagement Report*).

"If I had seen 988 posted I would have called them instead of calling 9-1-1 every time I couldn't get myself together." – Focus Group Participant

Trust is also essential to ensuring equitable and accessible services.[67] Workgroup members and participants in interviews and focus groups repeatedly mentioned how stigma, fear, mistrust, and past (including intergenerational) trauma can inhibit the use of 988 and other behavioral health services. Some community members are apprehensive due to perceived uncertainties about disclosure of confidential information, including disability status and location.[68]

Data shows that the public, especially individuals from historically marginalized communities, are mistrustful of contacting 988. National polling data indicates that Black/African American and AAPI respondents were less likely to trust 988 (and 9-1-1) than White respondents. For instance, a NAMI/Ipsos poll conducted in June 2024 found that "total trust" in 988 among White respondents was 83% as compared to 80% among Black/African American respondents, 80% for Latino/Latina/Hispanic, and 77% among AAPI respondents.[69] Some of the reasons for this mistrust, as expressed in the focus groups and in national polling, include fear of unnecessary law enforcement involvement, fear of being placed on an involuntary hold, fear that their children will be removed from home, and fear that they will be charged to use the service.[70] Native American participants in focus groups were particularly mistrustful of calling 988. Some reasons that focus group participants provided included not having enough information about 988 services and/or misunderstanding of what would happen if they called 988. Focus groups participants also shared a desire for crisis counselors who were not only culturally responsive but that were also demographically similar to them. In the case of the Native American focus groups, one participant stated that "[We] need to have more

Tribal staff embedded in 988 for rapport building and connection," a statement that the Native American focus group participants from across the state agreed with and supported.[71]

FOCUS GROUP PARTICIPANT

"Trust is a big issue… People need to be able to trust you. Once you've built the trust, people will start to reach out."

To address such concerns, the PAG encouraged developing and sharing transparent and clear guidelines on what to expect when someone calls 988. They also encouraged sharing how individual data will be used, stored, and shared and how privacy will be protected. Such transparency will support trust building, especially among communities that are historically underserved and have had negative and adverse interactions engaging with the crisis system.

Importantly, only a small percentage of calls to California 988 Crisis Centers result in an emergency dispatch of any kind. Between July 2022 and June 2023, the California 988 Suicide and Crisis Lifeline answered 381,534 contacts. Of those contacts, 10,886 (2.85%) resulted in mobile crisis referrals, 8,378 (2.20%) resulted in emergency rescues, and just 882 (0.23%) resulted in transfers to 9-1-1.[72] Focus group participants from historically marginalized communities were particularly concerned about law enforcement intervention, citing this as one reason they may not feel safe calling 988 when in crisis.

"Some people are afraid of the police. It heightens things. People need someone with an easy voice, to keep them calm and explain the process."

– Focus Group Participant

The following are key recommendations and potential implementation activities to enhance public awareness of 988.

Recommendations

1. Coordinate statewide behavioral health crisis communications strategies, informed by the 988 Suicide and Crisis Lifeline and the Substance Abuse and Mental Health Services Administration (SAMHSA).

CDPH is actively engaged in public health awareness and education campaigns focused on a range of populations and issues, including but not limited to existing state and local campaigns on preventing suicide and ending the opioid crisis. For example, CDPH is providing oversight to Never a Bother, a youth-focused suicide prevention campaign funded through the CYBHI. DHCS, which oversees behavioral health care delivery systems and 988 Crisis Center services, has been working with SAMHSA, state partners, and community organizations on a communications strategy to share resources and tactics for the successful implementation and increased utilization of 988 in California.

CalHHS recommends a closely coordinated communications effort, led by CDPH, in consultation with the DHCS, EMSA, and other state agencies, informed by city and county representatives, and other trusted partners. This effort will seek to assess existing efforts, develop communications goals, identify key audiences, and leverage best practices and research-informed resources from federal, state, and community partners.

The PAG and Workgroups emphasized communications strategies that reach people where they are and that leverage trusted messengers to build greater awareness of and trust in 988. They highlighted that such a strategy for 988 and behavioral health crisis services also presented an opportunity to continue to educate, normalize, and destigmatize behavioral health conditions, in general, as well as serious mental illness (SMI), severe SUD and co-occurring SMI/severe SUD disorders. It could also help to address the additional stigma faced by individuals who are, or who are at risk of justice-involvement. They also underscored the need to implement communications strategies in a culturally responsive manner that considers the linguistic and cultural needs of different communities (see also Equity, Recommendation E.1).

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
A.1.a	Assess existing state campaigns and communications initiatives to determine where and when communicating about 988 may be appropriate or effective	CDPH	DHCS, EMSA	●	●	○	○

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
A.1.b	Identify audiences for 988 communications strategies to include (1) populations not reached through national campaigns and/or are distrustful of 988 or other emergency or crisis lines; (2) populations at greatest risk of suicide or other behavioral health crisis; (3) populations that may need or benefit from accommodations	CDPH	DHCS, 988 Crisis Centers, Tribal/CBO Partners, County/Tribal BH	●	●	●	●
A.1.c	Define the goals and objectives of the communications strategy to provide clarity about how and when to use 988; what to expect when someone contacts 988; what 988 can and cannot do; and how individual data will be used, stored, shared, and protected	CDPH	DHCS, Cal OES, EMSA, 988 Crisis Centers, County/Tribal BH	●	●	●	●
A.1.d	Determine forums and trusted messengers to inform the public about 988, segmented by audience	CDPH	DHCS, 988 Crisis Centers, County/Tribal BH	●	●	●	●
A.1.e	Coordinate statewide communications campaign with federal and local partners to anticipate and evaluate potential impact to service capacity	CalHHS, Cal OES	CDPH, DHCS, EMSA, 988 Crisis Centers, County/Tribal BH, PSAPs	●	●	●	●

2. Engage key partners in developing and disseminating statewide and regional communications strategies regarding behavioral health crisis services including 988 and other support lines (e.g., 211, County Access Lines, CalHOPE Red Line, and other warmlines).

PAG members and focus group participants raised the need to provide clarity about what to expect when calling 988, making explicit the types of outcomes that can result from a 988 call or text encounter, as well as communicating how personal information and data from callers may be used and will be protected. They also expressed a strong desire to integrate the voices and perspectives of populations most impacted by suicide, mental health, and other behavioral health conditions in the development of statewide communications. They further recommended promoting information about other behavioral health services across the crisis care continuum and to tailor specific communication strategies for different populations of focus (e.g., using social media platforms popular among teenagers and educational programs in schools for younger children).

> "Messengers need to 'come down' to the community level to have these conversations."
>
> -Focus Group Participant

The PAG encouraged a community-informed communications approach to build trust, ensure transparency, and set clear expectations for 988 and other emergency and support lines (e.g., 9-1-1, peer warmlines, state, county, municipal information and access lines, and other emergency hotlines). Engaging and generating support from trusted messengers – including individuals with lived/living experience and trusted community leaders and organizations - paired with research and data will be critical to support successful implementation. The PAG further suggested flexibility for regional communications strategies to support direct connections to community resources and services, understanding that "what to expect" from 988 may differ based on the array of services available locally and in the state, and that those resources and services may change over time. This will involve the development of guidance, best practices, and toolkits that can be tailored to different audiences and community needs, services, and resources.

The PAG also recommended gathering input from the community in developing communications strategies and messaging. They emphasized gathering perspectives from different communities to appropriately tailor messages and leveraging trusted messengers and using storytelling and testimonials from individuals who have experienced crises to build trust, empathy and understanding in the community.

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
A.2.a	Develop a comprehensive statewide public health communications strategy for 988 and other behavioral health crisis services across the crisis care continuum to increase public awareness and support behavior change, including willingness to seek help	CDPH	DHCS, 988 Crisis Centers, County/ Tribal BH, Tribal/CBO Partners	●	●	●	●
A.2.b	Engage populations of focus as well as those with lived experience to support the development of tailored public health messages (translated appropriately and accessible in California's threshold languages) and dissemination strategies[73]	CDPH	DHCS, 988 Crisis Centers, Tribal/CBO Partners	●	●	●	●
A.2.c	Engage CBOs and other trusted partners (e.g., educational institutions, state and peer run warmlines, etc.) as vehicles for delivering locally tailored messages using guidance and toolkits to support consistent messaging	CDPH	DHCS, EMSA, 988 Crisis Centers, County/ Tribal BH, Tribal/CBO Partners	●	●	●	●

3. Monitor the success and impact of communications strategies.

Metrics should be established to evaluate the extent to which communications strategies lead to changes in awareness, perception, and behavior in alignment with the cross-cutting recommendation on data and metrics to develop a public-facing state dashboard (see Recommendation E.3). In addition to quantitative measures, the state should gather qualitative data to assess the efficacy, sufficiency, and cultural and linguistic responsiveness of its communications strategies.

Workgroup members and focus group participants emphasized the importance of engaging individuals with lived experience, particularly among populations of focus, to

provide input. Communications efforts should also be reviewed and adjusted periodically as the 988 system develops and/or as crisis services are added, changed, or integrated.

#	Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
A.3.a	Establish metrics to evaluate the extent to which communications strategies lead to changes in awareness, perception, and behavior	CDPH	DHCS, EMSA, Cal OES, 988 Crisis Centers, Tribal/CBO Partners	●	●	○	○
A.3.b	Evaluate communications strategies based on agreed-upon metrics developed with community input	CDPH	DHCS, EMSA, Cal OES, 988 Crisis Centers, Tribal/CBO Partners	○	●	●	●
A.3.c	Review and update communications messages and materials to ensure they reflect services available and are responsive to community needs	CDPH	DHCS, EMSA, Cal OES, 988 Crisis Centers, Tribal/CBO Partners	○	○	●	●

Goal B: Statewide Infrastructure and Technology:

Establish the systems, inclusive of technology, policies, and practices, to connect help seekers to the appropriate call/chat/text takers.

AB 988 Required Area (2) GOV 53123.3. (b)(2): Maintenance of an active agreement with the administrator of the National Suicide Prevention Lifeline for participation within the network.

AB 988 Required Area (3) GOV 53123.3. (b)(3): Compliance with state technology requirements or guidelines for the operation of 988.

AB 988 Required Area (5) GOV 53123.3. (b)(5): 988 infrastructure, staffing, and training standards that will support statewide access to crisis counselors through telephone call, text, and chat, 24 hours per day, seven days per week.

AB 988 Required Area (7) GOV 53123.3. (b)(7): Resources and policy changes to address statewide and regional needs in order to meet population needs for behavioral health crisis services.

Rationale: Ensuring California's 988 system has the necessary infrastructure and technology to meet the needs of a large and diverse population – 24 hours a day, 7 days a week – is a complex undertaking. When the United States transitioned from the 10-digit NSPL to 988 in July 2022, over 30,000 calls per month were already being routed to California. The average monthly call volume in the first year (from July 2022 to June 2023) was 28,058, with an in-state answer rate of 88 percent.[74] In the second year (from July 2023 to June 2024), the average monthly call volume increased to 31,927, with a slightly lower in-state answer rate of 86 percent. New features – like chat and text – have continued to place staffing and technology demands on 988 Crisis Centers, and such methods for contacting 988 are likely to grow further in future years.[75]

California's call volume is substantial. More than 336,000 calls were routed to California during 988's first year (from July 2022 to June 2023), more than twice the number of any other state. In 988's second year (from July 2023 to June 2024), the total call volume routed to California increased 14 percent to 383,123. One in every ten calls to 988 originated from

California in 2023-2024, which was a slight decrease from 2022, when one in every eight calls originated from lines with California area codes.[76]

The state is seeking to implement technological solutions to manage and route 988 calls, texts, and chats. This work is being done with guidance from the Cal OES TAB and based on the specific needs of 988 crisis counselors and 988 help seekers. Once implemented, the 988 technology platform will help to support:

- Integrated cybersecurity and active system monitoring
- Reliability and availability based on 9-1-1 system standards
- Full interoperability between 9-1-1 and 988[77]

More work is required to further develop and align the technology with the policies and plans being developed for 988 and the broader crisis care continuum.

Transferring help seekers at the point of the contact is one area where policy development is needed. In accordance with federal intent, 988 presents an opportunity to reduce unnecessary law enforcement involvement in behavioral health crisis response. How and when behavioral health crisis calls are transferred between 9-1-1 and 988 will also impact contact volume, staffing, and technology needs. Studies have found that between 5 and 15 percent of 9-1-1 calls nationally are for behavioral health emergencies.[78, 79] Annually, more than twenty-five million calls are made to 9-1-1 in California.[80] This suggests that between 1.25 million and 3.75 million of these calls may be related to a behavioral health crisis. If just 10 percent of that range were diverted to 988, this would result in 988 Crisis Centers managing an additional 125,000 to 375,000 calls annually, a percentage increase from the current annual call volume of between 32 percent and 98 percent.[81]

Handling such an increase in call volume will require additional growth in the capacity of 988 Crisis Centers to meet expected demand. A true alternative to 9-1-1 would also require alternative methods to respond to a behavioral health crisis. In some cases, that may be a warm hand-off or referral to other lines and resources, including but not limited to peer warmlines, county, and Tribal access lines, or 211 services. In other cases, it may require a community-based response, which includes many models, from street outreach teams and Peer Supporters to multi-disciplinary mobile crisis teams. Each of these resources represents a potential point of connection for Californians to access essential services before, during, or after crisis (see Goal D: Integration). As 988 matures, there will be new opportunities to increase coordination and interoperability between systems to link help seekers to services.

As the RAND Corporation notes in a recent series of case studies, interoperability between 988 and 9-1-1 requires more than the existence of a technology platform and associated transfer criteria; it requires concrete guidance, cross-training opportunities, building trust among call-takers, and leveraging champions.[82] Interoperability has been a core focus of Cal OES and the California 988 TAB and will continue to be a core focus of the implementation work.[83]

The following are key recommendations and potential implementation activities to strengthen the state's 988 infrastructure and technology.

Recommendations

1. Support the technology to route 988 contacts safely and efficiently anywhere in California, including to mobile crisis dispatch.

As more Californians become aware of 988, the state needs to ensure that both the technical infrastructure and human resources are in place to manage additional contacts. Focus group participants – most notably from rural and Tribal communities – described technology access and cell phone service as barriers to crisis response services. They highlighted the prevalence of "dead zones" in remote areas of the state, where phone services are unavailable.

The PAG, Workgroup members, and individual interviews also underscored the importance of the technology platform to reliably route calls appropriately. They recommended that the California system be adaptable to allow for changes and new connection points in the system (e.g., connecting help seekers through resource directories, etc.). They also recommended an explicit call out to a system that can be connected to mobile crisis.

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
B.1.a	Build the technology platform to enable system interoperability and enhance coordination across 988 (including technical assistance and guidance) and the crisis care continuum	Cal OES, CalHHS	DHCS, EMSA, County/ Tribal BH, 988 Crisis Centers, PSAPs	●	●	●	●

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
B.1.b	Provide technology tools to support connection of help seekers to community-based crisis response	Cal OES, CalHHS	DHCS, EMSA, 988 Crisis Centers, County/ Tribal BH	●	●	●	●
B.1.c	Make upgrades to the state technology platform (e.g., geo-routing,[84] etc.) consistent with community input and technological innovations	Cal OES, CalHHS	DHCS, 988 Crisis Centers, County/ Tribal BH, PSAPs, Tribal/CBO Partners	●	●	●	●

2. Promote coordination and communications across state technology implementation partners to ensure alignment of technology, policy, and practice.

Not all 9-1-1 PSAPs divert behavioral health crisis-related contacts to 988. Cal OES has been working on technological solutions that will enable 9-1-1/988 interoperability in coming years, which may result in more 988 calls from a 9-1-1 transfer.

In addition to 9-1-1 and 988, other resources are available to help seekers, including other hotlines, warmlines, information lines, and emerging "digital apothecaries." As of December 2024, several warmlines, which provide emotional support and connection to help prevent situations from escalating into crises, operate in the state:

- CalHOPE's peer-run warmline, which connects calls and chats 24/7 to a peer counselor for non-emergency emotional support
- CalHOPE's Red Line, a phone and chat service that provides national, state, and county resources, referrals, and trauma-informed support for Native American populations
- CDA's Friendship Line, which acts as a warmline for older adults and can elevate callers to 988, as necessary

- Locally operated warmlines that are often tailored to different populations and community needs[85]

In addition, state-mandated 24/7 county access and crisis lines connect help seekers to SUD and/or mental health crisis intervention services. County lines can assess callers' needs, provide access to resources, coordinate emergency responses, and may include the ability to connect or dispatch a mobile crisis team. Some counties directly manage their lines; other counties contract out management to 988 services providers or other contractors, including 211 operators.

Another community-based response model operating in the state is the California Family Urgent Response System (Cal-FURS), which is a coordinated statewide, regional, and county-level system designed to provide 24/7 response during situations of instability. Cal-FURS offers trauma-informed support to current and former foster youth and their caregivers to help preserve the relationship between the caregiver and the child or youth[86] (Integration of community response models like Cal-FURS are discussed further in Goal D). There are also opportunities for closer connection with other state run, non-emergency lines including but not limited to the CA vs. Hate Resource Line and Network.[87]

CalHHS recommends continued collaboration with Cal OES, DHCS, and other partners to further assess guidance and technological needs for routing and other related 988 services (e.g., data collection and sharing, system interoperability, and contact routing and mobile dispatch). CalHHS and its implementation partners should work together to develop guidance, practices, and policies to ensure help seekers are routed quickly and appropriately. This includes the safe and timely transfer of necessary information to assist help seekers in accessing services and supporting service providers, including community-based response. It should also include training on transfer processes and the development of memorandum of understanding (MOU) templates to support data-sharing across agencies.

"[Crisis response] reminds me of a hostage situation where they'll send out a negotiator specially trained to deal with that type of situation, not just police or an ambulance. Have a mental health crisis expert come out first to address the situation without it escalating further."

– Focus Group Participant

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
B.2.a	Assess and recommend how the technology can support uniform data collection and inform service quality	CalHHS	Cal OES, DHCS	○	○	●	○
B.2.b	Review and support, as needed, revision/update of the draft transfer criteria between 9-1-1 and 988, being developed by the Cal OES TAB	Cal OES, CalHHS	DHCS, EMSA, PSAPs, 988 Crisis Centers	●	●	●	●
B.2.c	Support stepwise implementation of the transfer criteria between 9-1-1- and 988 developed by the Cal OES TAB, starting with suicide-related contacts, using national guidance such as the National Emergency Number Association (NENA) standards and evidence-based tools	Cal OES, CalHHS	DHCS, EMSA, PSAPs, 988 Crisis Centers	○	○	●	●
B.2.d	Develop guidance and related policy to connect and transfer help seekers bi-directionally to the appropriate call/text/chat support for transfers between 988 and other crisis service access points and helplines (e.g., 211, County Access lines, Mobile Crisis Dispatch Lines, Cal-FURS, Commercial Plans, Managed Care Plans, and Warmlines)	CalHHS, Cal OES	DHCS, EMSA, County/ Tribal BH, 988 Crisis Centers	●	●	○	○

Goal C: High-Quality 988 Response:

Support the 988 system in delivering a high-quality response.

AB 988 Required Area (1) GOV 53123.3. (b)(1): Federal Substance Abuse and Mental Health Services Administration requirements and national best practices guidelines for operational and clinical standards, including training requirements and policies for transferring callers to an appropriate specialized center, or subnetworks, within or external to, the National Suicide Prevention Lifeline network.

AB 988 Required Area (5) GOV 53123.3. (b)(5): 988 infrastructure, staffing, and training standards that will support statewide access to crisis counselors through telephone call, text, and chat, 24 hours per day, seven days per week.

Rationale: California's 988 Crisis Centers, in alignment with SAMHSA's standards, provide empathetic listening, emotional support, crisis de-escalation, and referrals to local resources to support individuals experiencing suicidal thoughts and other mental health crises. These services align with national standards, which require 988 Crisis Centers to provide:

- Support and de-escalation
- Risk assessment
- Safety planning
- Connection to care/resources
- Coordination of emergency services intervention, if necessary[88]

Recent updates to the national 988 network's 988 Suicide and Crisis Lifeline Suicide Safety Policy provide more explicit guidelines on the use of the safety assessment tool and involuntary emergency interventions. The new policy also places greater emphasis on establishing relationships with community providers, requiring documentation of outreach strategies where no alternative exists, and proactively requiring collaboration with mobile crisis teams.[89]

Suicide and crisis lifelines are important tools to prevent suicide and mental health crisis and to provide pathways to well-being. National studies have shown that 95 to 98 percent of 988 calls are resolved over the phone, and that most 988 callers report feeling less depressed or suicidal after calling.[90] [91] Studies specific to California are more limited. One 2017 RAND Corporation evaluation of suicide prevention found variability in service quality, including adherence to existing guidelines for suicide risk assessments and quality of service.[92]

While 988 Crisis Centers provide services for individuals with thoughts of suicide or who are experiencing a mental or emotional crisis, they also have the potential to help individuals with other types of behavioral health crisis, including substance use-related challenges, by connecting them to the larger crisis care continuum or some other form of assistance. Broadening the scope of 988 Crisis Centers to address a wider range of behavioral health challenges would align with feedback offered by the PAG, in Workgroups, and in focus groups that included individuals with lived experience. Many focus group participants shared they had experienced both mental health and substance use-related crises and would have benefited from a number to call and connection to additional resources.

"I needed a number. I needed help before I relapsed, but I had no one to reach or reach out to."

– Focus Group Participant

Most focus group participants did not distinguish between their having experienced a mental health versus a substance use crisis. They suggested having a single number to call would offer greater simplicity for help seekers, regardless of the type of crisis being experienced. Most contacts made to California's 988 Crisis Centers in 2024 were not reported as substance use-related, but many of the 988 Crisis Centers do report receiving them. As of July 2024, out of 37,000 answered contacts by California 988 Crisis Centers, 1,913 (5.2 percent) were reported as substance-related (Note: monthly data reporting varies[93]).

Critical to the implementation work ahead is getting to a next level of understanding with federal partners on a range of subjects, including state and federal authority, existing and emerging training standards and curriculum, as well as issues of data ownership and sharing, so that the state can determine what additional requirements and support may be needed in California.

The following are key recommendations and potential implementation activities to ensure a high-quality 988 contact.

Recommendations

1. Support 988 Crisis Centers in meeting current national standards in preparation for meeting future statewide standards and California's vision for a comprehensive crisis care continuum.

988's rapid growth, spurred by both federal and state action, has required 988 Crisis Centers to adjust in an uncertain operating environment with new and evolving key performance indicators set by the national 988 network.

The state should continue to support 988 Crisis Centers in meeting national standards, including assessing current capacity and potential future staffing needs. The state should also assess national training standards and emerging best practices to determine what additional training and supports might be necessary to help meet the needs of Californians.

