Building California's Comprehensive 988-Crisis System:

A Strategic Blueprint

Draft AB 988 Five-Year Implementation Plan to the State Legislature

For Second Public Comment

November 26-December 10, 2024

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About This Draft Document

The California Health and Human Services Agency (CalHHS) is sharing this document, developed in partnership with the 988-Crisis Policy Advisory Group (PAG), to gather additional community perspectives in draft form. A final copy of this plan will be transmitted to the California state legislature by December 31st.

- The *second* public comment period will extend from November 26-December 10, 2024
- Please send written comments to AB988Info@chhs.ca.gov
- For specific comments and feedback, please note the corresponding page and paragraph number
- Comments typed in a Word document or PDF format may be included as an e-mail attachment sent to the AB988Info email address listed
- The draft plan references The Community Engagement Report and a Chart Book, which are posted on the 988-Crisis Policy Advisory Group webpage

Acknowledgements

The 988-Crisis Policy Advisory Group (PAG) devoted substantial time and attention to supporting the development of this 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:

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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.[2] 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.[3]
- **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.[4] These services respond to acute behavioral health crisis[5] and connect help seekers in crisis to additional services as appropriate.[6]
- **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.[7]

Figure 1. Components of California Crisis Systems[8]

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).[9]**

Individuals experiencing behavioral health crises[10] often face barriers to timely and effective care, including lack of sufficient and appropriate services, insurance coverage limitations, and systemic inequities.[11] 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/Pacific Islander (particularly youth)[12]

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[13]

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 Asian/Pacific Islander 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[14]

[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 Five-Year Implementation 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 55).

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.[15]

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 BH crisis systems at the state and local levels.[16]

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.[17] 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.[18]

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.[19] 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 system. The resulting Plan must include recommendations related to 14 areas outlined in the legislation (see Appendix, Page 89).[20] As further described on page 9 (Process for Developing Recommendations to Support a 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. This fund may be used to support the operations of 988 Crisis Centers and mobile crisis teams.[21] Fees are capped at $0.08 per access line per month in the first two calendar years of enactment (2023 and 2024); in fiscal year (SFY) 2022-2023, the $0.08 surcharge fee generated $44.3 million.[22] 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 Office of Emergency Services (Cal OES) oversees the Fund and the process to calculate 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 November 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. With geo-routing, help seekers are routed to the nearest 988 Crisis Center based on the caller's approximate physical location.[23]

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, Tribal/state).[24]

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).

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[25]

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***.[26]

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 78 behavioral health authorities or Tribal entities for Crisis Care Mobile Units (CCMUs).[27] 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[28]

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.[29]

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[30]

- Investments in mobile crisis response of more than $202 million to 78 behavioral health authorities or Tribal entities for CCMUs through Round 1 of the Behavioral Health Continuum Infrastructure Program (BHCIP),[31] as well as training and technical assistance to support implementation of 24/7 mobile crisis response in all 58 California counties through a State Plan Amendment that adds "mobile crisis services" as a Medi-Cal Benefit[32]

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-department initiative to expand and redesign systems for children's mental health, including the Youth Suicide Reporting and Crisis Response Pilot Program, a statewide youth suicide prevention campaign ("Never a Bother"), 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 BH outcomes via policy and payment reform

- The soon-to-be launched California Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration proposal, which focuses on enhancing community-based care and treatment for California's highest needs populations

- Implementation of the Community Assistance, Recovery, and Empowerment Act (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