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
C.1.a	Assess the current 988 network's capacity to meet existing key performance indicators	DHCS	Cal OES, 988 Crisis Centers	●	●	●	●
C.1.b	Evaluate existing staffing needs and identify mechanisms to assess future staffing needs to support the core requirements of 988 Crisis Centers	DHCS	Cal OES, 988 Crisis Centers	●	●	●	●
C.1.c	Evaluate existing national training standards for 988 crisis counselors to determine adequacy to meet state needs	DHCS	EMSA	●	●	●	●
C.1.d	Determine best practices and provide resources to 988 Crisis Centers to mitigate compassion fatigue and burnout among crisis counselors and support future recruitment and retention efforts	DHCS	EMSA, 988 Crisis Centers	●	●	●	●

2. Building on national standards and best practices to ensure trauma-informed, person-centered, and culturally responsive care, establish state-specific standards for staffing and training to equip 988 Crisis Centers to respond to suicide, mental health, and substance use-related 988 contacts.

Over time, 988 services will become more integrated into California's behavioral health crisis care continuum. Building upon SAMHSA best practices, the 988 Suicide and Crisis Lifeline's model, and the strength of California's existing network of 988 Crisis Centers, the state intends to develop a scope of services for California's 988 Crisis Centers. State standards should provide due deference to federal standards and performance targets, while maintaining the state's vision for its crisis care continuum.

The PAG and Workgroups underscored that future baseline statewide staffing and training standards should build on national standards and should be designed to help meet the needs of all Californians. These future standards should seek to ensure that 988 Crisis Centers provide effective, equitable, understandable, respectful, and quality care and services. This involves ensuring that 988 Crisis Centers are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs[94] (See also Recommendation E1. Equity). They further suggested staffing and training standards establish guidance for counselors to address a range of behavioral health needs, including substance use challenges and COD, as well as strategies for help seekers with IDD and physical health needs.[95] Members of the community suggested incorporation of SAMHSA harm reduction models as a possible resource for 988 system operations.[96] This aligns with feedback captured through the focus group with individuals with lived experience who highlighted the need for empathetic, culturally responsive, and trauma-informed services across the behavioral health crisis care continuum.

"Crisis responders and workforce need to treat every individual with empathy, dignity, and a sense of urgency…it could be a life and death situation for the person affected." – Focus Group Participant

The PAG and Workgroups also recommended training and standards for instances when family members call 988 for a loved one. They emphasized that training and standards should build on standardized national training and existing center-specific training, including but not limited to training and standards provided by SAMHSA and its contracted national administrator and other best practices in consultation with both clinicians and individuals with lived experience. They also underscored the importance of understanding and addressing the needs of populations of focus, recognizing the importance of training and baseline standards that build in culturally responsive, trauma-informed, harm reduction approaches to care. Specialized trainings were also suggested to meet the needs of diverse populations across the life cycle including youth and older adults as well as people of color and justice involved populations.

FOCUS GROUP PARTICIPANT

"I want someone who will listen to you. There should be more training for people to not be judgmental."

When developing standards, CalHHS recommends that the state should further determine the authority and oversight mechanisms for 988 Crisis Centers, including how their performance will be monitored and measured.

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
C.2.a	Identify mechanisms to aid 988 Crisis Centers with contact volume projections and growth forecasting	DHCS	Cal OES, 988 Crisis Centers	●	●	○	○
C.2.b	Establish the scope of services for 988 Crisis Centers to help move toward California's vision for an equitable, accessible, high-quality crisis system for all	CalHHS, DHCS	988 Crisis Centers	●	●	●	○
C.2.c	Align staffing standards with the evolving scope of services for 988 Crisis Centers	DHCS	988 Crisis Centers	●	●	●	●

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
C.2.d	Establish statewide training standards for 988 Crisis Centers inclusive of behavioral health crises, including those associated with suicide, mental health, and substance use	DHCS	EMSA, 988 Crisis Centers	●	●	●	○
C.2.e	Establish statewide training standards and guidance for the transfer of contacts between 9-1-1 and 988, inclusive of medical triage and response to warm handoffs that align with national best practices and meet the needs of Californians	EMSA, DHCS	Cal OES, 988 Crisis Centers, PSAPs, County/ Tribal BH, CBOs	●	●	●	●
C.2.f	Ensure future 988 training standards include training on cultural responsiveness, language access and other trainings for populations of focus[97]	DHCS	988 Crisis Centers, EMSA	●	●	●	●
C.2.g	Establish a process for state-level monitoring and support of 988 Crisis Centers, inclusive of technical assistance, to help them meet state and national quality standards	DHCS	Cal OES, EMSA, 988 Crisis Centers	●	●	●	○

3. Establish a process to review, designate and re-designate California 988 Crisis Centers.

SAMHSA has established minimum standards for 988 Crisis Centers in the national network;[98] however, California is a large and diverse state with complex population needs and behavioral health delivery systems. The state should examine local behavioral health needs in the context of 988 and other behavioral health services to develop a state-level process to designate and re-designate 988 Crisis Centers. PAG and Workgroups emphasized the importance of understanding the current role of 988 Crisis Centers in suicide prevention and connecting help seekers to needed services. They also highlighted

the varying needs across the state regarding how existing crisis systems and services are organized and delivered and the possibility of needing additional 988 Crisis Centers to connect help seekers to local services.

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
C.3.a	Develop a process to continually assess the overall capacity of the 988 Crisis Center network to meet federal and state requirements	CalHHS, Cal OES	DHCS, 988 Crisis Centers	●	●	●	●
C.3.b	Develop a process to continually assess adequate coverage of 988 services in California, so that the technology exists to answer 988 contacts and track metrics related to how well the 988 system is doing with capacity in answering incoming calls/chats/texts	CalHHS, Cal OES	DHCS, 988 Crisis Centers	●	●	●	●
C.3.c	Develop a process to continually assess 988 Crisis Centers' performance as a part of the behavioral health crisis care continuum, including but not limited to the training of 988 crisis counselors, performance, and quality of 988 services, and other standards.	DHCS	988 Crisis Centers, EMSA	●	●	●	○
C.3.d	Support 988 Crisis Centers to expand scope of services and capacity to address behavioral health crises inclusive of mental health and substance use challenges.	CalHHS, DHCS	988 Crisis Centers	●	●	●	○
C.3.e	Establish a process to review, designate, and re-designate 988 Crisis Centers to meet network coverage needs and to connect help seekers to local resources	CalHHS, DHCS	Cal OES, DHCS	●	●	●	●

Goal D: Integration of 988 and the Continuum of Services:

Increase coordination of behavioral health crisis services.

AB 988 Required Area (6) GOV 53123.3.(b)(6): Access to crisis stabilization services and triage and response to warm handoffs from 9-1-1 and 988 call centers.

AB 988 Required Area (9) GOV 53123.3.(b)(9): Recommendations to achieve coordination between 988 and the continuum of behavioral health crisis services. Recommendations shall address strategies for verifying that behavioral health crisis services are coordinated for a timely response to clearly articulated suicidal or behavioral health contacts made or routed to 988 services as an alternative to a response from law enforcement, except in high-risk situations that cannot be safely managed without law enforcement response and achieving statewide provision of connection to mobile crisis services, when appropriate, to respond to individuals in crisis in a timely manner

Rationale: California is at a pivotal moment in the evolution of its behavioral health crisis care system. Historic investments have been made in the crisis care continuum, including 988 Crisis Centers, CCMUs, and other crisis response systems. Funding through BHCIP, CYBHI, CalAIM and other initiatives has helped to create more opportunities to stabilize behavioral crisis and connect people in need to tools and resources aimed at preventing future crisis situations.

Behavioral health crises encompass a wide range of situations, with many different potential points of entry into the continuum of care and possible transitions in care (see **Figure 4.** Transitions in Care). Each requires a person-centered response to help meet a help seeker's needs where they are. Connecting these services together and coordinating them into the comprehensive continuum of crisis services envisioned by the state will take time and significant investment.

Examples of newly developed services for youth, funded by CYBHI, are two online applications that provide free coaching services with qualified behavioral health

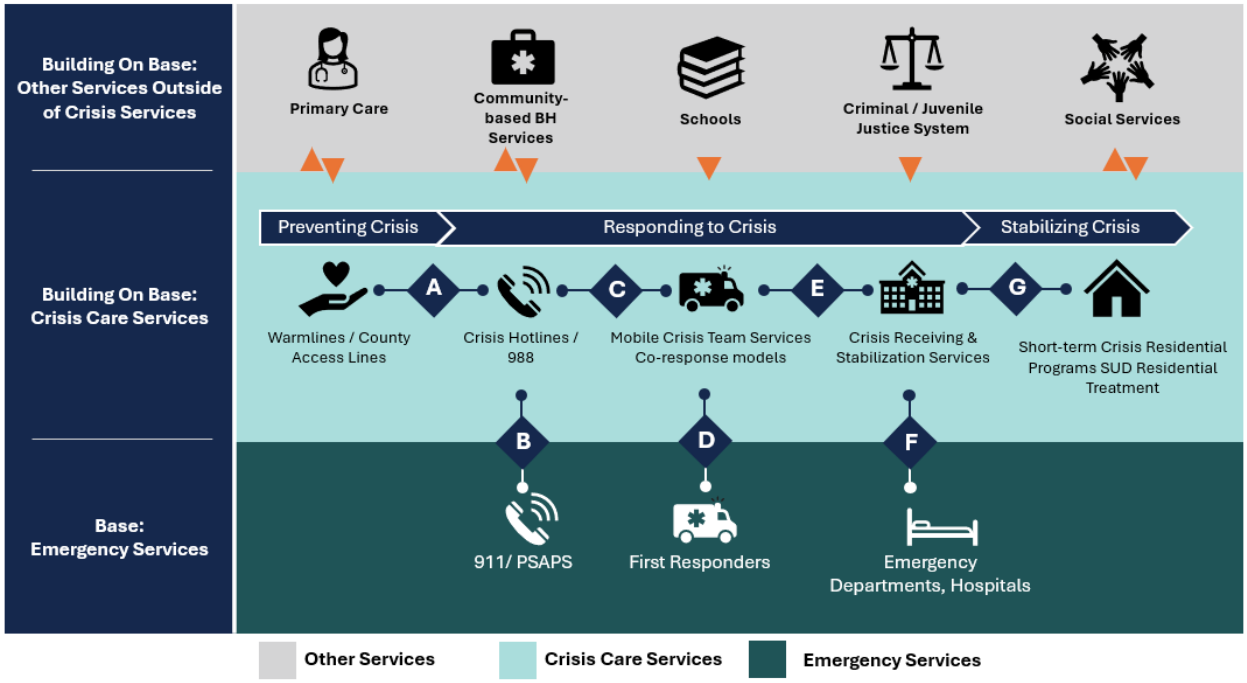
wellness coaches, and handoffs to 988 if/when appropriate. BrightLife Kids is for parents or caregivers and kids 0-12 years old. Soluna is for teens and young adults ages 13-25. Another youth focused program, the California Child and Adolescent Mental Health Access Portal (Cal-MAP), is designed to increase timely access to mental health care for youth in the state's most underserved communities. Cal-MAP's team of psychiatrists, psychologists, and social workers provide no-cost consultation, education, and resource navigation to California Primary Care Providers (PCPs) caring for mental and behavioral health concerns in youth ages 0-25.[99]

Properly connected and coordinated crisis services can offer timely services in the least restrictive setting, reduce inappropriate use of emergency departments and hospitals, and reduce unnecessary law enforcement involvement in mental health and substance use crises. System coordination can also help individuals receive follow-up care, as needed, irrespective of how, when, or where a crisis may have occurred.

> "At the age of 40, I went in and out of mental hospitals, jails, other facilities, but once I got connected with [dual diagnosis program], that all changed."
> – Focus Group Participant

The PAG and Workgroups highlighted the need to reduce unnecessary law enforcement involvement, improve experiences in emergency departments and hospitals, and increase options for places to go during a behavioral health crisis. Focus group participants shared what were often negative experiences while they were in crisis, as well as their desires for more specialized crisis response services and connections to longer-term support services (see the *Community Engagement Report*).

Figure 4. Transitions in Care



California's 988 services today are not fully connected to the broader behavioral health crisis care delivery system. Several counties do not have relationships with the 988 Crisis Centers that receive calls from help seekers in their respective counties. Notably, all counties are required to post a single telephone number for Medi-Cal beneficiaries who may need mobile crisis services. This number can be the same as the 24/7 access line or an existing crisis line. Many counties operate the access and crisis lines themselves or work with vendors (including 988 Crisis Centers in some counties) to provide this service.[100]

The state has already invested significant resources into creating or enhancing crisis care mobile units. As of September 2024, there were 458 mobile crisis teams created or enhanced across 51 county behavioral health authorities (52 total counties); two city behavioral health authorities; and one Tribe for CCMU services contracted.[101] Grantees used funding to support a variety of locally defined crisis models, including building teams that involve behavioral health clinicians, community paramedics, and other providers.[102]

"I've seen lots of people get forced out with no place to go. People have a set time, but not everyone gets connected to what they need in that time period. You can't kick people back to the street because then you start the cycle again." – Focus Group Participant

In July 2023, the Centers for Medicare & Medicaid Services (CMS) formally approved California's mobile crisis services as a Medi-Cal benefit.[103] This benefit went live in January 2024 and is helping to ensure 24/7 mobile crisis service access for Medi-Cal members.[104] As of December 2024, 48 counties had been approved to provide services under the benefit, covering 98 percent of Medi-Cal members.[105] Despite these efforts, 24/7 mobile crisis systems, both in California and nationally, are still nascent in many regions. Mobile crisis programs also report service gaps and challenges, including funding restrictions, lack of reimbursement for individuals with commercial health insurance, workforce shortages, and limits to where and how individuals can be transported.[106]

The state also has invested in crisis receiving and stabilization facilities and programs for individuals during and after a behavioral health crisis (e.g., CSUs, Crisis Residential Treatment Centers, Sobering Centers, etc.) through BHCIP, CalAIM, CYBHI, and other initiatives. The first five rounds of BHCIP funding have resulted in funding for 130 behavioral health treatment projects in 38 counties for behavioral health facility construction, 2,601 inpatient and residential beds funded statewide, and 281,146 total individuals statewide who can be served in outpatient settings.[107] These investments will continue to support the opening of facilities in communities across the state in the coming years, supported by new rounds of BHCIP funding through the Behavioral Health Infrastructure Bond Act, which authorizes $6.38 billion in funding for behavioral health housing, treatment, and residential sites.[108]

In addition, BH-CONNECT, a new Medicaid Section 1115 demonstration project, will help expand access to and strengthen the continuum of mental health services for Medi-Cal beneficiaries living with serious mental illness (SMI) and/or serious emotional disturbances (SED). BH-CONNECT will introduce and connect a range of community-based services and evidence-based practices that will help prevent, respond to, and stabilize crisis (including peer respites) and improve outcomes.[109] BH-CONNECT will also help advance a state bed tracking pilot program for behavioral health facilities and general acute care hospital beds.

The following are key recommendations and potential implementation activities to increase coordination across the continuum of behavioral health crisis services.

Recommendations

1. Coordinate state, Tribal, county, and regional behavioral health along with payers, providers, and cross-sector partners to connect individuals in behavioral health crises to immediate and ongoing care.

Coordination requires clear guidance — from the initial point of contact through ongoing care — to help providers determine when and how they should involve other providers in crisis situations such as mobile crisis teams, EMS, and other existing system services (e.g., Cal-FURS and developmental disability service providers, etc.). By fostering coordination, the state can decrease the number of times individuals in crisis are redirected to new providers or services, which will help them receive timely and appropriate care. Minimizing redirection will also reduce the number of times individuals need to share information about their situation, which can be a stressful process. The PAG encouraged the state to continue working across state agencies to identify existing crisis-related and relevant programs and explore linkages to the 988 system, as applicable. They also encouraged the development of guidance at the initial point of contact with a help seeker regarding the appropriate response and when additional support from EMS or other responders and providers might be appropriate.

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
D.1.a	Evaluate how 988 Crisis Centers coordinate with 9-1-1 Public Safety Answering Points (PSAPs), County behavioral health, Tribal behavioral health, Emergency Medical Services (EMS), and others	CalHHS, Cal OES	DHCS, EMSA, PSAPS, Local EMS providers, County/ Tribal BH, 988 Crisis Centers	●	●	○	○
D.1.b	Support the development and updating of resource directories to ensure 988 Crisis Centers have information about local response and safe places to be [110]	Cal OES, DHCS	EMSA, 988 Crisis Centers, County/ Tribal BH	●	●	●	●
D.1.c	Align coordination efforts with technology solutions (See Also Recommendation B.1.)	Cal OES, CalHHS	988 Crisis Centers, County/Tribal BH, Mobile Providers, PSAPs	●	●	●	●

2. Support connection, coordination, and referrals of 988 help seekers to timely and effective community-based, culturally responsive crisis response, including mobile crisis dispatch, when appropriate.

Community-based crisis response can take many forms, including mobile crisis teams, community co-response, and first responder models. The state has invested significantly in creating or enhancing community-based mobile crisis teams and co-response models through BHCIP's and CMS-approved mobile crisis services. Mobile crisis teams provide on-the-ground support, delivering person-centered care and connecting individuals to recovery resources, and may reduce unnecessary law enforcement involvement in behavioral health crises.[111] Other community-based responses, sometimes funded at the local level, are also operating throughout California.[112] For instance, Cal-FURS is a state-funded specialized response system for current or former foster youth and caregivers, which can connect help seekers to local mobile response teams to provide timely, trauma-informed support.

"Find a way to send only qualified individuals instead of police. Crisis teams instead of police intervention." – Focus Group Participant

The PAG recognizes that coordination of community-based crisis response and its interconnection to 988 and other places to contact is key to the development of a comprehensive 988-crisis system. CalHHS recommends further assessment of the crisis response system, including challenges raised by counties and community-based mobile providers related to funding restrictions, staffing shortages, and transportation limits. It further recommends a state process to identify strategies to ensure connection and coordination of community-based responses.

"Faster response time would build confidence in the system." – Focus Group Participant

#	Potential Implementation Activities	State Lead(s)	Implementation Partners	Year 1	Year 2	Years 3-4	Years 5+
D.2.a	Identify mechanisms to build and sustain 24/7 Medi-Cal Mobile Crisis Teams	DHCS	County BH	●	●	○	○
D.2.b	Identify mechanisms to build and sustain 24/7 all-payer Mobile Crisis Teams	CalHHS	DHCS, County BH, DMHC	○	●	●	●
D.2.c	Assess gaps in community-based crisis response capacity and identify strategies to address gaps	CalHHS	DHCS, EMSA, Cal OES, Counties and Cities	●	●	●	○
D.2.d	Evaluate and propose strategies to support coordination between 988 Crisis Centers and community-based response	CalHHS	DHCS, EMSA, Cal OES, County BH, 988 Crisis Centers, Mobile Crisis Providers, Counties, and Cities	○	●	●	○
D.2.e	Propose guidelines to support the technology to connect between 988 Crisis Centers and emergency response (Law Enforcement, EMS, Fire)	Cal OES, CalHHS	DHCS, EMSA, Counties, and Cities, 988 Crisis Centers, PSAPS	○	●	●	●

3. Continue to assist communities in expanding the range of facilities and services to individuals before, during, and after a behavioral health crisis.

Ensuring a menu of options for help seekers is critical to an effective crisis care continuum. Options should include a range of services informed by people with lived experience to ensure accessibility, trust, and alignment with the acuity and needs of the individual in crisis. These may include but not be limited to evidence-based services as well as traditional healing and community-defined evidence practices (CDEPs).[113]

FOCUS GROUP PARTICIPANT

"It's a cycle of input and output… People in crisis need stabilization and they need more than 3 to 5 days. They need to be connected somewhere to get them into services that will break the cycle."

Doing so recognizes that not all people in crisis require in-person response but may benefit from a support group, connection to a peer, counseling, and other upstream services. Once developed, these services should be further integrated to ensure long-term sustainability across all payors.

The state also recognizes the need for more treatment facilities and programs. A 2022 RAND report found that California faces a projected 1.7 percent growth in its adult psychiatric bed need between 2021 and 2026 and faces a shortage of approximately 3,000 adult community residential beds.[114] RAND has also cited bed shortages (acute, sub-acute and community residential) for children and youth in several related studies.[115] This problem continues to be corroborated by individuals with lived experience in 2024: focus group participants reported that longer-term facilities and services were not available to them after crises. Participants shared that they often needed more than a few days to stabilize from the physical and psychological effects of crises, and that, without a place to go after a hospital or short-term care facility, they got caught again in the cycle of crisis.

"Sometimes when we call for help, someone comes but the services provided aren't long enough to actually get the help we need." – Focus Group Participant

The PAG encouraged ongoing investments in peer respite services, sobering centers, and additional crisis residential treatment facilities (particularly for children and youth with significant behavioral health conditions). Tribal partners highlighted innovative models that could help weave cultural and traditional practices into behavioral health stabilization and treatment services for both youth and adults (e.g., traditional medicines, daily talking circles, and intergenerational connections). Warm lines can also play a role beyond emotional support and prevention, including providing connections to community resources and as additional support during stabilization and post-crisis recovery phases.

"We need our own Tribal residential stabilization facility." - Native Focus Group Participant

Notably, the state is continuing to collaborate with communities across the state to address facility shortages through BHCIP, including new funding through Proposition 1, and to enhance service offerings via CalAIM and BH-CONNECT. These efforts will take place at the county level, based on need, with the understanding that each county coordinates and organizes the delivery of services to vulnerable populations, including tribes, directly and/or through contracted partners.

With support from the state, these initiatives are helping to address existing gaps within the crisis care continuum including but not limited to:

- Increasing step-down options, coupled with quality and culturally responsive discharge planning and care coordination
- Improving access to outpatient programs and specialized crisis care services to individuals who recently experienced crises to reduce relapse rates
- Supporting person-centered, recovery-oriented crisis supports, such as sobering centers, peer respite, in-home crisis stabilization, and wellness centers, for people with or without Medi-Cal coverage[116]

NATIVE FOCUS GROUP PARTICIPANT

"Young people need residential support, and they are either not sick enough or too extreme; the ones who don't receive appropriate care often end up in jail."

As part of the Plan, CalHHS recommends supporting the coordination of existing efforts, including pilot projects and other initiatives to advance the development of resources that can be used to coordinate real-time availability of programs, services, and facilities for individuals in crisis. CalHHS also recommends development of policies that will increase equitable access to crisis receiving and stabilization facilities for help seekers. All activities should build upon existing statewide efforts wherever and whenever possible, including those intended to support development and operations of crisis receiving and stabilization facilities that operate outside of traditional business hours, meet the needs of children and youth, older adults, individuals with mental health, SUD and/or chronic health conditions and/or who are justice involved.