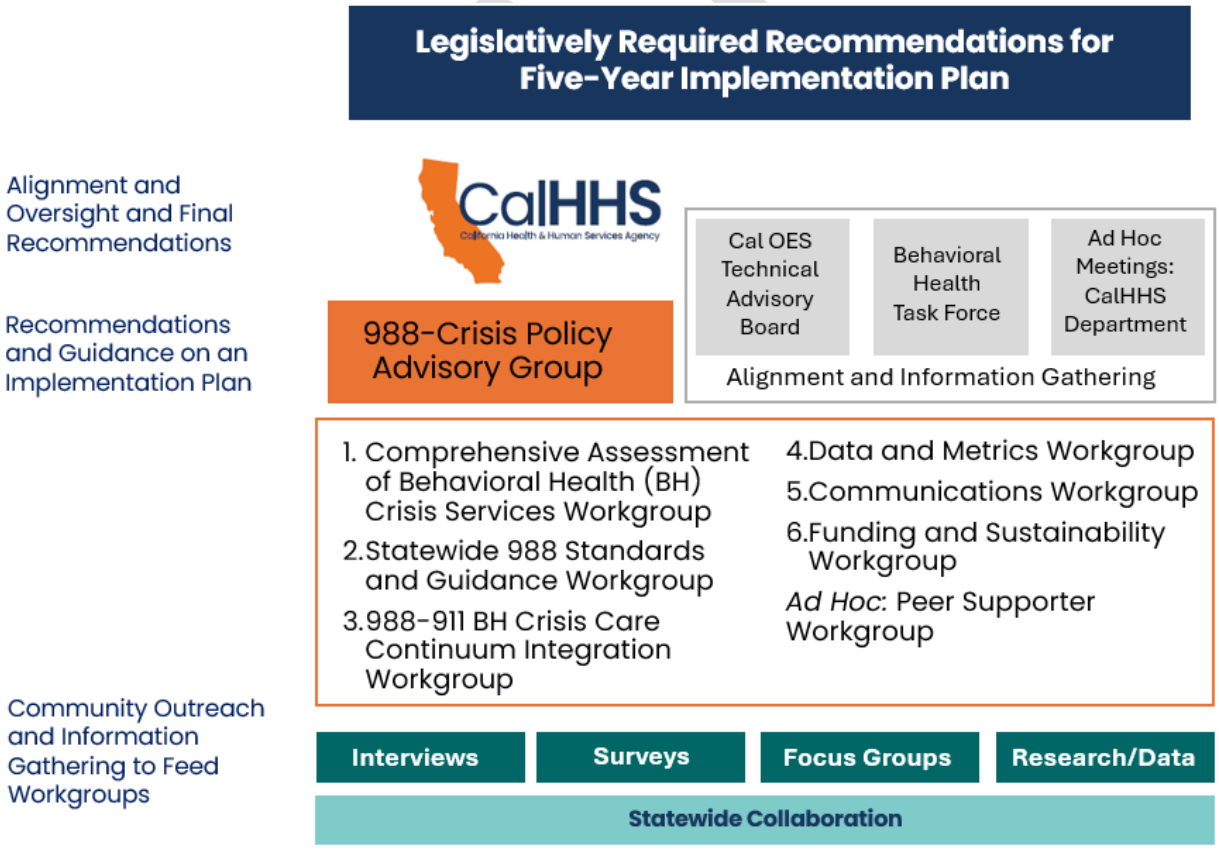
- Investments in housing, including Behavioral Health Bridge Housing to support county and Tribal development of housing for individuals experiencing homelessness who have serious behavioral health conditions

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

The advancements and investments 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 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 988-Crisis Policy Advisory Group (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. 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.[33] These Workgroups, totaling 140 members, are:

- Comprehensive Assessment of Behavioral Health (BH) Crisis Services
- Statewide 988 Standards and Guidance
- 988-911 BH Crisis Care Continuum Integration
- Communications
- Data and Metrics
- Funding and Sustainability
- Peer Supporter (Ad Hoc)

Workgroups met in a virtual format two to four times each to gather and discuss information relevant to the Workgroup's charge and to draft recommendations for PAG consideration. Each Workgroup was co-chaired by two 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, [34] 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. 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 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), Department of Managed Health Care (DMHC), 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 Five-Year Implementation 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 Children and Youth Behavioral Health Initiative (CYBHI), and from the Behavioral Health Task Force (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: 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 those counties' 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 provider of 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 Five-Year Implementation Plan. Focus group participants, totaling 90, included:

- Individuals with co-occurring disorders
- 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 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 the 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 the focus groups are integrated throughout this Plan and outlined further in the *Community Engagement Report.*

Engagement By the Numbers

Six (6) public 988-Crisis PAG Meetings (43 members)

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

Thirteen (13) 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

Comprehensive Assessment

The development of recommendations was informed by, per AB 988, "[f]indings from a comprehensive assessment of the behavioral health crisis services system that takes into account infrastructure projects that are planned and funded." 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 discussion with interested parties).[35] Additional details can be found in the AB 988 Chart Book.

The assessment revealed gaps in California's behavioral health crisis care continuum. Findings most relevant to implementing a comprehensive 988 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 need tailored services in order to equitably access behavioral health 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[36]

Select Data Points on California's Crisis Care Continuum Today

Numerous state and local warmlines are available as are new digital tools and resources for individuals and families

12 California-based 988 Crisis Centers across the state, with 1100+staff (the majority of whom are paid staff, a shift from previous staffing with volunteers)

Medi-Cal mobile crisis benefit implemented as of September 2024 in 45 counties, covering 97% of Medi-Cal members, with corresponding dispatch centers

CCMU grant funded/enhanced 403 mobile crisis teams (MCTs)

92 CSUs in 33 of the 58 counties

289 licensed Social Rehabilitation Programs in 35 of 58 counties

33 Mental Health Rehab Centers

10 Peer Respites

24 Sobering Centers

536 Hospitals, including 40 acute psychiatric hospitals, 7 chemical dependency hospitals, and 33 psychiatric health facilities

See the AB 988 Chart Book for additional information.

Findings also align with a May 2023 report from DHCS entitled, *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications*.[37] 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.[38]

Notably, findings from the CCC-P and DHCS's assessment were conducted prior to national 988 designation and the expansion of mobile crisis services reimbursement, both of which require greater connection and coordination within and around behavioral health crisis systems.

Organization of the Five-Year Implementation Plan

Developing a comprehensive 988 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 system:

1. All Californians, regardless of insurance coverage, location, or other factors (including but not limited to age, race, ethnicity, gender identity, 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, and the strategic priorities identified in the CCC-P.

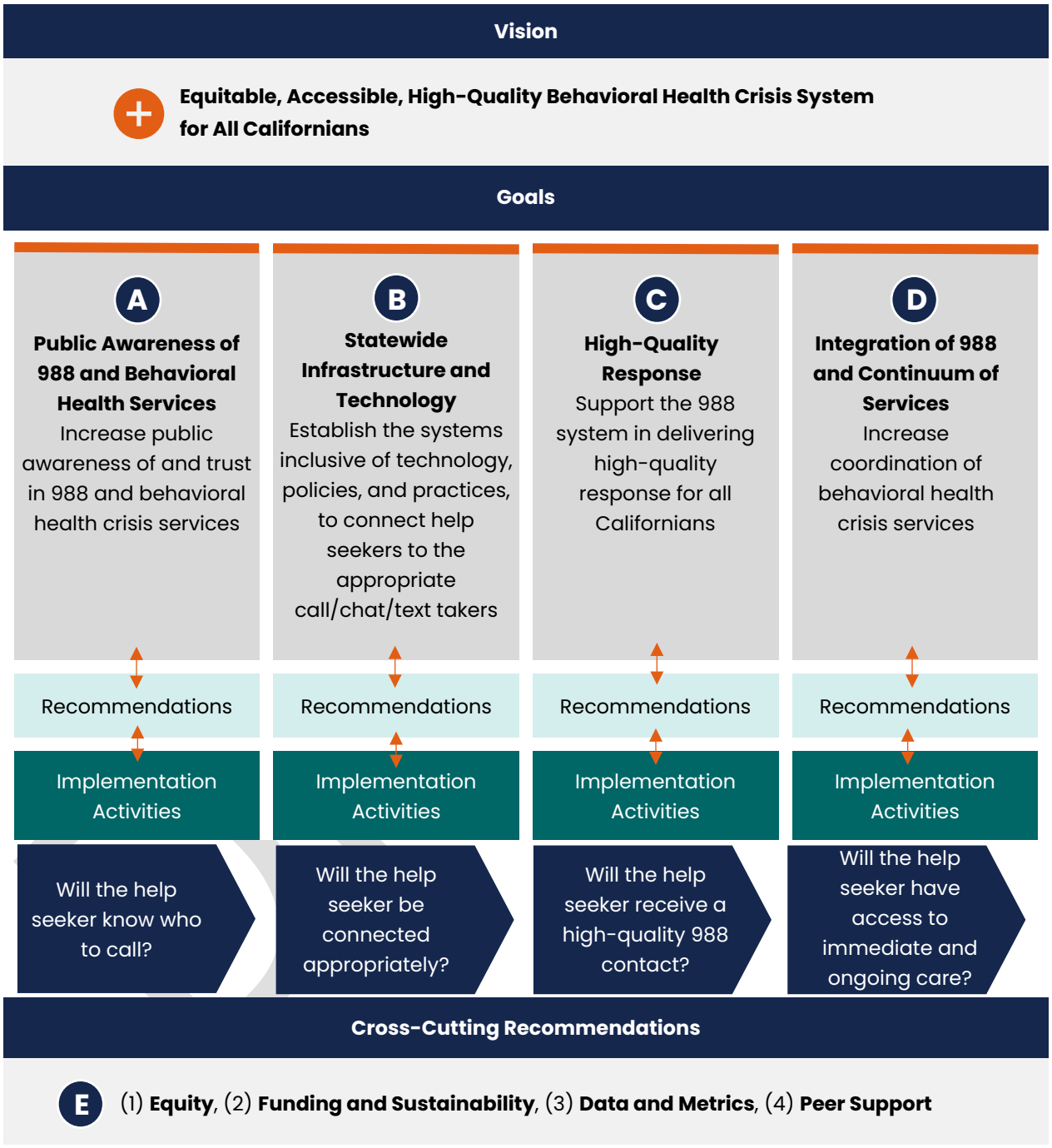
As shown in Figure 3, the Plan organizes the 14 required areas in AB 988 into four interdependent goals (A, B, C, D) and four recommendations (E) that cut across all the goals. The recommendations are broad "should" statements proposed by the PAG and centered around the opportunity of 988 to improve the crisis care continuum. The implementation activities represent what the state, given its structure and discussion among core departments and implementation partners, have identified as 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.