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
D.3.a	Coordinate efforts to inventory behavioral health services and facilities and assess opportunities to inform state policy for building upon or filling in gaps from existing initiatives	CalHHS	DHCS, CDPH, EMSA, County/ Tribal BH, Tribal/ CBO Partners	●	●	○	○
D.3.b	Develop policy recommendations to increase equitable access to crisis receiving and stabilization facilities (considering potential barriers such as costs, cultural factors, staffing, insurance coverage, acceptance and denial criteria, and other factors)	CalHHS	DHCS DMHC	○	○	●	●
D.3.c	Develop policy recommendations to address insurance coverage and local sustainability challenges for county and community providers of services that stabilize crisis (See Also Recommendation E.2.)	CalHHS	DMHC, DHCS	○	○	●	●
D.3.d	Build on Proposition 1, Behavioral Health Continuum Infrastructure Program (BHCIP), California Advancing and Innovating Medi-Cal (CalAIM), and other initiatives to increase the availability of alternative models including Peer Respite, Sobering Centers, and traditional Crisis Residential Treatment Programs	CalHHS	DHCS, County /Tribal BH	●	●	●	●

4. Develop more options or expand existing options for transporting individuals in crisis to a safe place to be.

The need for alternate transportation options for those experiencing a behavioral health crisis was elevated in multiple PAG and Workgroup meetings. One opportunity that California and other states have been exploring is Community Paramedicine (CP) programs, which allow paramedics to function outside their traditional emergency response and transport roles to facilitate more appropriate use of emergency care resources. Another is Triage to Alternate Destinations (TAD) programs, which offer people who have behavioral health needs, but no emergent medical needs, transport to a mental health crisis center or sobering center instead of an Emergency Department (ED) after screening by the Community Paramedic.[117]

In 2021, California implemented AB 1544, which granted local EMS agencies the authority to develop CP and TAD programs. A study published by the University of California, San Francisco in 2023 assessed different CP and TAD pilot programs implemented in the state. The study included four mental health pilot programs, which provide alternative destination options for people experiencing a mental health crisis. The study found that across pilot sites 27% to 40% of individuals with mental health needs who were screened as part of the pilot program were transported to an alternative destination rather than an ED. Among the three pilot programs with a sobering center program, less than 2% of patients receiving transport to sobering centers as an alternative to the ED were later transferred to an ED.[118]

Over the course of the implementation period, EMSA will identify specific implementation activities consistent with its role.

Cross-Cutting Recommendations

Several factors impact development and implementation of a comprehensive crisis care continuum, including equity, funding and sustainability, data and metrics, and peer support. The below recommendations and related implementation activities are critical to the overarching aims of the Miles Hall Lifeline and Suicide Prevention Act (AB 988). They also seek to build on some of the state's broader efforts that are focused on equity, behavioral health transformation, measurement, and accountability. Where applicable, the related required AB 988 areas are included in the description.

E.1. Equity

Prioritize inclusion and equity in crisis care service delivery for populations that may be at elevated risk for behavioral health crisis, experience discrimination and prejudice, and/or need adaptive/tailored services for equitable access due to physical, intellectual/developmental disability, or unique cultural and/or linguistic needs.

California envisions an equitable behavioral health crisis system that can serve anyone, anywhere, anytime. Achieving equity in the system requires addressing complex issues that disproportionately affect populations that may be, per the CCC-P, "at elevated risk for behavioral health crisis, experience discrimination and prejudice, and have unique cultural and/or linguistic needs." Equity in the context of the Plan is built on the foundational principle that "all Californians, regardless of insurance coverage, location, or other factors (including but not limited to age, race, ethnicity, gender, gender identity, disability status, sexual orientation) should have timely access to quality crisis care."

"We need an education campaign launch focused on the spirit of love and deserving of care, like the COVID period of masking campaigns like, 'Wear your mask to protect your grandma.'" - Focus Group Participant

Ensuring equitable access and reducing disparities was raised repeatedly across the planning process: in focus groups and interviews conducted as part of the *Community Engagement Report*, in Workgroup and PAG discussions, and during the public comment

periods. Population-level disparities among some groups and communities were further highlighted in the Comprehensive Assessment as a critical gap in the crisis system.[119] The following categories of populations – which are not mutually exclusive – need particular focus in order to improve equitable access in the comprehensive 988-crisis system: (1) populations not reached through national campaigns and/or that are distrustful of 988 or other emergency or crisis lines; (2) populations at greatest risk of suicide or other behavioral health crisis; (3) populations that may need or benefit from accommodations.

Discussions in the PAG and Workgroups highlighted many of the challenges to and opportunities for enhancing equity within the crisis care continuum. Consistent with community input, the state will be guided by the principles of targeted universalism, which recognizes that universal goals established for all groups are pursued through targeted processes and approaches.[120]

To prioritize populations of focus in the context of the Plan, the PAG began with the groups identified in the CCC-P, which include:

- LGBTQIA+ youth
- IDD
- Individuals who are d/Deaf or hard of hearing
- Veterans
- Native Americans
- Individuals with specific language needs (e.g., American Sign Language, languages other than English)
- Older adults
- System-impacted youth
- Individuals who are Black/African American, Latino/Latina/Hispanic, and AAPI (particularly youth)

Additional populations and communities determined to be at-risk of behavioral health crises and/or who may require specialized services to ensure equitable access were identified as part of the planning process by members of the BHTF as well as by members of the PAG and Workgroups and through the Comprehensive Assessment. These include the following additions:

- Justice-impacted youths
- Reentering justice-involved populations
- Rural communities
- Unhoused populations
- College-aged students
- Middle-aged White males
- Law enforcement
- Medical professionals
- Active military (not just veterans)
- Individuals in transition from active duty to veteran status
- Undocumented individuals
- Perinatal populations
- Individuals who use drugs

Below are initial findings, drawn from the *Community Engagement Report*, and Workgroup and PAG discussions, recognizing that ongoing engagement will be critical to advance many of the equity-related recommendations and implementation activities described in the Plan.

Increase awareness of 988 and behavioral health crisis services for populations of focus through community driven communications strategies (Goal A: Public Awareness of 988 and Behavioral Health Crisis Services)

California is one of the most culturally and linguistically diverse states in the United States. Approximately 39% of the state's population is Latino/Latina/Hispanic; non-Hispanic Whites represent around 35% of the population; about 16% of the population is of Asian descent; and roughly 6.5% identify as Black/African American. California is also home to one of the largest Native American populations in the country, including 109 federally recognized Tribes, each with distinct cultural heritage and historical significance.

Californians speak 200+ languages, and more than 44% of residents speak a language other than English at home.[121] The most common language spoken at home, aside from English, is Spanish, which is spoken in nearly 10.5 million households.[122] Another 3.2 million households speak one of the five most common languages after Spanish: Chinese (including Mandarin, Cantonese), Tagalog (including Filipino), Vietnamese, or Persian (including Farsi, Dari).[123]

Transparency, cultural responsiveness, language access, and community engagement were cited as critical to building trust and ensuring that all populations have access to clear, culturally relevant information about 988 and related crisis services.

The PAG and Workgroups expressed that implementation activities, including strategies to address historical and systemic barriers that have contributed to distrust among marginalized communities, should rely on the ongoing input from populations of focus. They further emphasized that communications strategies should account for cultural and linguistic diversity and should be differentiated, where possible or as determined necessary, for different populations or communities.

This approach aligns with the input provided by focus group participants, who shared how they receive information and what they believe would be most impactful for others in similar situations. They described building awareness and trust by leveraging trusted messengers, storytelling, and the use of testimonials. They also described the power of word-of-mouth communications among individuals with lived experience to build trust in 988 and crisis services more broadly.

"You need to go into the community with brochures and information: 'Here's where to call, here's where to go.'"

– Focus Group Participant

Importantly, SAMHSA has developed the "988 Partner Toolkit," an online resource that contains marketing tools for promoting 988.[124] The site contains a variety of tools to appeal to many "target audiences" and populations of focus. DHCS has further been working with SAMHSA to develop a 988 communications strategy, informed by community meetings and interviews, which contains an initial approach to increasing awareness and utilization among different populations in California. As previously described, CalHHS plans to coordinate with Cal OES, CDPH, DHCS, EMSA and other state entities to formulate a comprehensive and accessible state communications strategy that is informed by community input.[125]

Seek to lower barriers to accessing 988 and other BH services across the crisis care continuum (Goal C: High-Quality 988 Response; Goal D: Integration of 988 and the Continuum of Services)

A foundational principle in the Plan is that all Californians, regardless of insurance coverage, location, or other factors (including but not limited to age, race, ethnicity, gender, gender identity, disability status, sexual orientation) should have timely access to quality crisis care.

Doing so will require helping to lower barriers to access across different populations. The PAG and Workgroups began to explore access challenges for some, but not all, populations that face barriers to accessing care, as described below:

- Rural communities in California and throughout the nation have higher rates of suicide and depression compared with more urban communities.[126] While there are many reasons why these rates may be higher, one reason is access to care.[127] Individuals in rural and frontier communities often travel long distances to reach behavioral health providers, particularly for specialty services for children and individuals with intellectual or developmental disabilities or co-occurring disorders. Focus group participants suggested that 988 in rural communities and other telephonic options were critical lifelines. Additional strategies raised to address geographic disparities that affect access to outpatient services include supporting telehealth services and connecting 988 Crisis Centers in rural communities, wherever possible, to local prevention, response, and stabilization services.[128]

"The issue is if there is a building 300 miles away.
Just make the resources local. "
– Focus Group Participant

- Older populations in California and nationally are more likely to reside in rural areas, more likely to have a disability, and have higher rates of depression and suicide than people in other age groups.[129] The highest rates of death by suicide in California are males aged 85 years and older (46.1 per 100,000 in 2020).[130] Strategies raised to address high rates of suicide among older adults focused on increasing access to outpatient services and prevention strategies, including but not limited to reducing social isolation through programs like the Friendship Line, and ensuring older adults have access to housing and related supports.[131]
- Youth, particularly young people who are Black/African American, have higher rates of depression and higher rates of suicide compared to other youth.[132] Strategies raised in discussions to address this included but were not limited to providing developmentally appropriate interventions that recognize the unique needs of younger versus older youth (as well as other intersectional identities) and working closely with community based providers to ensure young people receive age specific, person-centered and culturally responsive services.
- Many cultural, ethnic, and linguistic groups — Native American, Black/African American, Latino/Latina/Hispanic and AAPI communities—along with other populations, such as the LGBTQIA+ community, have faced historic marginalization. These communities in California and nationally may have limited access to crisis and other behavioral health care due to systemic inequities and discriminatory practices. Strategies to increase access and build trust among historically marginalized communities focused on ensuring that 988 and related crisis services are culturally and linguistically responsive and inclusive in their design and implementation. They also suggested tailoring services to the needs of different populations and seeking to ensure that individuals who provide services understand their cultural identity and, where possible, shared that cultural identity.

"In the African American community, there's nowhere to go.
You need to go by bus to get help, and some aren't willing."
– Focus Group Participant

- Native American focus group participants expressed a belief that non-Tribal treatment is often ineffective for their communities because it is disconnected from their culture and lacks traditional practices and culturally meaningful care. Participants shared particular concern for Native American youth, who they believe are falling through the cracks of the behavioral health crisis system. They reported that non-Tribal care often ends with Native American youth returning to their communities without the cultural integration and tools needed to prevent the reoccurrence of a crisis. Participants emphasized the importance of weaving Native American values and traditions across the crisis care continuum. Many participants strongly advocated for crisis services designed specifically for Native American communities, including crisis receiving and crisis stabilization services.

LGBTQIA+ FOCUS GROUP PARTICIPANT

"We [LGBTQIA+ individuals] don't often feel confident going into many places…I don't feel safe. I've been judged and laughed at. It makes you want to give up."

- Many LGBTQIA+ individuals face historic marginalization in the behavioral health crisis system. Focus group participants and Workgroup members shared that LGBTQIA+ individuals' negative experiences, such as being misgendered or encountering culturally insensitive care, can lead to long periods of disengagement. Similar experiences and feelings of mistrust were raised by Black/African American focus group participants and is bolstered by national polling data specific to 988 and related crisis services and other research evidence.

"Lots of people are less willing to talk to people who don't look like them. More would reach out if they knew they really understood and cared and were not just going through the motions."

– Focus Group Participant

PAG, Workgroup, and focus group participants also elevated the need for language access standards to improve access to 988 services for people whose language of preference is not English or Spanish. The national 988 network is accessible 24/7 in English and Spanish for voice, chat, and text. It also offers 24/7 interpretation service for voice calls to all network crisis contact centers via a contract with a third party language line.[133] According to the national

988 administrator, 988 Crisis Centers can have an interpreter on the line in one of over 240 possible languages with an average connect time of 30 seconds or less (depending on the language). The national administrator also provides 988 Crisis Centers with guidance on best practices for interacting with an interpreter for a crisis conversation.[134] For d/Deaf and Hard of Hearing populations, the national 988 network offers American Sign Language services, which connect help seekers to their preferred relay service. Dial pad and chat options are also available for persons who identify as LGBTQIA+ and veterans, respectively.

Several California 988 Crisis Centers shared that they actively recruit crisis counselors who represent specific immigrant or cultural populations, depending on the population needs in their community. Additional assessment is needed to determine levels of public awareness of these access service options as well as the quality of such services.

> "Word of mouth is good. Get the people who use it [988 and prevention services] to spread the word. Get the people who use it involved."
> – Focus Group Participant

The national 988 network also offers training and educational resources for some populations who may need accommodation. For example, the national 988 network has some resources for 988 Crisis Centers for help seekers with IDD. According to the national 988 administrator, this includes a guidance document on identifying, supporting, and guiding individuals with IDD who are experiencing a crisis. The national network also has guidance and a recorded webinar to support crisis counselor interactions with people with autism (Crisis Supports for Autism Community, Warning Signs of Suicide: Considerations for the Autism Community, 988 Information for the Autism Community, and Reasons for Living: A Suicide Prevention Resource for Autistic Individuals).[135]

Building on this and other trainings, as well as guidance and resources for populations of focus from the national network, will be critical to increase access and ensure appropriate accommodations and resources are available.

Across the implementation plan, the PAG and Workgroups stressed the importance of partnering with advocacy organizations, CBOs, and people with lived experience to ensure that services across the continuum are accessible to and inclusive of all Californians. They raised the need to create statewide standards to meet California's diverse cultural and linguistic needs, including trainings to support culturally responsive crisis services, and

implicit bias trainings, across the 988 and crisis care continuum. They suggested that these trainings should cover topics including appropriate terminology, historical and racial trauma, and trauma-informed care.

> "There's generational trauma and you need someone who understands what we've been through. You need to understand the condition and experience to heal it."
>
> – Focus Group Participant

Dedicated Native Line

Representatives from Native American communities shared that, for many members of their communities, embedding equity in the 988 system means having dedicated *Native-led and operated* 988 services. This view was expressed by participants in the Native American focus groups, organized by Kauffman and Associates, as well as by Native American association and groups, including in the 2023 Tribal Summits.[136] Focus group participants and entities representing Native Americans suggested the development of a dedicated Native American line with a dial pad option, similar to the one successfully operating in Washington state, in which individuals who contact 988 are given the option to transfer to the Native American line (similar to how existing 988 dial pad options can transfer 988 callers to the Veterans, Spanish or LGBTQIA+ lines).

The grounds for a dedicated Tribal 988 line are based on three important realities:

- *Native American communities are disproportionately affected by suicide.* Nationally, the Native American population has consistently surpassed all other racial and ethnic groups in suicide deaths.[137] According to the Suicide Prevention Resource Center, American Indian/Alaska Native communities "…may lack access to suicide prevention programs that meet their cultural needs."[138]

- *Tribal and non-Tribal governments share a unique government-to-government relationship.* California tribes and Native American communities have a unique relationship with the state and federal government. Executive Order (EO) N-15-19 (June 18, 2019) represents a crucial step in supporting a collaborative partnership between Tribal and non-Tribal governments. EO N-15-19 includes an apology for historical injustices that the State of California committed against Native Americans living within its post-Colonial borders, and addresses the long-lasting impacts of "… violence, maltreatment, and neglect California inflicted on tribes…"[139] EO N-15-19 also reaffirms EO B-10-11, which "requires the Governor's Tribal Advisor and the Administration to engage in government-to-government consultation with California Native American Tribes regarding policies that may affect Tribal communities."[140]
- *A dedicated Tribal line in Washington provides a potential template.* Washington state's dedicated Tribal crisis line, the Native and Strong Lifeline, reports metrics that consistently meet and often exceed national 988 baseline standards. Its success has been bolstered by a Native-specific complementary follow-up service, which provides essential support and culturally relevant resources to help seekers.

Address gaps in coverage that impede access to a comprehensive crisis care continuum (Cross-Cutting Recommendation E.2: Funding and Sustainability)

Insurance coverage gaps also impede access to crisis services. Low behavioral health provider participation in insurance networks limits crisis service access for many individuals. Comprehensive policy changes are needed to encourage behavioral health providers to participate in insurance networks, to address disparities between commercial insurance and Medi-Cal, and to remove the financial barriers preventing families from seeking timely help.

Incorporate equity into ongoing measurement and accountability activities (Cross-Cutting Recommendation E.3: Data & Metrics)

Data collection and evaluation are crucial for understanding and addressing disparities in crisis care. Workgroup members expressed the importance of population-specific metrics that reflect the unique challenges facing people experiencing homelessness, justice-involved youth, and individuals with physical and developmental disabilities.

Workgroup members also emphasized the need to disaggregate data by race, ethnicity, socioeconomic status, and insurance type/coverage to identify gaps in service and tailor interventions to meet the needs of specific populations. Publicly tracking these equity metrics

will enable the state to identify disparities and make data-driven adjustments to improve service quality and accessibility. Workgroup members noted the challenge of balancing the utility of data with the importance of privacy, which is essential to build and maintain community trust.

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
E.1.a	Explore the development of a dedicated Native American line/dial pad option	CalHHS	Cal OES, DHCS, Tribal/CBO Partners	●	○	○	○
E.1.b	Examine current linguistic translation and language access standards to identify opportunities to improve access to 988 services for people whose language of preference is not English or Spanish[141]	CalHHS, Cal OES	DHCS, 988 Crisis Centers	●	●	○	○

Additional equity-focused implementation activities are embedded in the Plan and include the following:

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
A.1.b	Identify audiences for 988 communications strategies to include (1) populations not reached through national campaigns and/or are distrustful of 988 or other emergency or crisis lines; (2) populations at greatest risk of suicide or other behavioral health crisis; (3) populations that may need or benefit from accommodations	CDPH	DHCS, 988 Crisis Centers, Tribal/CBO Partners. County/ Tribal BH	●	●	●	●
A.2.b	Engage populations of focus as well as those with lived experience to support the development of tailored public health messages (translated appropriately and accessible in California's threshold languages) and dissemination strategies[142]	CDPH	DHCS, 988 Crisis Centers, Tribal/CBO Partners	●	●	●	●

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
A.2.c	Engage CBOs and other trusted partners (e.g., educational institutions, state and peer run warmlines, etc.) as vehicles for delivering locally tailored messages using guidance and toolkits to support consistent messaging	CDPH	DHCS, EMSA 988 Crisis Centers, County/ Tribal BH, Tribal/CBO Partners	●	●	●	●
C.2.e	Ensure future 988 training standards include training on cultural responsiveness, language access, and other trainings for populations of focus	DHCS	988 Crisis Centers, EMSA	●	●	●	●
D.3.b	Develop policy recommendations to increase equitable access to crisis receiving and stabilization facilities (considering potential barriers such as costs, cultural factors, staffing, insurance coverage, acceptance and denial criteria, and other factors)	CalHHS	DHCS, DMHC	○	○	●	○
E.3.c	Examine mechanisms, consistent with privacy standards, to disaggregate 988 data by specific subgroups to identify disparities and opportunities to advance equity	DHCS	988 Crisis Centers, EMSA	●	●	●	●

E.2. Funding and Sustainability

Continue to implement strategies to support sustainable crisis systems at the local level that are connected to broader behavioral health transformation efforts, including behavioral health parity.

AB 988 Required Area (13) GOV 53123.3.(b)(13): Procedures for determining the annual operating budget for the purposes of establishing the rate of the 988 surcharge and how revenue will be dispersed to fund the 988 system consistent with Section 53123.4 and Section 251a of Title 47 of the United States Code.

AB 988 Required Area (14) GOV 53123.3.(b)(14): Strategies to support the behavioral health crisis service system is adequately funded, including mechanisms for reimbursement of behavioral health crisis response pursuant to Sections 1374.72 and 1374.721 of the Health and Safety Code, including, but not limited to:

(A) To the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized, seeking to maximize all available federal funding sources for the purposes of behavioral health crisis services and administrative activities related to 988 implementation, including federal Medicaid reimbursement for services; federal Medicaid reimbursement for administrative expenses, including the development and maintenance of information technology; and federal grants.

(B) Coordinating with the Department of Insurance and Department of Managed Health Care to verify reimbursement to 988 centers for behavioral health crisis services by health care service plans and disability insurers, pursuant to Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code and consistent with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. Sec. 1185a).

Sustainable funding sources are essential to maintain an effective and high-quality crisis system. AB 988 contributes to the system's fiscal sustainability by providing a dedicated funding source for 988 Crisis Centers and for mobile crisis teams accessed through 988.[143] Though AB 988 makes it clear that the state will distribute surcharge funds to, first, 988 Crisis Centers and, second, mobile crisis teams accessed through 988, more communication and education should be provided to 988 Crisis Centers and the public to explain the 988 surcharge fee, the funding procedures, and the types of support provided by the 988 State

Suicide and Behavioral Health Crisis Services Fund (Overviews of both the 988 surcharge and the state process for 988 Funding can be found in the Appendix).

Reimbursing crisis services beyond the initial 988 contact also is crucial for the financial sustainability of California's crisis system. Because individuals with all insurance types use the crisis system, it is important that all types of insurance reimburse for BH crisis services. For instance, county behavioral health delivery systems report that upward of 50 percent of Medi-Cal mobile crisis response calls involve individuals who are not Medi-Cal members.[144]

Several laws and subsequent implementation guidance issued by the DMHC and CDI[145] govern reimbursement of behavioral health services in California for health plans and insurers licensed by CDI and DMHC. A landmark piece of legislation, SB 855, requires health plans that cover hospital, medical, or surgical care to also provide coverage of medically necessary mental health or SUD treatment under the same terms and conditions applied to other medical conditions (HSC 1374.72, HSC 1374.721, INS 10144.5, INS 10144.52).