- 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, to guide state action relevant to AB 988 and the crisis care continuum
- Under each recommendation is a list of **Implementation Activities** that describes how the state, given its structure and discussion among core departments and implementation partners, would operationalize the recommendations (assuming the necessary resources, staffing, and approval processes for 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, Public Safety Answering Points (PSAPs), Local Emergency Medical Services Authorities (LEMSAs)and community-based organizations (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 in order to address the needs of specific populations; agency and/or department equity offices will also be engaged as appropriate.)*
- **Timing of implementation** is listed in the tables by state fiscal year (SFY), 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 (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 five-year implementation timeline (beginning July 1, 2025). Flexibility is critical given changes in the landscape, including emerging federal guidance on 988, other state and local BH initiatives, and existing staffing and resources. Activity periods are designated in the Plan with the following:

Implementation Activity	No 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 a Five-Year Implementation Plan

Implementation Plan Overview

The Five-year Implementation Plan includes 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.** The state should coordinate state 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.** The state should 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.** The state should 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.** The technology should be in place to route 988 contacts safely and efficiently anywhere in California, including to mobile crisis dispatch. **B.2** The state should coordinate 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.** The state should 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, the state should 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.** The state should have 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.** The state should 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.** The state should support connection, coordination, and referrals of 988 help seekers to timely and effective community-based, culturally competent crisis response, including mobile crisis dispatch when appropriate. **D.3.** The state should continue to assist communities in expanding the range of facilities and services to individuals before, during, and after a behavioral health crisis. **D.4.** The state should develop more options or expand existing options for transporting individuals in crisis to a safe place to be.

CROSS-CUTTING RECOMMENDATIONS

E1. Equity: The state should 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 need adaptive/tailored services for equitable access due to physical, intellectual/developmental disability, or unique cultural and/or linguistic needs.

E2. Funding and Sustainability: The state should 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.

E3. Data and Metrics: T The state should establish data systems and data standards to support monitoring of 988 and the behavioral health crisis care continuum's performance.