AB 988 and the subsequent trailer bill language (AB 118) introduce additional requirements for health plan coverage of BH crisis services (HSC 1374.724, INS 10144.57). The law clarifies that health plan coverage for mental health and SUD treatment includes BH crisis services provided by a 988 Crisis Center, mobile crisis team, or other BH crisis service providers, regardless of whether the provider or facility is in-network or out-of-network. The law also prevents health plans from charging individuals who receive out-of-network BH crisis care, including post-stabilization care, more than the cost-sharing amount they would pay for in-network services. Moreover, the law requires health plans to cover all items and services eligible for Medi-Cal reimbursement, with respect to BH crisis services provided by a 988 Crisis Center or mobile crisis team.

Additionally, under the law, health plans cannot require prior authorization for behavioral health services that stabilize crises. Legislation permits health plans to require prior authorization for mental health and SUD services following stabilization from a BH crisis but with certain restrictions. The law provides that a health care service plan must, within 30 minutes of being contacted by a BH crisis service provider requesting authorization for post-stabilization services, either authorize post-stabilization care or inform the provider that it will arrange for the prompt transfer of care. Plans must also prominently display on their websites the specific phone number for noncontracting providers to obtain prompt authorization.[146]

Additional efforts are needed to put this legislation into practice. The PAG encouraged support for counties and providers to bill commercial insurance for BH crisis services and for the state to ensure that commercial payors will reimburse for these services. In addition to

ensuring insurance reimbursement, sustainability efforts should also focus on maximizing federal funding, including federal grants and reimbursements for Medi-Cal services and administrative expenses as well as other payor sources. More work is also needed to determine how funding from the surcharge fee can be used for mobile crisis teams accessed through 988.

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
E.2.a	Convene state entities, organizations, and implementation partners (e.g., California health plans, County behavioral health, and state regulatory agencies) to seek pathways to ensure coverage and reimbursement of essential behavioral health crisis services from payors	CalHHS	DMHC, DHCS, CDI, Health Plans, County/Tribal BH, CBOs	●	●	●	●
E.2.b	Maximize commercial health plan reimbursement of crisis services through training and technical assistance for health plans, counties, and providers	DMHC	CDI, DHCS, County/Tribal BH, Health Plans	●	●	●	●
E.2.c	Maximize Medi-Cal reimbursement of crisis services through training and technical assistance for counties and providers	DHCS	DMHC, Medi-Cal MCPs, County/ Tribal BH	●	●	●	●
E.2.d	Maximize reimbursement for crisis services across all public and private payor sources (i.e., federal, state, and local)	CalHHS	DHCS, DMHC, Cal OES	●	●	●	●
E.2.e	Develop and disseminate clear information about funding procedures for 988 Crisis Centers, the process for determining the 988 surcharge fee, and the types of support provided by the 988 State Suicide and Behavioral Health Crisis Services Fund	Cal OES, DHCS	Cal OES, DHCS	●	●	○	○
E.2.f	Determine the process and related criteria for how funding from the surcharge fee can be used for mobile crisis teams accessed via telephone calls/texts/chats made to or routed through 988	CalHHS	Cal OES, DHCS	●	●	●	○

E.3. Data and Metrics

Establish data systems and data standards to support monitoring of 988 and the behavioral health crisis care continuum's performance.

> AB 988 Required Area (10) GOV 53123.3.(b)(10): Quantifiable goals for the provision of statewide and regional behavioral health crisis services, which consider factors such as reported rates of suicide attempts and deaths.
>
> AB 988 Required Area (11) GOV 53123.3.(b)(11): A process for establishing outcome measures, benchmarks, and improvement targets for 988 centers and the behavioral health crisis services system. This may include recommendations regarding how to measure, the feasibility of measuring 988 system performance, including capacity, wait time, and the ability to meet demand for services for 988 State Suicide and Behavioral Health Crisis Services Fund recipients. This may also include recommendations for how to determine and report the amount billed to and reimbursed by Medi-Cal or other public and private health care service plans or insurers related to 988 services.

CalHHS's IT & Data Strategic Plan (March 2024) notes that the state "…must securely capture and generate data to inform necessary improvements to policies, programs, and the very technology that underpins these services."[147] This recognition of data as an enabling factor in supporting a person-centered approach to service delivery was central to the development of the Plan.

AB 988 stipulates the need for "a process for establishing outcome measures, benchmarks, and improvement targets for 988 centers and the behavioral health crisis services system." In considering outcome measures, the PAG and Data and Metrics Workgroup relied on the Results Based Accountability (RBA) model.[148] Specifically, the RBA model hinges on three data-related questions:

- How much did we do?
- How well did we do it?
- Is anyone better off?

The first two questions seek to address levels of effort (the quantity and the quality of the work done) and the third the level of impact. Data are useful for shaping services, addressing

gaps, delivering improved outcomes, and, when communicated effectively, building trust in the systems of care.

The members of the Data and Metrics Workgroup agreed that data standards and measures should evolve as the system evolves. Initial measures should be based on available data, including those measures that 988 Crisis Centers are required to capture and report on currently. For example, AB 988 legislation requires any entity seeking funds available through the 988 Suicide and Behavioral Health Crisis Fund (such as 988 Crisis Centers) to submit an annual outcomes and expenditures report, which must include the total budget, number, and job classification of personnel and the number of individuals served. If known, it must also include outcomes of individuals served and their health coverage status. Beginning July 1, 2025, the report must include measures of system performance, including capacity, wait times, and the ability to meet demand for services.[149] As part of their existing contracts, 988 Crisis Centers also must report on: total number of contacts received and answered, speed to answer, abandonment, and rollover rates. Additional data points may include reasons for referrals and consumer/third party satisfaction rates. The state is working with SAMHSA and the national 988 network administrator on data access and data sharing standards and practices to support state oversight of the California 988 Crisis Center network.

In addition to existing 988 data, the state should also draw from existing required data reporting for other systems, including but not limited to California Health Interview Survey (CHIS), External Quality Review Organization Report (Cal EQRO), Medi-Cal Claims Data, Hospital ED data, and CDPH surveillance data, to support the development of system performance measures and population outcomes.

A state data dashboard is one tool that states have used to support monitoring and accountability. In collaboration with implementation partners — and building upon the CCC-P, PAG, and Workgroup discussions — the state should determine the appropriate metrics for a public dashboard to track performance for both 988 Crisis Centers and the broader crisis care continuum.

The initial set of measures for a public dashboard should focus on information that is helpful for the public to know about and understand crisis response, distinct from the broader set of measures needed by service providers, potential state leads, and policymakers during implementation. The dashboard should also include user experience data.[150] Consistent with the state's equity principles, any public-facing dashboard should be accessible and understandable to all members of the public. Where possible, data should include disaggregated data by demographic categories (race/ethnicity, gender identity, age, sexual

orientation, geography, language/language assistance, etc.) and other filters (Notably, identifying information including demographic data is provided on a voluntary basis by 988 help seekers).

Though the implementation activities outlined below focus on responding to crisis, PAG and Workgroup discussions emphasized that crisis services operate within a complex ecosystem, involving multiple players and partners, with many factors outside (or upstream of) the crisis system influencing behavioral health outcomes.[151] Consistent with the IT & Data Strategic Plan and its emphasis on collaboration, the state should work across agencies and departments as part of broader behavioral health transformation efforts to monitor and evaluate the effectiveness of a comprehensive 988-crisis system. Community feedback further emphasized the importance of creating a data governance structure and process to address key issues of privacy, security, and data-sharing.

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
E.3.a	Convene state entities to determine methods and measures to monitor, evaluate, and communicate the performance of the crisis system in the context of California's broader behavioral health transformation effort	CalHHS	DHCS, DMHC, EMSA, Cal OES, HCAI	●	●	○	○
E.3.b	Develop and maintain a publicly facing dashboard that tracks performance of 988 Crisis Centers including, but not limited to: contact volume (incoming contacts), answer rate, average wait time, number of transfers between 9-1-1/emergency response and 988, mobile crisis dispatch, percentage of calls resolved without the need to transfer or dispatch emergency services, and call dispositions	CalHHS	Cal OES, DHCS, CDPH, EMSA, 988 Crisis Centers, County/Tribal BH, Tribal authorities, counties, and cities	●	●	●	●
E.3.c	Examine mechanisms, consistent with privacy standards, to disaggregate 988 data by specific subgroups to identify disparities and opportunities to advance equity	DHCS, CalHHS	Cal OES, 988 Crisis Centers, EMSA	●	●	●	●
E.3.d	Determine population level outcome measures and quantifiable goals to support assessment of the broader crisis care continuum	CalHHS, CDPH, Cal OES	DHCS, DMHC, EMSA	○	○	●	●

E.4. Peer Support

Integrate peer support across the crisis care continuum to support person-centered, culturally responsive, and recovery-oriented care.

Peer supports offer individuals who are experiencing a mental health or substance use crisis with support from either a person who is in sustained recovery from their own experience with a mental health or substance use or from a person who has lived experience as a parent or family member of a person with a mental health or substance use condition.

Peer Supporters are role models for recovery who are uniquely able to promote hope and bring a shared understanding to people who are experiencing crises at every access point across the crisis continuum. Peers provide person-centered, culturally responsive care, and improve the overall effectiveness and responsiveness of crisis services. They provide recovery-oriented, trauma-informed, culturally appropriate services that promote engagement, socialization, self-sufficiency, self-advocacy, and engagement with natural supports.

Peer support is nonclinical and nonhierarchical, meaning that peers share power with those they are supporting and can, in this way, also be role models for clinicians as they aim to provide non-coercive, person-centered crisis services.[152] Several focus group participants described their experiences in peer-run programs/facilities and the impact that they had.

> "For me, I had been running for so long until I got into a psycho-social program where members had 'say so' about the program. I was finally in this environment where I had nothing to push against, no reason to run, so I had to surrender. And after that, I began to heal."
>
> - Focus Group Participant describing a peer-run program

Based on the value of peer support, California has instituted the qualification of "Certified Peer Support Specialist" (PSS) to enable providers, counties, and other entities to bill Medi-Cal for peer support services.[153] Certification administered by counties and designed for individuals who are 18 years of age or older, who self-identify as having lived experience with the process of recovery from mental illness, SUD, or both, either as a consumer of these services or as the parent or family member of the consumer. Peer Support Specialists are also qualified Medi-Cal Mobile Crisis Services team members. As of June 2024, California has 3,416 Certified Medi-Cal Peer Support Specialists.[154]

Understanding the important role of peers, the PAG established an Ad Hoc Peer Supporter Workgroup to help identify activities needed to integrate peer support in the behavioral health crisis care continuum.

#	Potential Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
E.4.a	Increase consumer and provider awareness of the availability of peer support in behavioral health crisis services	CalHHS	DMHC, CDPH, DHCS	●	●	○	○
E.4.b	Drawing on best practices from California and nationally, explore opportunities for increased engagement and integration of peer roles in settings across the crisis care continuum	CalHHS	DMHC DHCS, County/ Tribal BH, Tribal/CBO Partners	●	●	○	○
E.4.c	Gather and share information on billable Peer Supporter roles/activities and other funding/reimbursement opportunities (e.g., through commercial insurance, Medi-Cal managed care, and Medicare)	CalHHS	DMHC, DHCS	●	●	○	○
E.4.d	Gather and share state- and county-level data and information on the current state of peer support, including peer-provided, peer-operated, and family peer supports, to inform ongoing system design and improvement	CalHHS	Cal OES, DHCS	●	●	○	○
E.4.e	Promote training and supervision resources to support the ongoing development and advancement of Peer Supporters	CalHHS	DHCS	●	●	●	●

Governance

AB 988 Required Area (4) GOV 53123.3.(b)(10): A state governance structure to support the implementation and administration of behavioral health crisis services accessed through 988.

Process

AB 988, the Miles Hall Lifeline and Suicide Prevention Act, requires CalHHS to recommend "a state governance structure to support the implementation and administration of behavioral health crisis services accessed through 988."[155] A robust governance structure with clearly defined roles and responsibilities is necessary to ensure ownership and accountability and to successfully execute the Plan. CalHHS conducted a thorough vetting process to create the 988 state governance structure envisioned for the future comprehensive 988-crisis system depicted in **Figures 5-7.**

An overview of the process used to develop the governance structure follows:

First: Agencies, offices, and departments with roles and responsibilities outlined in AB 988 were identified. These include:

- CalHHS
- Cal OES
- DHCS
- CDPH
- DMHC
- CDI

Second: As work progressed, EMSA was identified as a state entity that plays an important role in the 988-crisis care continuum. Emergency medical services (EMS) provide services and transportation for individuals experiencing a crisis. Despite not being identified in AB 988, EMSA was integrated into the proposed governance structure.

Third: Once the relevant agencies, offices, and departments were identified, an initial governance structure draft **(Figure 5)** was created based on the CCC-P governance structure. DHCS, CDPH, EMSA, and DMHC reviewed the draft, and their feedback was incorporated.

Fourth: The 988-crisis roles and responsibilities of CalHHS, Cal OES, CDI, and relevant departments were mapped out, discussed, and agreed upon. Overlapping responsibilities were identified, prompting the creation of a Venn diagram to delineate the individual roles and responsibilities of each state entity, as well as their overlapping roles and responsibilities **(Figure 6).**

Fifth: Federal partners were added to the Venn diagram **(Figure 7)** to demonstrate the ongoing relationship between federal and state partners related to 988 and the crisis care continuum.

Sixth: The governance structure was presented to the PAG.

State entities, including Cal OES and CDI, and relevant departments, including DHCS, CDPH, EMSA, and DMHC, vetted the Venn diagrams, which went through multiple rounds of edits. CalHHS leadership and the administration also vetted **Figures 5-7**.

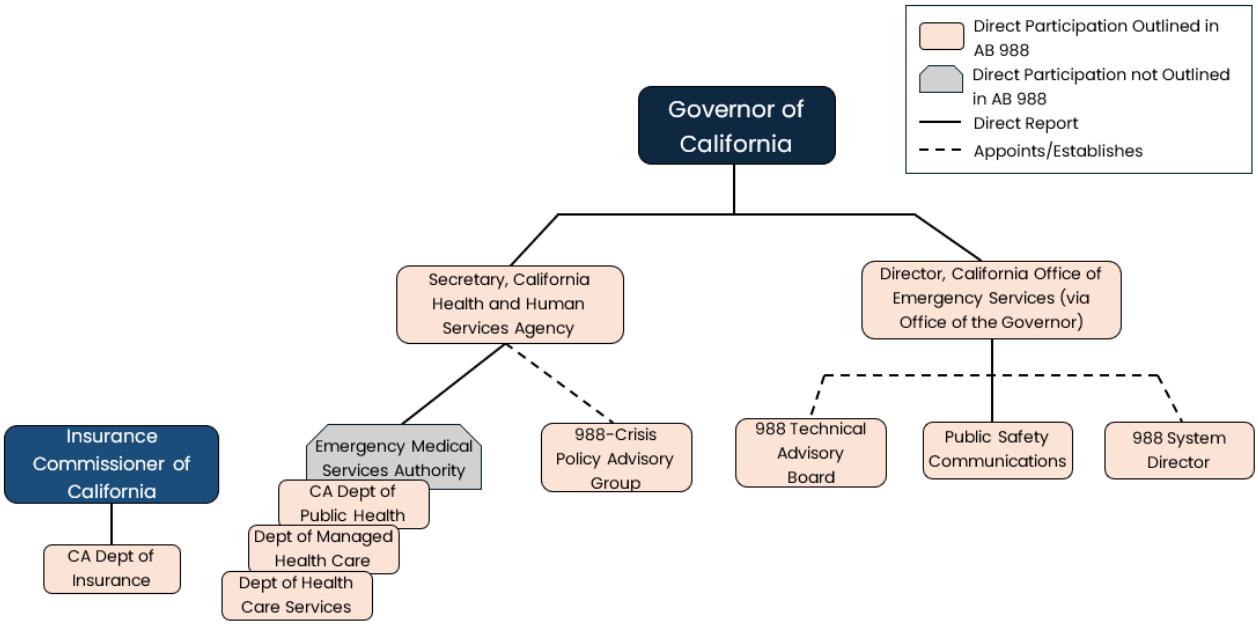
Governance Structure Overview

Figure 5 is based on the CCC-P's preliminary synthesis of AB 988 roles and responsibilities and provides a high-level overview of an organizational structure for implementing the Plan.

CalHHS and Cal OES both are required to establish advisory boards—the CalHHS PAG and the Cal OES 988 TAB, respectively—as shown by the dotted line. CalHHS and the three departments with direct participation outlined in AB 988 (DHCS, DMHC, and CDPH) are in orange. EMSA, which has direct participation but is not identified in AB 988, is in grey. These departments report directly to the Secretary of CalHHS, as indicated by the solid line.

In addition to the 988 TAB, AB 988 requires Cal OES to appoint a 988 system director to implement and oversee the policy and regulatory framework for the technology infrastructure, coordination, and transfer of calls between 988, 9-1-1, and behavioral health crisis services.

Figure 5. State Governance Structure



Developed in consultation with other impacted state partners, CalHHS's recommendations on the future 988-crisis state governance structure are outlined below. **Figure 6** depicts the recommended future 988-crisis roles and responsibilities of CalHHS, DHCS, DMHC, EMSA, CDPH, Cal OES, and CDI and where they overlap.

CalHHS oversees 12 departments and five offices, including DHCS, DMHC, CDPH, and EMSA.

- CalHHS was charged with convening the PAG to advise on the creation of the Plan for a comprehensive 988-crisis system and delivering the plan to the California legislature by December 31, 2024. This responsibility included coordinating with the departments and Cal OES to create an actionable and implementable plan. CalHHS has completed this responsibility with the submission of the plan.
- Moving forward, CalHHS and other impacted state partners collectively recommend that CalHHS should:
    - Post annual updates on the progress of the plan's implementation on its website. Progress updates should include, but not be limited to, the status of mobile crisis services, behavioral health crisis parity, and 988-crisis system data as required in AB 988, GOV 53123.3(c).

- Coordinate and support departments and state entities named in AB 988 to facilitate implementation of the plan.
- Engage with other state entities and system partners to support the implementation of the plan.
- Engage with key implementation partners, including counties, which play a critical role as the public behavioral health safety net in California, to support implementation of the plan.
- Monitor and offer solutions, as needed, to issues that arise during implementation.
- Establish and manage a public-facing 988 data dashboard (see implementation activity E.3.b).
- Monitor and offer solutions to improve mobile crisis services, including dispatch, in relation to 988 and the broader crisis continuum (see Goals B and D and implementation activity E.2.f).
- Connect the Plan recommendations and ongoing implementation activities with other behavioral health initiatives such as Proposition 1, CalAIM, and behavioral health parity work.

DHCS is California's Medicaid Single State Agency.

- DHCS is responsible for administering Medi-Cal Specialty Mental Health Services through County Mental Health Plans, as well as Medi-Cal SUD services through the Drug Medi-Cal and the Drug Medi-Cal Organized Delivery System programs. Medi-Cal Mobile Crisis Services are administered through these Medi-Cal behavioral health delivery systems.
- Moving forward, CalHHS recommends that DHCS should:
  - Oversee and provide administrative support to 988 Crisis Centers and staff (see Goal C).
  - Oversee 988 crisis counselor training, including clinical protocols and triage for behavioral health services (see Goal C).
  - Oversee the behavioral health aspects of clinical quality assurance of 988 Crisis Centers (see Goal C).

- Create a state designation process for 988 Crisis Centers and admit/redesignate 988 Crisis Centers based on this process (see implementation activity C.3.e).
- Distribute funds to support staffing and training of 988 Crisis Centers (see AB 988, GOV 53123.4, and implementation activity E.2.e).
- Work with DMHC on coverage and reimbursement of behavioral health crisis services, with the goal of achieving parity between Medi-Cal and commercial health plans (see implementation activities E.2.a, E.2.b, and E.2.c).

DMHC issues guidance to commercial health care service plans (health maintenance organizations [HMOs] and some preferred provider organizations [PPOs]) and enforces provisions of the law.

- Moving forward, CalHHS recommends that DMHC should:
  - Work with DHCS on coverage and reimbursement of behavioral health crisis services, with the goal of achieving parity between Medi-Cal and commercial health plans (see implementation activities E.2.a, E.2.b, E.2.c, and E.2.d).
  - Coordinate, as necessary, with CDI for reimbursement of behavioral health crisis services by commercial health care service plans and health insurers (see implementation activity E.2.b).

EMSA provides statewide coordination and leadership of local EMS systems. EMSA provides regulations for and approves triage to alternate destinations (TAD) and community paramedicine (CP) programs. EMSA also provides regulations for EMS personnel scope of practice and for Emergency Medical Dispatch.

- Moving forward, CalHHS recommends that EMSA should:
  - Oversee 988 crisis counselor training on clinical protocols/triage for call transfers to emergency medical dispatch services (see implementation activities B.2.b, B.2.c, B.2.d, C.1.c, C.2.d, C.2.e, C.2.f, D.2.d and D.2.e.).
  - Oversee the medical aspects of clinical quality assurance of 988 Crisis Centers (see implementation activities C.2.d, C.2.f, C.2.g, C.3.c).

CDPH is California's public health department.

- Moving forward, CalHHS recommends that CDPH should:

- Oversee 988 public messaging[2] (see recommendations A.1 and A.2).
- Oversee public health data collection and surveillance related to 988 to evaluate intervention strategies for prevention of crisis, suicide, and overdose to support efforts of the Office of Suicide Prevention (see recommendations A.3 and E.3).
- Be responsible for population-based prevention.

Cal OES is California's hub during major emergencies and disasters.

- Cal OES is charged with verifying 988 technology that allows for transfers between 988 Crisis Centers as well as between 988 Crisis Centers and 9-1-1 PSAPs and verifying the interoperability between 988 and 9-1-1 (required in AB 988, GOV 53123.2).
- Cal OES is responsible for determining the 988 surcharge fee amount. This role, among other responsibilities, is laid out in Tax and Revenue Code Sections 41001 through 41176.
- Cal OES is charged with establishing and convening the 988 TAB, which advises Cal OES on the following (required in AB 988, GOV 53123.2(b)(2)(A)):
  - Recommendations on the feasibility and plan for sustainable interoperability between 988, 9-1-1, and behavioral health crisis services, including the identification of any legal or regulatory barriers to the transfer of 9-1-1 calls
  - The development of technical and operational standards for the 988 system that allow for coordination with California's 9-1-1 system
  - The creation of standards and protocols for when 988 Crisis Centers will transfer 988 calls into the "9-1-1" PSAPs, and vice versa
- Moving forward, CalHHS recommends that Cal OES should:
  - Continue to distribute funds to support technology infrastructure and interoperability of 988 and 9-1-1 (see Goal B, implementation activities C.3.a and C.3.b, and recommendations D.1 and D.2).

CDI is California's Department of Insurance. With regard to health insurance, CDI implements and enforces requirements set forth in the Insurance Code and issues guidance to CDI

[2] See glossary for definition.

regulated health insurance companies (indemnity insurance, some PPOs, and Exclusive Provider Organizations [EPOs]).

- Moving forward, CalHHS recommends that CDI should:
    - Coordinate, as necessary, with DMHC for reimbursement of behavioral health crisis services by health insurers and commercial health care service plans (see implementation activity E.2.b).

The state entities' recommended roles and responsibilities often overlap. The Venn diagram of State 988 Responsibilities **(Figure 6)** demonstrates the overlap and highlights the additional coordination necessary between state entities to complete 988 activities. The recommendations for coordination were developed in consultation and with the full support of impacted state partners.

The overlap between departments includes:

DHCS and DMHC Both departments oversee health care coverage in California. DHCS oversees Medi-Cal (including Medi-Cal non-specialty and specialty mental health services) and DMHC oversees commercial health plans. **CalHHS recommends:**

- DHCS and DMHC work with each other, with coordination support from CalHHS, to ensure coverage and reimbursement of behavioral health crisis services, with the goal of achieving parity between Medi-Cal and commercial health plans (see implementation activities E.2.a, E.2.b, E.2.c, and E.2.d).

DMHC and CDI: CalHHS recommends:

- DMHC and CDI coordinate with each other, as necessary, for reimbursement of behavioral health crisis services by commercial health care service plans and health insurers (see implementation activity E.2.b).

DHCS and EMSA: Both should have a role in developing 988 Crisis Center staff training and clinical quality assurance/improvement of services provided by 988 Crisis Centers. **CalHHS recommends**:

- DHCS oversee the behavioral health aspects of training and clinical quality assurance and EMSA oversee medical aspects of training and clinical quality improvement of 988 services (see Goal C).

EMSA and CDPH: Though CDPH is the primary department overseeing 988 public messaging and communications, **CalHHS recommends**:

- CDPH work with EMSA to create messaging about the services accessed through 988 versus 9-1-1 (see recommendation A.3 and implementation activities A.1.a, A.1.c, A.1.e, and A.2.c).

CDPH and DHCS: CalHHS recommends:

- DHCS coordinate with CDPH to report on 988 data (see recommendation E.3).
- CDPH work with DHCS and other state entities, such as EMSA and Cal OES, with coordination support from CalHHS, to create public messaging about 988 (see Goal A).

Overlap between Cal OES, CalHHS, and departments includes:

CalHHS and Cal OES: CalHHS and Cal OES should coordinate their activities to create a comprehensive 988-crisis system in California. Cal OES manages 988 and mobile crisis dispatch technology, and CalHHS manages policy, both of which inform one another.

CalHHS recommends:

- CalHHS serve as the 988-crisis policy lead on the Cal OES TAB until it is disbanded on December 31, 2028 (required in AB 988, GOV 53123.2(b)(2)(c)).
- CalHHS and Cal OES coordinate to create the 988 public-facing data dashboard (see implementation activity E.3.b).
- CalHHS and Cal OES coordinate and communicate on an ongoing basis about the administrative costs of the 988 Suicide & Crisis Lifeline.

Cal OES and EMSA: The draft 9-1-1/988 transfer/handling criteria were written by the Cal OES 988 TAB, which includes EMSA as a member. EMSA is a key partner in the 988/9-1-1 crisis system and in overseeing medical triage protocols, training, and clinical quality assurance and improvement in a comprehensive 988-crisis system.

CalHHS recommends:

- Cal OES and EMSA coordinate, as necessary and with other key implementation partners (including PSAPs), to review and update the 9-1-1/988 transfer/handling criteria document[156] as a state guidance document.

CalHHS, Cal OES and DHCS: CalHHS, Cal OES, and DHCS should coordinate the distribution of AB 988 funding.

CalHHS recommends that:

- CalHHS determine the process and related criteria for how funding from the 988 surcharge fee can be used for mobile crisis teams accessed via telephone calls/texts/chats made to or routed through 988 (see implementation activity E.2.f).
- DHCS distribute funds to support staffing and training of 988 Crisis Centers as entities that qualify for 988 State Suicide and Behavioral Health Crisis Services Fund (see AB 988, GOV 53123.4, and implementation activity E.2.e).
- Cal OES continue to distribute funds to support technology infrastructure and interoperability of 988 and 9-1-1 (see Goal B, implementation activities C.3.a and C.3.b, and recommendations D.1 and D.2).
- Cal OES and DHCS work together to develop and disseminate clear information about the funding process for 988 Crisis Centers and the process for determining the 988 surcharge fee and funding (see implementation activity E.2.e).

CalHHS, Cal OES, DHCS, EMSA, and CDPH: Cal OES has ownership of the 988 aggregate data from contacts answered via the California 988 Call Handling System (CHS), whereas 988 Crisis Centers have ownership over individual call level data.

CalHHS recommends:

- CalHHS and Cal OES coordinate access to aggregate data through a data sharing agreement, facilitated by a business use case proposal process. CalHHS should also coordinate with 988 Crisis Centers to access individual call level data as necessary to fulfill their state responsibilities (see implementation activity E.3.a).

Figure 6. Future 988-Crisis State Governance Structure Venn Diagram

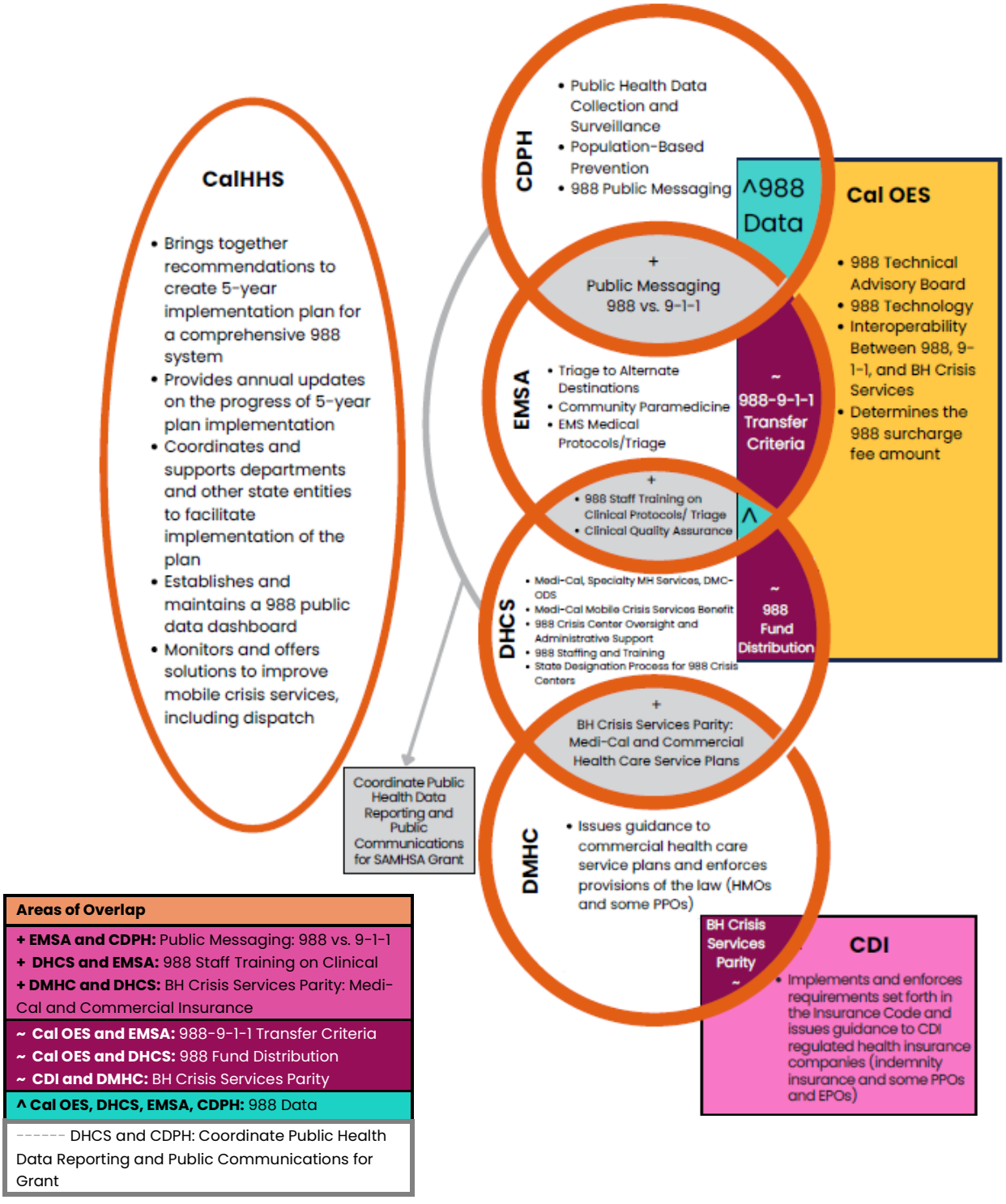


Figure 7 outlines the state entities' 988-related responsibilities with federal partners, including SAMHSA, Centers for Disease Control and Prevention (CDC), CMS, FCC, and National Highway Traffic Safety Administration (NHTSA) as follows:

SAMHSA

- CalHHS should continue to maintain communication with SAMHSA and the administrator of the 988 dialing code for the NSPL.
- CalHHS should continue discussions with SAMHSA to arrive at a next level of understanding around data ownership, data sharing, and training curriculum to determine whether and how to augment national standards to meet the needs of the state.
- DHCS should continue to cooperate with SAMHSA on its 988 grants and the crisis set-aside in the Mental Health Block Grant.
- Cal OES should continue to coordinate with SAMHSA on technology and 988/9-1-1 interoperability.

CDC

- CDPH should continue to coordinate with CDC on its grant for a comprehensive suicide prevention program.

CMS

- DHCS coordinates with CMS on Medicaid services, such as the Medi-Cal Mobile Crisis Services Benefit.

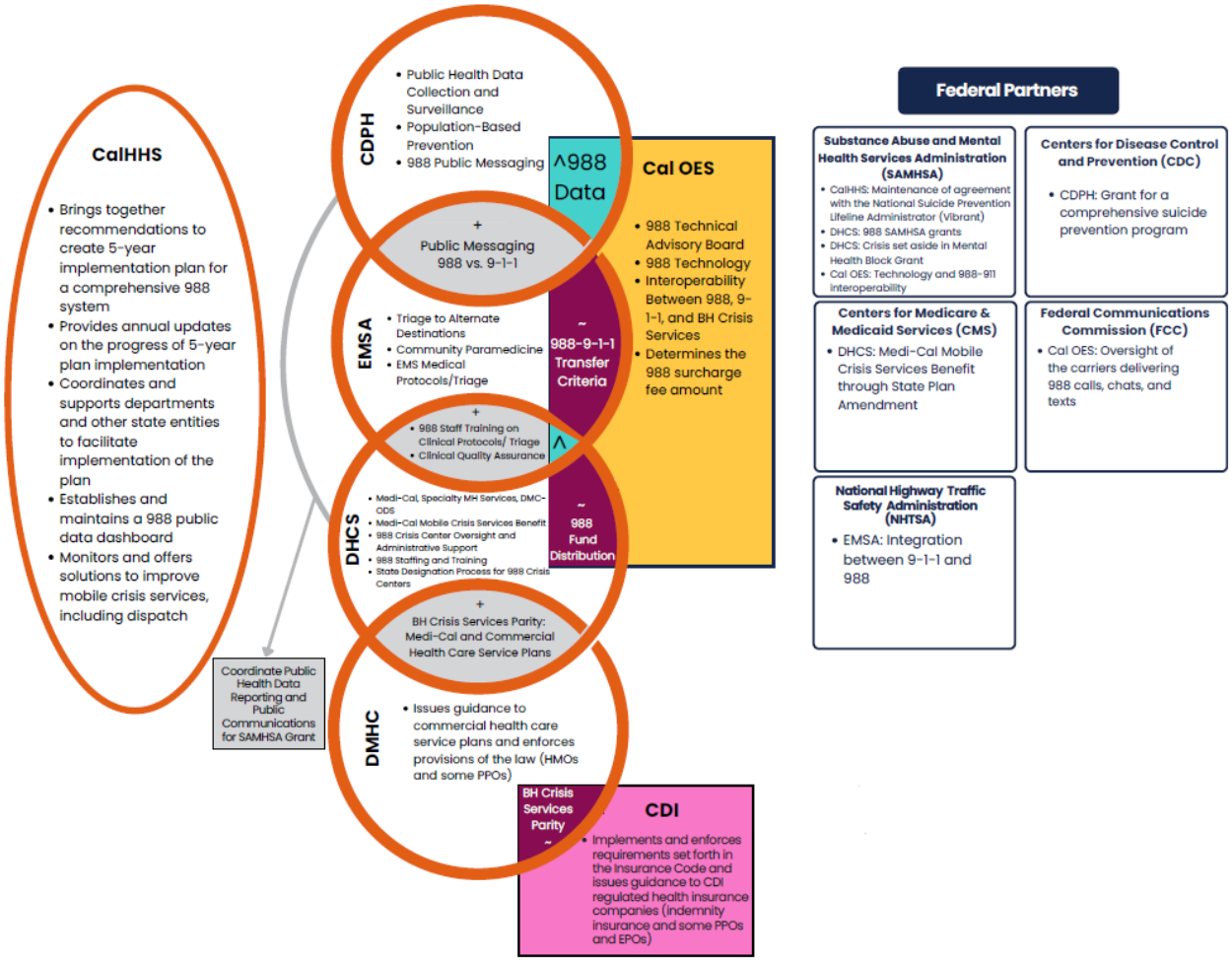
FCC

- Cal OES should continue to coordinate with the FCC, which has oversight of the carriers delivering 988 calls, chats, and texts.

NHTSA

- EMSA should continue to coordinate with NHTSA on the integration between 9-1-1 and 988.

Figure 7. Future 988-Crisis State Governance Structure Venn Diagram with Federal Partners



The governance framework for implementing the Plan for a comprehensive 988-crisis system involves intensive coordination among federal, state, and local partners. The roles and responsibilities of the identified state entities, including CalHHS, Cal OES, CDI, DHCS, DMHC, EMSA, and CDPH, are outlined in **Figures 5-7** with attention to their overlap and necessary collaboration. This coordinated effort is essential for effective execution and accountability in developing a robust and responsive 988 system that is integrated into the crisis care continuum.

Conclusion

AB 988 Five Year Plan

AB 988, the Miles Hall Lifeline and Suicide Prevention Act, requires CalHHS to convene a state policy advisory group, known as the 988-Crisis Policy Advisory Group (PAG), to advise on a set of recommendations for a Five-Year Implementation Plan (the Plan) for a comprehensive 988-crisis system by December 31, 2024. AB 988 outlines 14 key topics to guide the development of these recommendations.

The 43-member 988-Crisis PAG, along with seven associated workgroups, played a pivotal role in shaping the development of the Plan, bringing diverse community perspectives and expertise. Additional input was gathered from community and local implementation partners through focus groups, interviews, and presentations. Feedback was also collected through a subcontract specifically focused on engaging and gathering feedback from Native American communities. This collaborative engagement allowed CalHHS to identify and focus on critical needs and gaps across the crisis care continuum, informing the Plan's recommendations.

The goals, recommendations, and implementation activities in the Plan mark a significant step toward achieving California's larger vision of a comprehensive crisis care continuum – a system that aims to provide Californians with consistent, high-quality, equitable, and accessible resources for preventing, responding to, and stabilizing behavioral health crises.

CalHHS' Roles in Coordination, Accountability/Transparency, and Community Engagement

Pending available resources, CalHHS will work toward implementing and improving the Plan, continuously identifying challenges, opportunities, and solutions to improve California's crisis care system. To support the Plan's success, CalHHS recognizes its critical role in three key areas:

1. Coordination
2. Accountability and Transparency
3. Community Engagement

CalHHS should coordinate with departments and other state entities, promote accountability and transparency throughout the implementation of the Plan, and ensure the active engagement of key implementation and community partners and individuals with lived experience.

Coordination

CalHHS should coordinate with its departments, state entities, and implementation partners so efforts are aligned, resources are shared, and the Plan is effectively operationalized.

An example of CalHHS coordination recommended in the implementation activities includes:

1. **Behavioral Health Crisis Services Parity.** DHCS, DMHC and CDI oversee health care coverage in California. DHCS administers Medi-Cal, including both non-specialty and specialty mental health services; DMHC regulates commercial health plans operating in the state; and CDI issues guidance to CDI regulated health insurance companies. Numerous implementation partners are also involved, including County/Tribal Behavioral Health, CBOs, providers, associations, and others. CalHHS can and has already begun to coordinate with state and local entities to identify strategies and best practices to maximize Medi-Cal and commercial health plan reimbursement for behavioral health crisis services, including training and technical assistance. The ultimate goal is to achieve parity in behavioral health crisis care and sustainable funding for crisis services (see E.2).

Accountability and Transparency

CalHHS should provide accountability so that systems and entities responsible for the care of individuals who are in crisis are better able to deliver quality services in a transparent manner.

Examples of implementation activities to promote accountability and transparency recommended include:

1. **988 Data Dashboard.** The PAG recommends that CalHHS develop and maintain a public-facing 988 data dashboard to support monitoring and accountability of the 988-crisis system (see E.3). Using data from the dashboard will help support continuous quality improvement of the 988-crisis system. The PAG recommends the dashboard should track the performance of 988 Crisis Centers including, but not limited to:

    ✓ Contact volume (incoming contacts)

    ✓ Answer rate

    ✓ Average wait time

- ✓ Number of transfers between 9-1-1/emergency response and 988, mobile crisis dispatch
- ✓ Percentage of calls resolved without need to transfer or dispatch emergency services

In the future, CalHHS, in collaboration with state entities such as CDPH, DHCS, EMSA and Cal OES, should work to identify population level outcome measures and establish quantifiable goals to assess the broader crisis care continuum.

2. **Annual Progress Reports.** AB 988 requires CalHHS to publish regular updates, no less than annually, regarding the implementation of 988 on its website. These updates aim to provide the public with insights into the progress of 988 implementation, the performance of the crisis system, and whether further improvements are needed (see Governance).

Community Engagement

Ongoing community engagement is important to improve public awareness of and build trust in 988 services as well as to ensure the services provided across the behavioral health crisis system are high quality and effective. Community engagement is particularly critical among populations that are (1) not being reached through national campaigns and/or are distrustful of 988 or other emergency or crisis lines; (2) populations at greatest risk of suicide or other behavioral health crisis; and (3) populations that may need or benefit from accommodations. While community engagement has been a critical aspect of the Plan's development, CalHHS recognizes that more community engagement is needed to ensure that all Californians have access to clear, culturally relevant information about 988 and related crisis services.

Among the implementation activities where community engagement will be most critical are:

- Supporting development of statewide communications strategies, including message development and outreach
- Partnering with advocacy organizations, CBOs, and people with lived experience to ensure that services across the continuum are accessible to all populations and address diverse needs (e.g., through linguistically accessible, culturally responsive services and community-defined evidence practices)
- Gathering information to support coordination and assessment of crisis services across the continuum in local communities

Navigating State Leadership in 988 Implementation: Challenges and California's Path Forward

SAMHSA's leadership has been essential in laying out the national vision of "someone to call, someone to come, and a safe place to be" and establishing the 988 national network. The leadership role of states in implementing 988 is relatively new. As of October 2024, only 10 states have passed legislation to establish a 988 surcharge fee. Many states continue to navigate a complex behavioral health landscape, which can make integrating 988 services into the broader crisis care continuum challenging. Operationalizing the national and state vision will require ongoing engagement at the state, county, and local levels.

Several key issues remain unresolved at the state level that require time and effort to address:

- **Mobile Crisis Response:** Historically, mobile crisis response has been provided by county and local jurisdictions. However, with new legislation and additional resources, states are increasingly taking on a larger coordination and oversight role in this area. States are developing guidance and providing resources to support mobile crisis teams, while also working to better coordinate mobile crisis response with 988 Crisis Centers and other key points across the crisis care continuum. SAMHSA is expected to release guidelines and toolkits in 2025 to help states enhance and standardize mobile crisis response services.
- **988 Data:** States have not yet fully developed agreements and coordination mechanisms for data sharing and reporting related to crisis services, since it often involves multiple state entities. SAMHSA is also expected to release guidance to support states in addressing data coordination challenges.
- **Behavioral Health Crisis Service Parity:** Achieving parity in behavioral health crisis services is complicated by the diverse and complex health insurance landscape. More work is needed to ensure both Medi-Cal and commercial health plans fully reimburse crisis services equitably.

988 and California's Behavioral Health Transformation

The transformation of California's behavioral health system is a top priority for the state. A key element of this transformation is building a comprehensive behavioral health crisis care continuum, as outlined in the CCC-P. The CCC-P envisions a future where person-centered behavioral health crisis services are seamlessly connected to provide an equitable and

accessible continuum of care for all Californians. AB 988 was enacted in parallel with the CCC-P's development.

The proposed Five-Year Implementation Plan provides goals, recommendations, and potential implementation activities to support the CCC-P's vision and AB 988's goal of creating a comprehensive 988-crisis system in California. It also aligns with the Governor's mission to transform California's mental health and SUD system and to provide "mental health for all" Californians.

This Plan is just one part of California's broader effort to reshape its behavioral health system, with the state investing billions to strengthen the continuum of community-based care options for those living with mental health and substance use needs. Together, these initiatives represent a significant step toward creating a more resilient, responsive, and equitable behavioral health system for all Californians.

Appendix

AB 988: The Miles Hall Lifeline and Suicide Prevention Act: Required Recommendation Areas

GOV 53123.3 requires CalHHS and the PAG to develop recommendations to support a Five-Year Implementation Plan for a comprehensive 988 system, which must cover the following recommendation areas:

(1) Federal Substance Abuse and Mental Health Services Administration requirements and national best practices guidelines for operational and clinical standards, including training requirements and policies for transferring callers to an appropriate specialized center, or subnetworks, within or external to, the National Suicide Prevention Lifeline network.

(2) Maintenance of an active agreement with the administrator of the National Suicide Prevention Lifeline for participation within the network.

(3) Compliance with state technology requirements or guidelines for the operation of 988.

(4) A state governance structure to support the implementation and administration of behavioral health crisis services accessed through 988.

(5) 988 infrastructure, staffing, and training standards that will support statewide access to crisis counselors through telephone call, text, and chat, 24 hours per day, seven days per week.

(6) Access to crisis stabilization services and triage and response to warm handoffs from 9-1-1 and 988 call centers.

(7) Resources and policy changes to address statewide and regional needs in order to meet population needs for behavioral health crisis services.

(8) Statewide and regional public communications strategies informed by the National Suicide Prevention Lifeline and the Substance Abuse and Mental Health Services Administration to support public awareness and consistent messaging regarding 988 and behavioral health crisis services.