E4. Peer Support: Peer support should be integrated across the crisis care continuum to support person-centered, culturally responsive, and recovery-oriented care.

Implementation 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): 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.[39] 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.[40]

Public awareness of available services is one key factor that influences access to behavioral health. For 988, 56 percent of Californian adults polled (n=1.671 adult) in a statewide survey conducted in September 2023 said they knew "nothing at all" about 988,[41] a level of awareness similar to national polling.[42] [43] 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.[44] One cross-sectional study found that use and awareness of the 988 Suicide & Crisis Lifeline was significantly higher among adults with serious and moderate psychological distress.[45]

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

Younger California adults (ages 18-34) in the September 2023 poll 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.[46] 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.[47] 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.[48]

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 findings from the focus groups with 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.[49] 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.[50]

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 Asian American and Pacific Islander (AAPI) respondents were less likely to trust 988 (and 911) than White respondents. For instance, a NAMI/Ipsos poll conducted in June 2024 found that "total trust" in 988 among Whites was 83% as compared to 80% among Black/African American, 80% for Latino/Latina/Hispanic and 77% among AAPI populations.[51] Some of the reasons for this mistrust, as expressed in both focus groups in this process 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.[52] 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 competent but that were 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.[53]

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, including what could happen. They also encouraged developing and 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 & 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.[54] Focus group participants from historically marginalized communities were particularly concerned about police 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 implementation activities to enhance public awareness of 988.

Recommendations

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

The California Department of Public Health (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 campaigns on preventing youth suicide and ending the opioid crisis. The Department of Health Care Services (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 strategies for the successful implementation and increased utilization of 988 in California.

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

Focus group participants emphasized communications strategies that reach people where they are and that leverage trusted messengers to build greater awareness of and trust in 988. PAG and community members 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 substance use disorder (SUD) and co-occurring SMI/severe SUD disorders, in particular. 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 communication strategies in a culturally competent manner that considers the linguistic and cultural needs of different communities (see also Equity, recommendation E1).

#	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	●	●	○	○
A.1.b.	Identify audiences for 988 communications strategies[55] 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 benefit or need 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. The state should 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 the state's communications campaign. 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. For example, 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 recommended 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 and county 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. This will involve the development of guidance, best practices, and toolkits that can be tailored to different audiences and community needs, services, and resources.

Focus group participants also recommended utilizing storytelling and testimonials in communications. They felt that stories from individuals who have experienced crises would resonate most with them and build empathy and understanding in the community.

#	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 communication 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 development of tailored public health messages (translated appropriately and accessible in California's threshold languages) and dissemination strategies[56]	CDPH	DHCS, 988 Crisis Centers, Tribal/CBO Partners	●	●	●	●
A.2.c	Engage community-based organizations (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/ Trbal BH, Tribal/CBO Partners	●	●	●	●

3. The state should 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 E3). 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, and adjusting communications as appropriate. 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): Maintenance of an active agreement with the administrator of the National Suicide Prevention Lifeline for participation within the network.

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

AB 988 Required Area (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): 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 large and complex undertaking. When the United States transitioned from the 10-digit National Suicide and Prevention Lifeline 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.[57] 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.[58] 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.[59]

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), 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.[60]

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[61]

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.[62, 63] Annually, more than twenty-five million calls are made to 9-1-1 in California.[64] 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 998 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.[65]

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 will 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. As 988 matures, new opportunities are presented for increasing coordination and interoperability between systems to link help seekers to services. As the RAND Corporation

notes from their recent study, interoperability between 988 and 911 requires more than the existence of a technology platform and associated transfer criteria; it will require concrete guidance, cross-training opportunities, building trust among call-takers, and leveraging champions.[66] Interoperability has been a core focus already by Cal OES and the California 988 TAB.[67]

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

Recommendations

1. The technology should be in place 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 groups 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. PAG and Workgroup members as well as individuals interviewed also suggested technical approaches to help connect help seekers to resources (e.g., resource directories).

   NATIVE FOCUS GROUP PARTICIPANT

   "A non-native person might not understand, and we would want to talk to someone with experience."