(9) Recommendations to achieve coordination between 988 and the continuum of behavioral health crisis services. Recommendations shall address strategies for verifying that behavioral health crisis services are coordinated for a timely response to clearly articulated suicidal or behavioral health contacts made or routed to 988 services as an alternative to a response from law enforcement, except in high-risk situations that cannot be safely managed without law enforcement response and achieving statewide provision of connection to mobile crisis services, when appropriate, to respond to individuals in crisis in a timely manner.

(10) Quantifiable goals for the provision of statewide and regional behavioral health crisis services, which consider factors such as reported rates of suicide attempts and deaths.

GOV 53123.3 requires CalHHS and the PAG to develop recommendations to support a Five-Year Implementation Plan for a comprehensive 988 system, which must cover the following recommendation areas:

(11) A process for establishing outcome measures, benchmarks, and improvement targets for 988 centers and the behavioral health crisis services system. This may include recommendations regarding how to measure, the feasibility of measuring 988 system performance, including capacity, wait time, and the ability to meet demand for services for 988 State Suicide and Behavioral Health Crisis Services Fund recipients. This may also include recommendations for how to determine and report the amount billed to and reimbursed by Medi-Cal or other public and private health care service plans or insurers related to 988 services.

(12) Findings from a comprehensive assessment of the behavioral health crisis services system that takes into account infrastructure projects that are planned and funded. These findings shall include an inventory of the infrastructure, capacity, and needs for all of the following:

- (A) Statewide and regional 988 centers.
- (B) Mobile crisis team services, including mobile crisis access and dispatch call centers.
- (C) Other existing behavioral health crisis services and warm lines.
- (D) Crisis stabilization services.

(13) Procedures for determining the annual operating budget for the purposes of establishing the rate of the 988 surcharge and how revenue will be dispersed to fund the 988 system consistent with Section 53123.4 and Section 251a of Title 47 of the United States Code.

(14) Strategies to support the behavioral health crisis service system is adequately funded, including mechanisms for reimbursement of behavioral health crisis response pursuant to Sections 1374.72 and 1374.721 of the Health and Safety Code, including, but not limited to:

- (A) To the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized, seeking to maximize all available federal funding sources for the purposes of behavioral health crisis services and administrative activities related to 988 implementation, including federal Medicaid reimbursement for services; federal Medicaid reimbursement for administrative expenses, including the development and maintenance of information technology; and federal grants.
- (B) Coordinating with the Department of Insurance and Department of Managed Health Care to verify reimbursement to 988 centers for behavioral health crisis services by health care service plans and disability insurers, pursuant to Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code and consistent with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. Sec. 1185a).

Acronyms Used

Abbreviation	Definition
AAPI	Asian American and Pacific Islander
AB 988	Assembly Bill 988 - The Miles Hall Lifeline and Suicide Prevention Act
BH	Behavioral Health
BHCIP	Behavioral Health Continuum Infrastructure Program
BH-CONNECT	California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHSA	Behavioral Health Services Act
BHTF	Behavioral Health Task Force
CalAIM	California Advancing and Innovating Medi-Cal
Cal EQRO	External Quality Review Organization Report
Cal-FURS	California Family Urgent Response System
CalHHS	California Health and Human Services Agency
CalHOPE	California Hope, Outreach, Possibilities and Empowerment
Cal OES	California Governor's Office of Emergency Services
CARE Act	Community Assistance, Recovery, and Empowerment Act
CBHDA	County Behavioral Health Directors Association
CBO	Community-Based Organization
CCC-P	Crisis Care Continuum Plan
CDA	California Department of Aging
CDC	Centers for Disease Control and Prevention
CDI	California Department of Insurance
CDII	Center for Data Insights and Innovation
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CHIS	California Health Interview Survey
CMS	Centers for Medicare & Medicaid Services
COD	Co-Occurring Disorders
CP	Community Paramedicine
CSAC	California State Association of Counties
CSU	Crisis Stabilization Unit

Abbreviation	Definition
CYBHI	Children and Youth Behavioral Health Initiative
DDS	California Department of Developmental Services
DHCS	California Department of Health Care Services
DMHC	California Department of Managed Care
ED	Emergency Department
EMS	Emergency Medical Service
EMSA	California Emergency Medical Services Authority
EMT	Emergency Medical Technician
EO	Executive Order
FCC	Federal Communications Commission
HCAI	Health Care Access and Information
HMA	Health Management Associates
HSC	California Health and Safety Code
IDD	Intellectual and/or Developmental Disability
INS	California Insurance Code
IT	Information Technology
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual
LPS	Lanterman-Petris-Short Certification
MAT	Medication Assisted Treatment
MOU	Memorandum of Understanding
MCP	Managed Care Plan
NAMI	National Alliance on Mental Illness
NENA	National Emergency Number Association
NHTSA	National Highway Traffic Safety Administration
NSHD	The National Suicide Hotline Designation Act of 2020
NSPL	National Suicide and Prevention Lifeline
PAG	CalHHS 988-Crisis Policy Advisory Group
PSAP	9-1-1 Public Safety Answering Point
PSS	Peer Support Specialist
RBA	Results Based Accountability
SAMHSA	Substance Abuse and Mental Health Services Administration

Abbreviation	Definition
SED	Serious Emotional Disturbances
SFY	State Fiscal Year
SMHS	Specialty Mental Health Services
SMI	Severe Mental Illness
SUD	Substance Use Disorder
TAB	Cal OES 988 Technical Advisory Board
TAD	Triage to Alternate Destinations

Glossary of Terms

TERM	DEFINITION(S)	SOURCE
Abandonment Rate	Rate at which contacts disconnect after being routed to a 988 Crisis Center and before being engaged by a counselor. Disconnection may happen for several reasons, including the person seeking contact decides to seek care another time; the person no longer feels the environment is private or safe, or a random technical service interruption occurs due to internet instability, carrier glitches, etc.	SAMHSA Performance Metrics
Access	Access to health care means being able to receive timely personal health services to achieve the best outcomes. Access to health care consists of four components: • Coverage: Uninsured people are less likely to receive medical care and more likely to have poor health status. • Services: Having a regular source of care is associated with adults receiving recommended screening and prevention services. • Timeliness: Ability to receive health care when needed. • Workforce: Capable, qualified, culturally responsive providers.	Agency for Healthcare Research and Quality
Accessible	Accessible is defined as able to be accessed by users of any ability level or physical constraint.	CA Accessibility Guidance

TERM	DEFINITION(S)	SOURCE
Acute Psychiatric Hospital	A mental health care facility that is licensed by the CDPH, has a duly constituted governing body with overall administrative and professional responsibility, and has an organized medical staff to provide 24-hour inpatient care for mentally disordered, incompetent, or other patients referred to in Division 5 (commencing with section 5000) or Division 6 (commencing with section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services.	CDPH
Answered	Contacts who are connected to a 988 Crisis Center and then engaged by a counselor.	SAMHSA Performance Metrics
Average Contact Time	The average amount of time counselors spend talking/chatting/texting with answered contacts. As this measure is an average, people contacting the Lifeline may have conversations that vary in length, depending on their individual needs.	SAMHSA Performance Metrics
Average Speed of Answer (ASA)	The average time it takes people to have their call answered after listening to the automated greeting (calls) or answering a pre-chat or pre-text survey (chat/text). As ASAs are by nature an "average," the experience of those contacting the 988 Lifeline at different centers in different states or times of day may experience variations in individual wait times.	SAMHSA Performance Metrics
Behavioral Health (BH)	A vital part of a person's overall health includes emotional, psychological, and social well-being. Conditions that may affect behavioral health include mental illnesses, SUD, and co-occurring mental and SUDs	CCC-P Glossary (Page 73)

TERM	DEFINITION(S)	SOURCE
Behavioral Health Continuum Infrastructure Program (BHCIP)	A DHCS authorized program to award $2.2 billion to construct, acquire, and expand properties and invest in mobile crisis infrastructure related to behavioral health.	BHCIP Website
Behavioral Health Crisis	Any event or situation associated with an actual or potential disruption of stability and safety because of behavioral health issues or condition	CCC-P Glossary (Page 73)
Behavioral Health Crisis Services	The continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or SUD crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis stabilization services.	Definitions from AB 988 Section 53123.1.5
Children and Youth Behavioral Health Initiative (CYBHI)	Established as part of the Budget Act of 2021, the CYBHI is a multiyear, multi-department package of investments that seeks to reimagine the systems, regardless of payer, which support behavioral health for all California children, youth, and their families. Efforts will focus on promoting social and emotional well-being, preventing behavioral health challenges, and providing equitable, appropriate, timely, and Acute Psychiatric Hospital services for emerging and existing behavioral health (mental health and substance use) needs for children and youth ages 0-25.	CYBHI
Contact	A call, chat, or text with the 988 Lifeline.	SAMHSA Performance Metrics
Community-Based Organizations (CBOs)	Public or private not-for-profit resource hubs that provide specific services to the community or targeted populations within the community.	CCC-P Glossary (Page 73)

TERM	DEFINITION(S)	SOURCE
Community Paramedicine (CP)	An innovative and evolving model of community-based healthcare designed to provide more effective and efficient services at a lower cost. CP allows paramedics to function outside their traditional emergency response and transport roles to facilitate more appropriate use of emergency care resources and enhance access to primary care for medically underserved populations.	Community Paramedicine & Triage to Alternate Destination
Co-Occurring Disorders (COD)	People with SUD are at particular risk of developing one or more primary conditions or chronic diseases. The coexistence of both a mental illness and SUD is known as a co-occurring disorder and is common among people in treatment.	SAMHSA
County Access Lines	All county mental health departments have 24/7 access lines for residents seeking assistance in a crisis and accessing local mental health programs.	CCC-P Glossary (Page 73)
Crisis Care	A range of services for individuals experiencing an acute mental and/or SUD crisis.	CCC-P Glossary (Page 73)
Crisis Care Continuum Plan (CCC-P)	The CalHHS Plan and vision for the future state of behavioral health crisis services in California, including crises relating to suicide, mental health, or substance use challenges.	CCC-P
Crisis Receiving and Stabilization services	Provide short-term (under 24 hours) observation and crisis stabilization services in a homelike, nonhospital environment.	CCC-P Glossary (Page 73)
Crisis Residential Treatment Programs (CRTP)	Provide in-person 24-hour crisis care with the option for multiday stays.	CCC-P Glossary (Page 73)

TERM	DEFINITION(S)	SOURCE
Crisis Respite Services	Provide 24-hour observation and support until a person is stabilized. Provided by crisis workers or trained counselors, including peer support specialists.	Assessing the Continuum of Care for Behavioral Health Services in California (Page 80)
Crisis Stabilization Unit (CSU)	Provide BH services on an urgent basis for less than 23 hours. Designed for those with BH condition that requires timelier response than regularly scheduled visit but does not require evaluation and stabilization in an ED. People who require additional treatment and observation may be referred to Crisis Residential Services.	Assessing the Continuum of Care for Behavioral Health Services in California (Page 79)
Cultural responsiveness	"[A] set of behaviors, attitudes, and policies that…enable a system, agency, or group of professionals to work effectively in cross-cultural situations." It involves honoring and respecting "the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services." Cultural responsiveness includes ensuring that 988 offers appropriate services for different cultural backgrounds and languages	Advising People on Using 988 Versus 911: Practical Approaches for Healthcare Providers (p VI) SAMHSA, December 2024
Digital Apothecary	An online repository of evidence-based digital interventions.	CCC-P Glossary (Page 73)
Emergency Department (ED)	The National Hospital Ambulatory Medical Care Survey (NHAMCS) defines an ED as a hospital facility that is staffed 24 hours a day, 7 days a week, and provides unscheduled outpatient services to patients who have a condition that requires immediate care.	CDC

TERM	DEFINITION(S)	SOURCE
Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH)	EmPATH units offer empathetic rather than coercive care. These hospital-based outpatient programs rapidly admit all medically appropriate patients in psychiatric crisis, including people under involuntary psychiatric detention. The EmPATH unit serves as the destination for people with acute mental health conditions who are transferred from the ED.	Psychology Today
Emergency Medical Service (EMS)	EMS is a system that responds to emergencies involving people in need of highly skilled prehospital clinical care.	Ems.gov
Emergency Medical Technician (EMT)	EMTs provide outpatient emergency medical care and transportation for people with critical and emergent conditions who access the EMS system.	NREMT.org
Emergency Rescue	Emergency rescue refers to the need to provide potentially lifesaving services. These immediate services include but are not limited to police departments, fire departments, county sheriff offices, mobile crisis/psychiatric outreach teams, hospital emergency departments, public safety answering points or 9-1-1 centers, and EMSs (e.g., ambulance/transport services).	Vibrant Imminent Risk White Paper
Equity	Equity is achieved when the dimensions of our identity (e.g., sex, gender identity and expression, cultural identity, race/ethnicity, disability, national origin, age, language, family structure, religion/faith, immigration status, or sexual orientation) and other dimensions of difference—defined by social, economic, demographic, and/or geographic characteristics—are no longer predictive of unjust cycles of harm, and oppression across generations is stopped.	CYBHI Working Definition

TERM	DEFINITION(S)	SOURCE
Behavioral Health Equity	Behavioral health equity is the right of all individuals, regardless of race, age, ethnicity, gender identity, disability, socioeconomic status, sexual orientation, or geographic location, to access high-quality and affordable healthcare services and support. Advancing behavioral health equity means working to ensure that every individual has the opportunity to be as healthy as possible. In conjunction with access to quality services, this involves addressing social determinants of health—employment and housing stability, insurance status, proximity to services, and culturally responsive care—all of which have an impact on behavioral health outcomes.	SAMHSA Behavioral Health Equity, 2023
Family Urgent Response System (Cal-FURS)	A coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth.	DDS
Geo-Location	Determining the approximate physical location of a person or an object through technology, such as a cloud computing server.	National Institute of Standards and Technology
988 Geospatial Routing	Geospatial routing directs phone calls locally without including the precise location information in the transferred call data. A person calling the 988 Lifeline is connected to a 988 Crisis Center near their physical location. With geospatial routing, the routing and service providers would not receive detailed information about the exact locations of callers.	National Council

TERM	DEFINITION(S)	SOURCE
Harm Reduction	Approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower People Who Use Drugs (PWUD) and their families with the choice to live healthier, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities.	SAMHSA
Hotline or Crisis Line	Hotlines or crisis lines are intended for use when a person has suicidal thoughts and/or intent, or another mental health crisis that poses immediate or imminent risk to the caller. Crisis lines, staffed by trained counselors, are more focused on keeping people safe in the moment and getting them connected to crisis resources as quickly as possible. Example: 988 Suicide and Crisis Lifeline	CDPH Definitions
Inpatient services	Services are provided in a hospital or another inpatient facility where patients are admitted and spend at least one night	CCC-P Glossary (Page 73)
Intellectual and Developmental Disability (IDD)	IDDs are differences that are usually present at birth and that uniquely affect the trajectory of the individual's physical, intellectual, and/or emotional development. Many of these conditions affect multiple body parts or systems.	National Institute of Child Health and Human Development
Inter-operability	Data interoperability refers to the ways in which data are formatted that allow diverse datasets to be merged or aggregated in meaningful ways.	National Library of Medicine

TERM	DEFINITION(S)	SOURCE
Lanterman-Petris-Short (LPS) Designated Facilities	County LPS designated facilities are mental health treatment facilities that the county has determined have the capacity to provide evaluation and treatment services, approved by the DHCS, and licensed as a health facility as defined in subdivision (a) or (b) of Section 1250 or 1250.2 of the Health and Safety Code or is certified by the DHCS to provide mental health treatment. A designated facility may include, but is not limited to, a licensed psychiatric hospital, a licensed psychiatric health facility, and certified crisis stabilization units.	DHCS
Lived Experience	Personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people. Drawing on SAMHSA's National Model Standards, "lived experience" in this context "specifically refers to those who are directly affected by social, health, public health, or other issues associated with a mental health and/or substance use condition (including their family members) and who have experience with strategies that aim to address associated challenges."	National Model Standards for Peer Support Certification
Mental Health Parity (SB 855)	Require a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. The bill would prohibit a health care service plan or disability insurer from limiting benefits or coverage for mental health and substance use disorders to short-term or acute treatment. The bill would revise the covered benefits to include basic health care services, as defined, intermediate services, and prescription drugs.	SB 855

TERM	DEFINITION(S)	SOURCE
Mental Health Rehabilitation Center	A 24-hour program that provides intensive support and rehabilitative services to assist people ages 18 and older with mental disorders who would have been placed in a state hospital or another mental health facility to develop skills to become self-sufficient and capable of increasing levels of independence and functioning.	DHCS
Mobile Crisis Team	Teams travel to home/community location to de-escalate and assess type of care needed, and link to crisis stabilization services, crisis respite services, sobering center, crisis residential services, and other BH treatment. If needed, transport people to an ED for more in-depth assessment and stabilization.	Assessing the Continuum of Care for Behavioral Health Services in California *Definitions for crisis services* (Page 79-81)
National Suicide Prevention Lifeline (NSPL) or 988 Suicide and Crisis Lifeline	The National Suicide Prevention Lifeline (now called the 988 Suicide and Crisis Lifeline) is the national network of local crisis hotline centers that provides free and confidential support to people in suicidal or other behavioral health crisis 24 hours per day, seven days per week via a toll-free telephone hotline number that receives calls made through the 988 system. The toll-free telephone number is maintained by the Assistant Secretary for Mental Health and Substance Use under Section 520E-3 of the Public Health Service Act, Section 290bb-36c of Title 42 of the United States Code.	Definitions from AB 988 Section 53123.1.5
No-Wrong-Door Policy	The no-wrong-door policy ensures that Medi-Cal beneficiaries receive mental health services without delay, regardless of where they initially seek care. They can continue to see the provider with whom they have built a trusted relationship.	CCC-P Glossary (Page 73)

TERM	DEFINITION(S)	SOURCE
Outpatient Services	Any healthcare consultation, procedure, treatment, or other service that is administered without an overnight stay in a hospital or medical facility.	CCC-P Glossary (Page 73)
Peer, Peer Support, or Peer Supporter	Peer Supporters are people with life-altering lived experience of psychiatric, substance use, or other challenges who have made a personal commitment to their own recovery and who want to use what they have learned to assist others with similar challenges. (This is distinct from and broader than a Certified Medi-Cal Peer Support Specialists). Peer support is the "process of giving and receiving encouragement and assistance to achieve long-term recovery."	National Association of Peer Supporters
Peer Respite	A peer respite is a voluntary, short-term, overnight program that provides community-based, nonclinical crisis support to help people find new understanding and ways to move forward. It operates 24 hours per day in a homelike environment.	Live & Learn, Inc. Peer Respites
Population-Based Approach	Inclusive and culturally relevant care that accounts for the needs, disparities, and experiences of a population	CCC-P Glossary (Page 73)

TERM	DEFINITION(S)	SOURCE
Populations of Focus	Populations identified as having greater need or having been historically underserved. For purposes of this plan this term includes: LGBTQIA+ youth, people with intellectual and/or developmental disabilities, individuals who are d/Deaf or hard of hearing, Veterans, Native Americans, individuals with specific language needs (e.g., American Sign Language, persons who speak a language other than English), older adults, system-impacted youth, individuals who are Black/African American, Latino/Latina/Hispanic and AAPI (particularly youth). Additional populations identified as part of the 988-planning work: rural communities (particularly among older, White men), unhoused individuals, youth (particularly college-age students), perinatal populations.	CCC-P
Public Health Communication	Broadly refers to strategies to inform and influence individual and community decisions that enhance population-level health. These strategies are scalable – from simple informational posters and factsheets to robust multimedia communications campaigns, and are tailored to account for a program's goals, audience, and available resources. Quality public health communications campaigns are grounded in established public health and communication theory, are adapted based on performance, and are evaluated for effectiveness.	Making Health Communication Programs Work (NCI Pink Book)

TERM	DEFINITION(S)	SOURCE
Public Health Messaging	A component of a larger communications strategy, campaign, or plan. Effective messages are developed and tested to ensure that they are clear, meaningful, and memorable with the intended audience, and that they influence knowledge, attitudes, perceptions, or behavior change in support of the campaign goal. Messages that are repeated consistently across multiple communication channels and coordinated partners over time will be more impactful to the intended audience.	CDC Health Communications Playbook CDC National Prevention Information Network Health Communication Strategies and Resources
Public Safety Answering Point (PSAP)	PSAP is a call center or dispatch center that receives and handles emergency calls. PSAPs are responsible for routing 9-1-1 calls to emergency service personnel, such as law enforcement, fire, or EMS. A secondary PSAP is defined as a PSAP to which 9-1-1 calls are transferred from a primary PSAP.	NENA
Respite Care	Voluntary, short-term residential programs, often operated by peers.	CCC-P Glossary (Page 73)
Routed	Contacts routed to a center after the person listens to the greeting (calls) or sent to a counselor after answering a pre-chat or pre-text survey (chat/text).	SAMHSA Performance Metrics
Short-Term Residential Care	Provide in-person 24-hour crisis care with the option for multiday stays.	CCC-P Glossary (Page 73)

TERM	DEFINITION(S)	SOURCE
Short-Term Residential Therapeutic Programs (STRTP)	Residential facilities that provide an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term, 24-hour care and supervision to children. STRTPs are licensed by the California CDSS; however, DHCS is responsible for the oversight of the mental health program approval. Although DHCS has oversight for the mental health program approval, some counties have been delegated the authority to issue a mental health program approval to STRTPs within their borders.	DHCS
Sobering Center	A short-term care facility designed to allow an individual who is intoxicated and nonviolent to recover from the acute effects of alcohol and drugs safely.	CCC-P Glossary (Page 73)
Social Rehabilitation Program (SRP)	SRPs provide a wide range of alternatives to acute psychiatric hospitalization and institutional care based on the principles of community-based treatment. Community-based treatment includes a high level of care provided in a homelike setting, individual and group counseling, psychiatric services, pre-vocational and vocational assistance, community participation, and linkages to other community services.	DHCS
Special Treatment Programs (STP)	Licensed by CDPH as a skilled nursing facility (SNF) that has opted to have a mental health program approved by the DHCS. STPs provide mental health services for patients who have a diagnosed chronic psychiatric impairment and whose adaptive functioning is moderately impaired.	DHCS

TERM	DEFINITION(S)	SOURCE
Specialty Mental Health Services (SMHS)	The DHCS administers California's Medicaid program (Medi-Cal). The Medi-Cal Specialty Mental Health Services (SMHS) program is carved out of the broader Medi-Cal program and operates under the authority of a waiver approved by CMS under Section 1915(b) of the Social Security Act. DHCS is responsible for administering and overseeing the Medi-Cal SMHS Waiver Program, which provides SMHS to Medi-Cal beneficiaries through county mental health plans (MHPs).	DHCS
Substance Use Disorder (SUD)	SUD is a complex condition in which person experiences uncontrolled use of a substance despite harmful consequences. People with SUD have an intense focus, sometimes called an addiction, on using a certain substance(s), such as alcohol, tobacco, or other psychoactive substances, to the point where their ability to function in day-to-day life becomes impaired. People keep using the substance even when they know it is causing or will cause problems.	American Psychiatric Association
Targeted Universalism	Setting universal goals pursued by targeted processes to achieve those goals. Within a targeted universalism framework, universal goals are established for all groups concerned. The strategies developed to achieve those goals are targeted, based upon how different groups are situated within structures, culture, and across geographies to obtain the universal goal. Targeted universalism is goal oriented, and the processes are directed in service of the explicit, universal goal.	Targeted Universalism Policy & Practice
Trauma-Informed Care	Services or care are based on the knowledge and understanding of trauma and its far-reaching implications.	CCC-P Glossary (Page 73)

TERM	DEFINITION(S)	SOURCE
Warmline	The CCC-P defines warmlines as a service, often peer-run, which offers callers emotional support. CDPH defines warmlines as providing emotional support that can prevent a crisis. Typically staffed by peers (paid or volunteer) that have experience with mental health challenges, warmlines provide comfort and support during challenging times, such as challenges with interpersonal relationships, anxiety, pain, depression, finances, alcohol/drug use, etc. Example: California Peer-Run Warm Line	CCC-P Glossary (Page 73) CDPH Definitions
988	988 is the three-digit telephone number designated by the Federal Communications Commission for the purpose of connecting individuals experiencing a behavioral health crisis with the national suicide prevention and mental health crisis hotline system in accordance with Section 52.200 of Title 47 of the Code of Federal Regulations.	Definitions from AB 988 Section 53123.1.5 - Definitions
988 Center or 988 Crisis Center	988 centers operate on a county or regional basis in California and participate in the NSPL/988 Suicide and Crisis Lifeline network to respond to statewide or regional 988 calls. Now called 988 Crisis Center.	Definitions from AB 988 Section 53123.1.5 - Definitions

Workgroup Members and Meeting Dates

988-Crisis Workgroup 1:

Comprehensive Assessment

Meeting Dates: January 30, 2024, February 29, 2024, March 19, 2024, April 11, 2024

Workgroup Members

Aimee Moulin, Department of Emergency Medicine and Department of Psychiatry, UC Davis

Alice Gleghorn, Phoenix House of California

Andrew Holcomb, San Francisco Department of Emergency Management

Anete Millers, *California Association of Health Plans (CAHP)*

Astin Williams, California LGBTQ Health and Human Services Network

Chad Costello, *California Association of Social Rehabilitation Agencies (CASRA)*

Christina Ramirez, SHIELDS for Families

Corinne Kamerman, California Department of Health Care Services (DHCS)

Courtnie Thomas, California Council of Community Behavioral Health Agencies (CBHA)

Darrell Hamilton, Kings View

Don Taylor, Pacific Clinics

Elizabeth Basnett, California Emergency Medical Services Authority (EMSA)

Erika Cristo, *California Department of Health Care Services (DHCS)*

Ivan Bhardwaj, California Department of Health Care Services (DHCS)

Jana Lord, *Sycamores*

Javon Kemp, Kern County Behavioral Health and Recovery Services

Jennifer Oliphant, *Two Feathers Native American Family Services*

Jessica Jimenez, California Department of Public Health (CDPH)

Jodi Nerell, Sutter Health

Kelsey Andrews, Star Vista Center

Le Ondra Clark Harvey, *California Council of Community Behavioral Health Agencies (CBHA)*

Lei Portugal Calloway, *Telecare Orange County*

Lishaun Francis, Children NOW

Mark Salazar, Mental Health Association of San Francisco (MHA)

Maurice Lee, Center Point, Inc.

Michelle Doty Cabrera, *County Behavioral Health Directors Association (CBHDA)*

Miguel Serricchio, *LSQ Funding Group*

***Phebe Bell,** *Nevada County*

Scott Perryman, Sacramento Fire Department

Sonia Hwang, California Department of Public Health (CDPH)

Stephanie Welch, *California Health and Human Services Agency (CalHHS)*

Tara Gamboa-Eastman, *Steinberg Institute*

Tasnim Khan, Western Health Advantage

Taun Hall, *The Miles Hall Foundation*

Uma Zykofsky, California Behavioral Health Planning Council (CBHPC)

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988-Crisis Workgroup 2:

Statewide Standards & Guidance

Meeting Dates: February 2, 2024, February 27, 2024, March 20, 2024, April 9, 2024

Workgroup Members

Alec Smith, Department of Health Care Services (DHCS)

Andrew Holcomb, San Francisco Department of Emergency Management

Angela Vazquez, The Children's Partnership

Astin Williams, California LGBTQ Health and Human Services Network

***Brenda Grealish,** *Council on Criminal Justice and Behavioral Health (CCJBH)*

Budge Currier, *Public Safety Communications California Governor's Office of Emergency Services (Cal OES)*

Casey Heinzen, Department of Health Care Services (DHCS)

Catherine Hess, California Department of Public Health (CDPH)

Darcy Pickens, California Department of Public Health (CDPH)

Diana Gutierrez, Riverside University Health System (RUHS) Behavioral Health

Elizabeth Whitteker, Molina Healthcare

Ivy Song, University of California Davis

Karla Luna, Kings View 988 Center

Lei Portugal Calloway, *Telecare Orange County*

Liseanne Wick, WellSpace Health

Mayu Iwatani, Orange County Department of Education (OCDE)

Michelle Doty Cabrera, *County Behavioral Health Directors Association (CBHDA)*

Robert Harris, Service Employees International Union (SEIU)

Ruqayya Ahmad, California Pan-Ethnic Health Network (CPEHN)

Shari Sinwelski, *Didi Hirsch*

Susan DeMarois, *California Department of Aging (CDA)*

Tara Gamboa-Eastman*, Steinberg Institute*

Van Hedwall, San Francisco Suicide Prevention Felton Institute

Yolanda Cruz, State Council on Developmental Disabilities (SCDD)

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988-Crisis Workgroup 3:

Integration

Meeting Dates: January 31, 2024/March 22, 2024/April 12, 2024/July 30, 2024

Workgroup Members

Andrew Holcomb, San Francisco Department of Emergency Management

Angela Kranz, California Department of Public Health (CDPH)

Ben Conway, California Department of Justice

Casey Heinzen, Department of Health Care Services (DHCS)

Christine Gephart, Madera County Department of Behavioral Health Services

Connie Moreno-Peraza, Department of Behavioral Health Services of Napa County

Corinne Kamerman, California Department of Health Care Services (DHCS)

Curt Guillot, California Governor's Office of Emergency Services (Cal OES)

***Doug Subers,** *California Professional Firefighters*

Elena Lopez-Gusman, California American College of Emergency Physicians (ACEP)

Elizabeth Basnett, *California Emergency Medical Services Authority (EMSA)*

Hernando Garzon, California Emergency Medical Services Authority (EMSA)

Jacqueline Alvarez, California Community Colleges

Jana Lord, *Sycamores*

Keris Jän Myrick, *Inseparable (Mental Health Advocacy Programs)*

Kim Lewis, National Health Law Program (NHELP)

***Lan Nguyen,** *County of Santa Clara Behavioral Health Services Department*

Le Ondra Clark Harvey, *California Council of Community Behavioral Health Agencies (CBHA)*

Lee Ann Magoski, *Monterey County*

Lei Portugal Calloway, *Telecare Orange County*

Melissa Lawton, *Seneca Family of Agencies*

Michael Tabak, *San Mateo County Sheriff's Office*

Paul Rains, CommonSpirit Health

Peter Stoll, Humboldt County Office of Education

Rebecca Neusteter, University of Chicago Health Lab

Rhyan Miller, *Riverside County*

Sandri Kramer, Didi Hirsch Mental Health Services

Stephanie Welch, *California Health and Human Services Agency (CalHHS)*

Tara Gamboa-Eastman, *Steinberg Institute*

Victoria Kelly, Redwood Community Services

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988-Crisis Workgroup 4:

Communication

Meeting Dates: May 23, 2024, June 13, 2024

Workgroup Members

Adrienne Shilton, California Alliance of Child and Family Services

Alec Smith, Department of Health Care Services (DHCS)

Angela Vazquez, The Children's Partnership

Ariella Cuellar, California LGBTQ Health & Human Services Network

***Ashley Mills,** *Community Wellness, California Department of Public Health (CDPH)*

Chrissy Corbin, California Department of Public Health (CDPH)

Christie Gonzales, WellSpace Health

David Grady, Central Coast at State of California

Debra Roth, Disability Rights

Elizabeth Basnett, *California Emergency Medical Services Authority (EMSA)*

Erika Cristo, *California Department of Health Care Services (DHCS)*

Hernando Garzon, California Emergency Medical Services Authority (EMSA)

Ivan Bhardwaj, California Department of Health Care Services (DHCS)

Jeanine Gaines, The Social Changery

Jennifer Oliphant, *Two Feathers Native American Family Services*

Jessica Hwang, California Department of Public Health (CDPH)

Jevon Wilkes, California Coalition for Youth

John Donoghue, County of Santa Clara Behavioral Health Services

Julie Korinke, Didi Hirsch

Ka Ramirez, Department of Health Care Services (DHCS)

Katherine Katcher, Yurok Tribe

***Kenna Chic,** *California Health Care Foundation*

Kenyon Jordon, Buckelew Programs

Kiran Savage-Sangwan, California Pan-Ethnic Health Network (CPEHN)

Lishaun Francis, Children NOW

Mayu Iwatani, Orange County Department of Education (OCDE)

Michael Tabak, *San Mateo County Sheriff's Office*

Miguel Serricchio, *LSQ Funding Group*

Miriam Goldblum, Stanford Health Care

Neha Shergill, California Department of Public Health (CDPH)

Rachael Steidl, YouthWell

Robin Christensen, California Department of Public Health (CDPH)

Ruqayya Ahmad, California Pan-Ethnic Health Network (CPEHN)

Sara Mann, California Pan-Ethnic Health Network (CPEHN)

Stephanie Welch, *California Health and Human Services Agency (CalHHS)*

Stephen Sparling, *California Coalition for Youth*

Taun Hall, *The Miles Hall Foundation*

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988-Crisis Workgroup 5:

Data & Metrics

Meeting Dates: May 17, 2024, July 31, 2024

Workgroup Members

Alec Smith, Department of Health Care Services (DHCS)

Ashley Metoyer, UCSD Mobile Crisis

Blanca Gutierrez, Contra Costa Crisis Center

Brandon Jacobs, Riverside University Health Systems (RUHS) Behavioral Health

Casey Heinzen, Department of Health Care Services (DHCS)

Curt Guillot, California Governor's Office of Emergency Services (Cal OES)

David Bond, Blue Shield of California

Elizabeth Manley, University of CT

Erika Cristo, *California Department of Health Care Services (DHCS)*

Jana Lord, *Sycamores*

Jonah Cox, California Department of Public Health (CDPH)

***Kirsten Barlow,** *California Hospital Association (CHA)*

Mark Salazar, Mental Health Association San Francisco

Molly Miller, Interagency Council on Homelessness

Rebecca Bauer-Kahan, *State of California, AD 16*

***Robb Layne,** *California Association of Alcohol and Drug Program Executive, Inc. (CAADPE)*

Sae Lee, Didi Hirsch

Sarah Feingold, Youth for Change

Shauna Simon, California Department of Public Health (CDPH)

Sheree Lowe, California Hospital Association (CHA)

Tara Gamboa-Eastman, *Steinberg Institute*

Tony Kildare, Yolo County Health and Human Services

Tracy Lacey, California Behavioral Health Directors Association (CBHDA)

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988-Crisis Workgroup 6:

Funding & Sustainability

Meeting Dates: May 30, 2024, July 29, 2024, August 27, 2027

Workgroup Members

***Amanda Levy,** *California Department of Managed Health Care (DMHC)*

Amanda Miller-McKinney, CA Department of Managed Healthcare (DMHC)

Andrea Tolaio, Family Service Agency Central Coast, 988/ Suicide Prevention

***Anete Millers,** *California Association of Health Plans (CAHP)*

Budge Currier, *Public Safety Communications California Governor's Office of Emergency Services (Cal OES)*

Casey Heinzen, Department of Health Care Services (DHCS)

Chad Costello, *California Association of Social Rehabilitation Agencies (CASRA)*

Christine Stoner-Mertz, *California Alliance of Child and Family Services*

Corinne Kamerman, California Department of Health Care Services (DHCS)

Diana Vasquez-Luna, CA Department of Finance

Ivan Bhardwaj, California Department of Health Care Services (DHCS)

Jacob Ruiz, Riverside University Health System (RUHS)

Jana Lord, *Sycamores*

John Boyd, *Kaiser Permanente Northern California*

Ka Ramirez, Department of Health Care Services (DHCS)

Kenna Chic, *California Health Care Foundation*

Kirsten Barlow, *California Hospital Association (CHA)*

Lauren Finke, The Kennedy Forum

Melissa Lawton, *Seneca Family of Agencies*

Michelle Galvan, Optum Public Sector San Diego

Narges Dillon, Crisis Support Services of Alameda County

Phebe Bell, *Nevada County*

Raven Lopez, County Behavioral Health Directors Association of California (CBHDA)

Reuben Wilson, Los Angeles County Department of Mental Health

Ryan Banks, *Turning Point of Central Valley, Inc.*

Shari Sinwelski, *Did Hirsch*

Stephanie Welch, *California Health and Human Services Agency (CalHHS)*

Tara Gamboa-Eastman, *Steinberg Institute*

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988-Crisis Ad Hoc Workgroup

Peer Supporter

Meeting Dates: June 11, 2024/August 6, 2024

Deborah Diaz de Leon, NAMI Orange County

Gwen Schrank, Schrank's Clubhouse & Peer Connect and Collaborate Coalition

Jana Spaulding, Setup4Success

Jason Robinson, SHARE

Kenna Chic, *California Health Care Foundation*

***Keris Jän Myrick,** *Inseparable (Mental Health Advocacy Programs)*

Lei Portugal Calloway, *Telecare Orange County*

Lori Fischer, Telecare AOT/CARE Act

Michelle Tanner, Pacific Clinics

***Rayshell Chambers,** *Mental Health Services Oversight and Accountability Commission*

Richard Krzyzanowski, Project Return Peer Support Network/California Association of Mental Patients' Rights Advocates (CAMHPRA)

Stephen McNally, Brain Health 24/7

Susan Gallagher, Cal Voices

Tiffany Murphy, Consumers Self Help Center

Tina Robinson, Owning My Own Truth

Vanessa Ramos, Disability Rights CA

Wendy Cabil, Independent Mental Health Care Professional

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988 Surcharge Overview

Legal Framework - Key Statutes

Government Code §§ 53123.1–53123.6. Details the establishment and management of the 9-8-8 surcharge and its associated fund. Full Text: CA GC 988

Revenue and Tax Code §§ 41001–41176. Outlines tax-related provisions applicable to the surcharge. Full Text: CA RTC 988

Federal Communications Commission (FCC). Regulations govern permissible uses of 9-8-8 funds. FCC Guidance: FCC 988

California Department of Tax and Fee Administration (CDTFA). 988 Surcharge Rate: CDTFA 988

Fee Determination

Assembly Bill 988 (Stats. 2022, ch.747) established both the 988 surcharge and the 988 State Suicide and Behavioral Health Crisis Services Fund. For calendar years 2023 and 2024, the 988 surcharge was set at eight cents ($0.08) per access line per month. For 2025 and beyond, the California Governor's Office of Emergency Services (Cal OES) will determine the surcharge rate.

The calculation is based on:

- Appropriations determined by the California Legislature.
- Access line data from service providers.

The surcharge amount shall not exceed thirty cents ($0.30) per access line per month. Cal OES calculates the surcharge rate and communicates the surcharge requirement to CDTFA by October 1st each year. As mandated by AB 988, Cal OES prepares a summary of the calculation of the proposed surcharge and posts the information publicly at the 988 Technical Advisory Board and on the Cal OES 988 website. [157]

Authorized Uses of 9-8-8 Funds

The revenue generated by the 988 surcharge shall, to the extent not prohibited by 47 U.S.C. § 251a and any applicable rules or regulations adopted by the FCC and in compliance with RTC §41136(b), be prioritized to fund the following:

First, the 988 centers, including the efficient and effective routing of telephone calls, personnel, and the provision of acute behavioral health services through telephone call, text, and chat to the 9-8-8 number.

Second, the operation of mobile crisis teams accessed via telephone calls, texts, or chats made to or routed through 9-8-8 as specified under Section 4(a)(2)(B) of Public Law 116-172.

Additionally:

- Money in the fund shall not be subject to transfer to another fund or to transfer, assignment, or reassignment for another use or purpose outside of those specified in this article.
- The revenue generated by the 988 surcharge shall be used to supplement, not supplant, federal, state, and local funding for 988 centers and behavioral health crisis services.
- The revenue generated by the 988 surcharge may only be used to fund service and operation expenses that are not reimbursable through Medicaid federal financial participation, Medicare, health care service plans, or disability insurers.

Funding Requests and Reporting Requirements

Pursuant to GC §53123, Cal OES shall require an entity seeking funds available through the 988 Fund to annually file an expenditure and outcomes report[158]

The report shall include, but is not limited to, the following:

- The total budget.
- Number and job classification of personnel.
- The number of individuals served.
- The outcomes for individuals served, if known.
- The health coverage status of individuals served, if known.

- The number of individuals who used the service and self-identified as veterans or active military personnel, if known.
- Beginning July 1, 2025, measures of system performance, including capacity, wait times, and the ability to meet demand for services.
- Beginning January 1, 2030, the amount billed to and reimbursed by Medi-Cal or other public and private health care service plans or insurers.

988 Funding Overview

Background

State Budget Process

California Department of Finance (Finance) describes the state budget process on its website, which explains:

1. In the Spring of each year, Department of Health Care Services (DHCS) develops and submits Budget Change Proposals (BCP) to Finance in the fall of the same calendar year.
    - If approved, the BCP is submitted for inclusion in the Governor's January Budget
2. The Governor's Budget is released by January 10 each year, followed by budget hearings that take place from January through June.
    - Based on updated financial forecasts, the May Revise may prompt renewed budget negotiations and adjustments to the BCP.
    - Once the Legislature passes the budget, the Governor signs it into law, typically by June 30, incorporating approved BCPs into the state budget plan.
    - Funding for approved proposals becomes available at the start of the new state fiscal year on July 1.

Distribution of AB 988 and Federal Funds

The funding of 988 Crisis Centers encompasses both fixed and variable allocations.

1. Assembly Bill (AB) 988 (Stats. 2022, Ch. 747) mandates that surcharges be established to support the 988 funding structure and 988 Crisis Centers.
    - The Emergency Telephone Users Surcharge Act sets the amount of surcharge at $0.08 for each access line/retail transaction for calendar year 2023 and 2024.
    - The California Governor's Office of Emergency Services (Cal OES) is the Administering Organization for the fund and responsible for determining the surcharge rate for calendar year by each October 1st.
2. DHCS applies for the Substance Abuse and Mental Health Services (SAMHSA) available funding opportunities and subsequently contracts with an Administrative Entity (AE). The AE is responsible for:
    - Allocating 100 percent of available 988 Crisis Center funds.

- Coordinating with, and remitting payment to, each 988 Crisis Center.
    - Reimbursing each 988 Crisis Center on a cost basis and determining the appropriate funding source to be used for payment.

Budget Setting Factors and Future Funding Considerations

California state support of 988 Crisis Centers has evolved as the National Suicide Prevention Lifeline (NSPL) has transitioned to the national 988 Suicide and Crisis Lifeline. Historically, DHCS supported NSPL centers with strategically allocated funding to bolster essential counseling services, acquire necessary supplies, and address administrative and operational costs. This funding model was comprised of state and federal funding sources that were not solely dedicated to support the NSPL, and therefore were not designed to fully cover operational costs of these centers. Instead, it aimed to supplement existing NSPL funding streams to enhance the NSPL centers' capacity, ensuring that resources were effectively aligned with demand to the extent possible.

Transitioning to a comprehensive budgeting process requires a multifaceted approach, integrating key performance indicators (KPIs) and other evaluative measures that have only recently been introduced by federal and state statutes and policies. DHCS, in collaboration with 988 Crisis Centers, remains committed to continuously assessing the evolving needs of these centers to facilitate the effective delivery of 988 services.

Over the next few months, DHCS will work with existing 988 Crisis Centers, county behavioral health plans, and other stakeholders on future funding considerations and methodologies to adequately support 988 Crisis Centers. This includes incorporating the rigorous federal performance requirements, including enhanced follow-up protocols and the implementation of aspirational KPIs. This shift not only reflects a commitment to professionalizing and streamlining program administration, but also underscores the necessity of establishing a well-structured and accountable operational model that can adapt to emerging challenges and improve service delivery outcomes.

End Notes

[i] Some PAG members identified delegates to support meeting attendance; these individuals included: Budge Currier, Cal OES (original PAG member who was replaced by Jessica Sodhi); Casey Heinzen, Community and Crisis Care Programs Branch, Chief Medi-Cal Behavioral Health Policy Division, DHCS (Erika Cristo); Hernando Garzon, Acting Medical Director, EMSA (Elizabeth Basnett); Chris Gephart, Deputy Director, Clinical Services, DDS (Nancy Bargmann); Elise Gyore, Chief of Staff, CA State Assemblymember Rebecca Bauer-Kahan; Stephanie Blake, Behavioral Health Specialist, California Department of Aging (Susan DeMarois); David Lawrence, Section Chief, Housing and County Support, CalVet (Roberto Herrera)

[2] America's Health Rankings analysis of CDC WONDER, Multiple Cause of Death Files, United Health Foundation, last accessed November 2024

[3] California Overdose Surveillance Dashboard. Prepared by CDPH – Substance and Addiction Prevention Branch (SAPB), last accessed November 2024; Drug Overdose Deaths in the United States, 2002-2022, Centers for Disease Control and Prevention, March 2024

[4] The age-adjusted rates of all drug-related overdose deaths in California increased 89% from 2019-2023. Data based on the California Overdose Surveillance Dashboard, last accessed November 2024

[5] HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022, last accessed November 2024

[6] The survey defined mental illness as one "that interferes with a person's life and ability to function (examples include bipolar disorder, major depressive disorder, and schizophrenia)" CHCF/NORC California Health Policy Survey (September 18–October 25, 2023)

[7] 988 Key Messages | SAMHSA, last accessed December 2024

[8] 988 Frequently Asked Questions, last accessed December 2024

[9] 9-1-1 Master PSAP Registry, last accessed December 2024

[10] Cal OES Technical Advisory Board website, last accessed December 2024

[11] BHCIP Crisis Care Mobile Dashboard, last accessed December 2024

[12] Information provided by DHCS as of December 2024

[13] DHCS Mobile Crisis Services, last accessed December 2024

[14] CalHHS, Mental Health for ALL: California's Behavioral Health Transformation, June 2024

[15] PPIC Statewide Survey: Californians and Their Government, September 2023

[16] FCC Adopts Rules Requiring Georouting for All Wireless Calls to 988

[17] 988 Lifeline Research and Evaluation, last accessed December 2024

[18] CalHHS, Behavioral Health Crisis Care Continuum Plan (CCC-P), May 2023

[19] Ibid, page 34

[20] Ibid, page 23

[21] The CCC-P defines "community-based care" as person-centered care delivered in the home and community, and further defines mobile crisis teams as community-based support where people in crisis are either at home or at a location in the community. Here we used the term community-based crisis response to refer broadly to the range of models in communities of responding to crisis beyond "mobile crisis teams." See Glossary for additional information.

[22] AB 988 defines "behavioral health crisis services" as the "continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis stabilization services." See glossary for additional information

[23] CalHHS, Behavioral Health Crisis Care Continuum Plan (CCC-P), May 2023, page 23

[24] Ibid, page 20

[25] Ibid, page 21; See also SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, September 13th BHTF meeting, DHCS: Existing California Medicaid Policies, proposed Medi-Cal Mobile Crisis Benefit, CalHHS; "Tribal Indian Behavioral Health" added August 15, 2024. *See also* September 13, 2023, DHCS BHTF: Existing California Medicaid Policies, proposed Medi-Cal Mobile Crisis Benefit, CalHHS; Tribal Indian Behavioral Health added August 15, 2024

[26] "Any event or situation associated with an actual or potential disruption of stability and safety as a result of behavioral health issues or condition"; see Behavioral Health Crisis Care Continuum Plan (CCC-P), page 73. Additional terms included in this Plan are in the Glossary

[27] CalHHS, Behavioral Health Crisis Care Continuum Plan (CCC-P), May 2023, page 67

[28] Ibid, page 37

[29] These additions were identified by members of the BHTF in a meeting in April 2024; See also discussion at 988-Crisis Workgroup 1, Meeting 3, March 19, 2024

[30] CalHHS, Behavioral Health Crisis Care Continuum Plan (CCC-P), May 2023, page 34

[31] Ibid, page 22

[32] At launch, the Biden-Harris Administration contributed $14 million to the state from $432 million in national 988 funding; DHCS provided $20 million for its first year, $19 million for 2023-2024, and the state has allocated $12.5 million for 2024-2025 to support staffing and operations at the 12 California 988 Crisis Centers; based on data from US Department of Health and Human Services, HHS Announces Additional $200 Million in Funding for 988 Suicide & Crisis Lifeline, May 17, 2023; California Dedicates $20 Million to Support New Mental Health "988" Crisis Hotline, September 3, 2021; and 2023-24 May Revision: Department of Health Care Services Highlights, May 12, 2023

[33] Office of the Governor, Letter to Members of California State Assembly, September 29, 2022

[34] At the time of signing the law, California was one of five states with dedicated state funding for 988; as of July 2024, nine states had "comprehensive 988 legislation enacted," according to the National Alliance on Mental Illness

[35] California Government Code: § 53123.3(a)3. "The advisory group shall include, but is not limited to, the State Department of Health Care Services, the office, the State Department of Public Health, representatives of counties, representatives of employees working for county behavioral health agencies and agencies who subcontract with county behavioral health agencies who provide these services, health plans, emergency medical services, law enforcement, consumers, families, peers, 988 centers, and other local and statewide public agencies."

[36] California Government Code: § 53123.3(b)

[37] California Government Code: § 53123.4.(b)2 states that "the revenue generated from the 988 surcharge should be prioritized to fund the following: (A) 988 centers, including the efficient and effective routing of telephone calls, personnel, and the provision of acute behavioral health services through telephone call, text, and chat to the 988 number; (B) the operation of mobile crisis teams accessed via telephone calls, texts, or chats made to or routed through 988, as specified under Section 4(a)(2)(B) of Public Law 116-172"

[38] Note: This document refers to 988 Crisis Centers throughout to connote National Suicide Prevention Lifeline (NSPL) designated (now called 988 Suicide and Crisis Lifeline) call centers referenced in AB 988. AB 988 references the American Rescue Plan Act of 2021 (Section 1947(b)(2) of Public Law 117-2) in its definition of Mobile Crisis Teams, which is defined under "Qualifying Community-based Mobile Crisis Intervention Services" as a "multidisciplinary mobile crisis team—(A) that includes at least 1 behavioral health care professional who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under State law, and other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response, including nurses, social workers, peer support specialists, and others, as designated by the State through a State plan amendment (or waiver of such plan); (B) whose members are trained in trauma-informed care, de-escalation strategies, and harm reduction; (C) that is able to respond in a timely manner and, where appropriate, provide—(i) screening and assessment; (ii) stabilization and de-escalation; and (iii) coordination with, and referrals to, health, social, and other services and supports as needed, and health services as needed; (D) that maintains

relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations (if applicable); and (E) that maintains the privacy and confidentiality of patient information consistent with Federal and State requirements." Notably, recommendations contained in the Plan provide a broader definition of mobile crisis response services

[39] Cal OES, 9-8-8 Surcharge State Emergency Telephone Number Account, January 2024

[40] With AB 988, the state sought to establish an additional entry point into the behavioral health crisis care continuum that includes 988 Crisis Centers. The implementation plan identifies action step to bolster 988 and further integrate 988 into the crisis care continuum

[41] 988 geo-routing was piloted for two of three major U.S. carriers (T-Mobile and Verizon) on September 17, 2024; an FCC ruling on October 17, 2024, mandated all carriers to implement geo-routing. The current phase is focused on voice calls to 988 for all three major carriers with future phases establishing geo-routing for smaller carriers and text FCC Adopts Rules Requiring Georouting for All Wireless Calls to 988

[42] CalHHS, Mental Health for ALL: California's Behavioral Health Transformation, June 2024, slide 4

[43] Behavioral Health Infrastructure Bond Act of 2024, last accessed October 10, 2024

[44] Ibid, slide 33

[45] CalHHS, A New Mindset: California's Behavioral Health Transformation, slide 5, April 17, 2024

[46] CalHHS, Crisis Care Mobile Units Program Grant, last accessed December 2024

[47] CalHHS, Behavioral Health Continuum Infrastructure Program, last accessed December 2024

[48] BHCIP Infographic, last accessed October 27. 2024

[49] Represents DHCS funding from the past five fiscal years (SFYs 2020, 2021, 2022, 2023, and 2024); funding sources have included the Mental Health Services Act, SAMHSA Mental Health Block Grants, State General Funds, and two SAMHSA grants for 988 services; data provided by DHCS, email correspondence June 26, 2024

[50] CalHHS, Crisis Care Mobile Units Program Grant, data as of September 2024, last accessed December 2024

[51] An additional Workgroup focused on peer roles in the crisis care continuum also convened in recognition of the important roles that the peer workforce plays in crisis services, with an emphasis on Peer Workforce-specific implementation considerations across the crisis continuum; Workgroup members were identified based on recommendations from PAG members

[52] California Government Code: § 53123.3(a)(3): "The advisory group shall include, but is not limited to, the State Department of Health Care Services, the Office of Emergency Services, the State Department of Public Health, representatives of counties, representatives of employees working for county behavioral health agencies and agencies who subcontract with county behavioral health agencies who provide these services, health plans, emergency medical services, law enforcement, consumers, families, peers, and other local and statewide public agencies"

[53] California Government Code: § 53123.3. Recommendation Area 12

[54] CalHHS, Behavioral Health Crisis Care Continuum Plan (CCC-P), May 2023

[55] DHCS, Assessing the Continuum of Care for Behavioral Health Services in California Data, Stakeholder Perspectives, and Implications, January 10, 2022

[56] Ibid, page 39

[57] KFF, Unmet Needs for Counseling or Therapy Among Adults Reporting Symptoms of Anxiety and/or Depressive Disorder During the Covid-19 Pandemic, 2022

[58] DHCS, Assessing the Continuum of Care for Behavioral Health Services in California, January 10, 2022

[59] PPIC Statewide Survey: Californians and Their Government, September 2023

[60] In a poll conducted nine months after 988's national launch, only 13% of adults in the U.S. had heard of the 988 Suicide and Crisis Lifeline and knew its purpose; Velazquez T, Pew, Most U.S. Adults Remain Unaware of 988 Suicide and Crisis Lifeline, updated November 8, 2023

[61] The Nation Alliance on Mental Illness poll released findings from its survey in July 2024, which found that 67% of respondents said they were aware of 988; only 23% said they were at least somewhat familiar with 988
[62] PPIC Statewide Survey: Californians and Their Government, September 2023
[63] Approximately 1 in 20 respondents with serious distress had used the 988 Lifeline, but only about one-third of these users were likely to use it in the future; Use, Potential Use, and Awareness of the 988 Suicide and Crisis Lifeline by Level of Psychological Distress, October 31, 2023
[64] PPIC, Californians' Mental Health Varies across Key Groups, October 4, 2023
[65] Blue Shield of California/The Harris Poll, BlueSky Youth Mental Health Survey, June 2023
[66] California Legislative Information – Text of SB-972
[67] Milbank Memorial Fund, Fifty Years of Trust Research in Health Care: What Does It Mean for Policymakers?, January 24, 2023
[68] Letter from Disability Right California to CalHHS and the 988 Project Team, August 16, 2024 as well as input from focus groups conducted as part of the development of the Community Engagement Report and public comments
[69] NAMI/Ipsos 988 Lifeline and Crisis Response Research, July 2024
[70] See full findings in the Community Engagement Report 2024. This particular finding aligns with a 2023 Pew Survey, which found that about 2 in 5 respondents expressed concern that calling 988 might result in law enforcement being sent, being forced to go to the hospital, incurring charges for services that they could not afford to pay, or other people finding out they had called
[71] See full findings in the Community Engagement Report 2024
[72] De-identified summary data emailed from DHCS on June 17, 2024; DHCS CDO, CDO 24-1149
[73] See CalHHS Language Access Policy, which states as its goal "to ensure that CalHHS and its Departments and Offices provide meaningful access to information, programs, benefits, and services to people with limited English proficiency (LEP) and to ensure that language is not a barrier to accessing vital health and social services"
[74] Vibrant monthly data, last accessed August 2024
[75] Ibid
[76] Ad Hoc Analysis conducted by AHP: Comparison of National and CA Annual 988 Call Volume, shared by DHCS via email, July 2024
[77] Additional benefits (shared by Cal OES) in a presentation to the PAG include: Transfers from 988 to 9-1-1 on a priority line just like a 9-1-1 call, transfers from 9-1-1 to 988 are geospatially routed to the correct 988 center based on 9-1-1 location, approved information and data from 988 can be sent to the 9-1-1 system, reduced workload and response because no need to verbally relay information, Direct Chat features are supported between 988 and 9-1-1, ability to share videos, photos, and other multimedia data, load sharing between all systems based on rules and requirements
[78] Gasior M, Power DMS, Policing the Mentally Ill: How Changes in Tactic and Best Practices Impact Your Department, 2020, accessed May 10, 2024
[79] Neusteter, SR Mapolski M, Khogali M, O'Toole M, Vera Institute of Justice, The 9-1-1 Call Processing System: A Review of the Literature as it Relates to Policing, July 2019
[80] In 2022, this figure was 27 million calls, as reported by Cal OES to the FCC, California Submission to FCC Communications Commission (Annual Fee Report) Approved OMB request (3060-1122), 2022
[81] Note: these estimates are for illustrative purposes only to show a potential range of volume in calls. National data on behavioral health calls may be higher or lower than California estimates
[82] RAND Corporation, The Road to 988/911 Interoperability: Three Case Studies on Call Transfer, Colocation, and Community Response, June 2024
[83] For more information see, California 988 Technical Advisory Board webpage, last accessed November 22, 2024.
[84] Geo-routing directs help seekers contacting 988 to a nearby 988 Crisis Center based on the individual's general location. It does not reveal the precise location of help seekers. As previously noted, 988 geo-routing was piloted for

two of three major U.S. carriers (T-Mobile and Verizon) on September 17, 2024; an FCC ruling on October 17, 2024, mandated all carriers to implement geo-routing. The current phase is focused on voice calls to 988 for all three major carriers with future phases establishing geo-routing for smaller carriers and text. FCC Adopts Rules Requiring Georouting for All Wireless Calls to 988

[85] CDPH, Crisis Hotlines, Warmlines & Resources, last accessed August 2024

[86] CDSS – Family Urgent Response System, last accessed December 2024

[87] California Civil Right Department CA vs Hate Website, last accessed December 2024

[88] Based on 988 Lifeline Best Practices; 988 Suicide & Crisis Lifeline Suicide Safety Policy (2024); an original list of services and functions was developed from discussion with 988 Crisis Centers and 988-Crisis Workgroup 2: Statewide 988 Standards and Guidance, February-April 2024 and prior 988 Safety Policy released by SAMHSA.

[89] Vibrant, 988 Suicide & Crisis Lifeline Suicide Safety Policy, 2024

[90] SAMHSA. 988 Frequently Asked Questions, accessed May 10, 2024

[91] See, for example, Gould MS, Cross W, Pisani AR, Munfakh JL, Kleinman M, Impact of Applied Suicide Intervention Skills Training on the National Suicide Prevention Lifeline Counselor, 2013

[92] RAND Corporation, Suicide Prevention Hotlines in California, RAND Health Quarterly, 2017

[93] This data was provided to CalHHS and the project team by DHCS as of July 2024. Notably, DHCS notes that not every California 988 Crisis Center submitted data points for every required item, and data values vary, which limit its utility

[94] Based on the principal Culturally and Linguistically Appropriate Services (CLAS) Standard in Health and Health Care

[95] See 988-Crisis Workgroup 2: Statewide Standards & Guidance Meeting 4 for a summary of the discussion on possible training topics. Additional presentations and discussions on standards and training (Workgroup 2) can also be found on the 988-Crisis PAG webpage

[96] SAMHSA Harm Reduction Framework, 2023

[97] As previously noted, see 988-Crisis Workgroup 2: Statewide Standards & Guidance Meeting 4 for a summary of the discussion on possible training topics. Additional presentations and discussions on standards and training (Workgroup 2) can also be found on the 988-Crisis PAG webpage

[98] Vibrant, 988 Suicide & Crisis Lifeline Minimum Standards For Crisis Contact Centers Applying To Join The 988 Lifeline Network, January 2022

[99] For more information, see Youth Mental Health Resources Hub - California Health and Human Services

[100] Page 5 of the BHIN states: "Medi-Cal behavioral health delivery systems shall identify and post a single telephone number that Medi-Cal beneficiaries who may require mobile crisis services can call. This number can be the same as the county's 24/7 access line, or an existing crisis line, if the Medi-Cal behavioral health delivery system ensures the line has the capacity to respond to beneficiaries in crisis and to dispatch mobile crisis teams when appropriate" DHCS Behavioral Health Information Notice No.: 23-025, June 19, 2023

[101] Data provided by DHCS contractor for BHCIP, as of September 2024

[102] Ibid

[103] CMS, Approval Letter for California State Plan Amendment (SPA) 22-0043, accessed May 10, 2024

[104] The benefit went live in California in January 2024; however, the CMS approval date shows a retroactive date to the application date, January 2023

[105] Correspondence with DHCS, December 17, 2024. Note: As of April 2024, the number of certified eligible population was 14,981,547; California Department of Health Care Services, Medi-Cal Monthly Enrollment Fast Facts, April 2021 through April 2024, accessed September 9, 2024

[106] These were common themes across interviews with county behavioral health departments and providers, including the in-depth interviews conducted in Los Angeles, Nevada, Riverside, Santa Clara, San Luis Obispo counties

[107] DHCS, Fact Sheet on Proposition 1, Accessed August 2024

[108] Text of AB-531 The Behavioral Health Infrastructure Bond Act of 2023
[109] DHCS, The California Behavioral Health Community-Based Continuum Demonstration: Concept Paper (Executive Summary), November 2022
[110] Note that these directories may include a comprehensive array of resources to meet the needs of those in crisis such as providers of services that stabilize and prevent crisis with the least restrictive interventions that can prevent hospitalization or re-hospitalization on an outpatient level. Details will be determined in the context of operationalizing the planned activity
[111] As noted in a SAMHSA funded National Survey of Mobile Crisis Teams: "Single-site research studies have shown that MCTs can decrease emergency department utilization and psychiatric hospitalization among people in crisis, thus reducing costs while simultaneously increasing engagement in community-based care. MCTs are more favorably perceived by people who receive these services than a law enforcement response"
[112] A number of locally funded programs are available across the state, including the Mobile Assistance Community Responders of Oakland (MACRO) Program, a community response program for non-violent, non-emergency 9-1-1 calls and modeled on Eugene' Oregon's Crisis Assistance Helping Out on The Streets (CAHOOTS) model. Other models were shared as part of the interviews conducted with California counties and outlined in the AB 988 Chart Book.
[113] See CYBHI Scaling Evidence-Based and Community-Defined Evidence Practices and DHCS EBP-CDEP-Grants as examples
[114] RAND Corporation, Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California, 2021
[115] RAND Corporation, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Sacramento County, California, 2022; RAND Corporation, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Santa Clara County, California, 2023; RAND Corporation, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in California: Merced, San Joaquin, and Stanislaus Counties, 2022
[116] These recommendations recognize that increasing options for where and how someone receives care are not only helpful to address shortages but also are important in helping to provide appropriate care and support to diverse populations
[117] EMSA, Community Paramedicine and Triage to Alternative Destinations, 2024
[118] Healthforce Center at UCSF, Evaluation of AB 1544: Community Paramedicine and Triage to Alternate Destination, October 2023
[119] AB 988 Chart Book: An Inventory of Needs, Services and Gaps of the Behavioral Health Crisis System, 2024
[120] Othering & Belonging Institute at UC Berkeley, Targeted Universalism Policy and Practice, May 2019
[121] Axios, The Californians who speak a non-English language at home, September 7, 2023
[122] Data from Migration Policy Institute tabulations, 2022, which uses the U.S. Census Bureau's American Community Survey (ACS), one-year ACS data file
[123] Ibid
[124] SAMHSA 988 Partner Toolkit, Accessed November 22, 2024
[125] Notably, all 988 digital marketing materials will seek to comply with Section 508 of the Rehabilitation Act
[126] For California suicide rates, see CDPH, California Injury Data Online EpiCenter; National studies regarding the prevalence of suicide in rural communities is well documented. For example, see Psychiatry Services, The Changing Context of Rural America: A Call to Examine the Impact of Social Change on Mental Health and Health Care, November 2016
[127] Suicide Trends Among and Within Urbanization Levels by Sex, Race/Ethnicity, Age Group, and Mechanism of Death, October 6, 2017
[128] Finding based on input from 988-Crisis Workgroup 1 Meetings, interviews conducted with county behavioral health departments and providers as well as focus groups conducted as part of the Community Engagement Report

[129] See slides in the AB 988 Chart Book; See also 988-Crisis Workgroup 1: Meeting 4: Slides 31-34; April 2024
[130] CDPH, California Injury Data Online EpiCenter, 2022
[131] The UCSF Benioff Homelessness and Housing Initiative, The California Statewide Study of People Experiencing Homelessness, 2013, found that 48% of all unhoused single adults in the state were age 50 or older, and 41% of unhoused older adults became homeless for the first time after age 50
[132] CYBHI, Youth at the Center, January 2023
[133] As of December 2024, the national 988 network used LanguageLine Solutions
[134] FAQ: Is the 988 Lifeline available in other languages for non-English speakers? - 988 Lifeline, last accessed December 2024
[135] 988 Lifeline Webpage: People with Neurodivergence, last accessed December 30, 2024
[136] DHCS, Didi Hirsch Mental Health Services, and California Assemblymember James C. Ramos, Outreach & Engagement with California's Native American Communities: Summary of Two Regional California 988 Tribal Summits, January 2024
[137] See, for example, Stone D, Trinh E, Zhou H, et al., Suicides Among American Indian or Alaska Native Persons — National Violent Death Reporting System, United States, 2015–2020, September 2022
[138] Suicide Prevention Resource Center at the University of Oklahoma Health Sciences Center, Online Library: American Indian/Alaska Native Setting, last accessed December 2024
[139] State of California – Executive Order N-15_19
[140] State of California – Executive Order B-10-11
[141] This examination will build on SAMHSA's language access plan, CalHHS Language Access Policy and existing language access policies and practices of implementation partners
[142] See CalHHS Language Access Policy, which states as its goal "to ensure that CalHHS and its Departments and Offices provide meaningful access to information, programs, benefits, and services to people with limited English proficiency (LEP) and to ensure that language is not a barrier to accessing vital health and social services"
[143] California Government Code: § 53123.4(2)
[144] CalHHS and Project Team discussion with CBHDA, August 2024
[145] California Health and Safety Code – HSC 1374.724
[146] This information is also posted on the DMHC's website, last accessed December 2024
[147] CalHHS, CalHHS IT & Data Strategic Plan, March 2024
[148] Clear Impact Website – What is Results-Based Accountability?, last accessed December 2024
[149] AB-988 Miles Hall Lifeline and Suicide Prevention Act, as amended, SECTION 1. Section 53123.4 of the Government Code
[150] As of December 2024, help seekers who use 988 can share feedback about their experience with the 988 Lifeline using the 988 Lifeline "Contact Us Form," which can be found at: 988lifeline.org/contact-us/ Separate user experience data may be collected by the state to help understand the specific needs and experience of users, including experience with California 988 Crisis Centers, subnetworks and other third party operators (e.g., language lines)
[151] This may include connected data relevant to preventing crisis, including but not limited to, outpatient services
[152] SAMHSA, Peer Support Services in Crisis Care, Advisory, SAMHSA Publication No. PEP22-06-04-001, June 2022
[153] DHCS, Medi-Cal Peer Support Services, last accessed December 2024
[154] CalMHSA Medi-Cal Peer Support Specialist Certification Data Dashboard, Peer Certification - California Mental Health Services Authority, last accessed September 2024
[155] California Government Code: § 53123.3. Recommendation Area 4
[156] California Governor's Office of Emergency Services. 9-1-1 / 988 TRANSFER/HANDLING CRITERIA – DRAFT. 9-1-1/988 Interface Working Group for the 988 Technical Advisory Board. Mach 2024. Last accessed December 2024
[157] California Revenue and Taxation Code – RTC 41030 (g)
[158] See the Crisis Center Annual Expenditure and Outcome Report as well as information on the Cal OES CA 9-8-8 Information page