   Participants in the Native American focus groups, organized by Kauffman and Associates, also expressed a desire for mechanisms to connect Native American help seekers to Native American counselors and services, an idea which was also expressed in 2023 Tribal Summits.[68] 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).

#	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	●	●	●	●
B.1.b.	Explore the development of a dedicated Native American line/dial pad option	CalHHS	Cal OES, DHCS, Tribal/CBO Partners	●	○	○	○
B.1.c.	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.d.	Make upgrades to the state technology platform (e.g., geo-routing,[69] etc.) consistent with community input and technological innovations	Cal OES CalHHS	DHCS, 988 Crisis Centers, County/ Tribal BH, PSAPs, Tribal/CBO Partners	●	●	●	●

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

Not all 9-1-1 public safety answer points (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." 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[70]

In addition, state-mandated 24/7 county access and crisis lines connect help seekers to SUD and/or mental health crisis intervention services. County and Tribal lines can assess callers' needs, provide access to resources, coordinate emergency responses, and may include dispatch of mobile crisis teams. Some counties directly manage their lines; other counties contract out management to 988 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 to provide 24/7 state-level phone-based response and county-level in-home, in-person mobile response during situations of instability. Cal-FURS offers immediate, 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.[71] (Integration of community response models like Cal-FURS are discussed further in Goal D.)

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 would 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

#	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.	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.c.	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): 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): 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.[72] These services align with national standards, which require 988 Crisis Centers to provide:

- Safety/risk assessment
- Safety planning
- De-escalation
- Connection to active rescue and support, when necessary[73]

Today, suicide and crisis lifelines are important tools to prevent suicide and mental health crisis and to provide pathways to well-being. Studies have shown that 98 percent of 988 calls are resolved over the phone, and that most 988 callers report feeling less depressed or suicidal after calling.[74, 75] 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 referrals.[76]

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. Broadening the scope of 988 Crisis Centers to address a wider range of behavioral health challenges would align with feedback

offered in Workgroup discussions and in focus groups the included individuals with lived experience. Many focus group participants had experienced both mental health and substance-use-related crises and shared that they 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 greatly 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. While the vast majority of contacts made to California's 988 Crisis Centers today are not reported as substance use related, many of the Centers do report receiving them. As of July 2024, out of 37,000 answered contacts by California 988 Crisis Centers, 1,913 were reported as substance-related or 5.2 percent (Note: monthly data reporting varies).[77]

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

Recommendations

1. The state should 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 key performance indicators set by national standards.

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

#	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	●	●	●	●
C.1.e.	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[78]	CalHHS,	DHCS, Cal OES 988 Crisis Centers,	●	●	○	○

2. Building on national standards and best practices to ensure trauma-informed, person-centered, and culturally responsive care, the state should 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 & 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 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.

PAG and Workgroups suggested that minimum staffing and training standards should also be developed in the future to ensure 988 Crisis Centers and crisis counselors possess the awareness, cultural competence, screening, and triaging skills to address a range of behavioral health needs, including substance use challenges and intellectual/ developmental disorders. Incorporation of SAMHSA harm reduction models was also raised as a critical for individuals working in the 988 system.[79] This aligns with feedback captured through the lived experience focus group participants who highlighted the need for empathetic, culturally responsive, and trauma-informed services.

"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

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 SAMSHA and its contracted national administrator, where possible and appropriate, and be developed based on 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 minimum

standards that build in culturally competent, trauma-informed, harm reduction approaches to care. Specialized trainings were also suggested to meet the needs of a number of different 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.

#	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 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	●	●	●	●
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 and cultural competence	DHCS	EMSA, 988 Crisis Centers	●	●	●	○

#	Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
C.2.e.	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. The state should have a process to review, designate and re-designate California 988 Crisis Centers.

California is a large and diverse state with complex population needs. The PAG recommends that 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.

#	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	●	●	●	●

#	Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
C.3.c.	Develop a process to continually assess 988 Crisis Centers' performance as a part of the BH 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 BH 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): Access to crisis stabilization services and triage and response to warm handoffs from 9-1-1 and 988 call centers.

AB 988AB 988 Required Area (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, California Advancing and Innovating Medi-Cal (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.

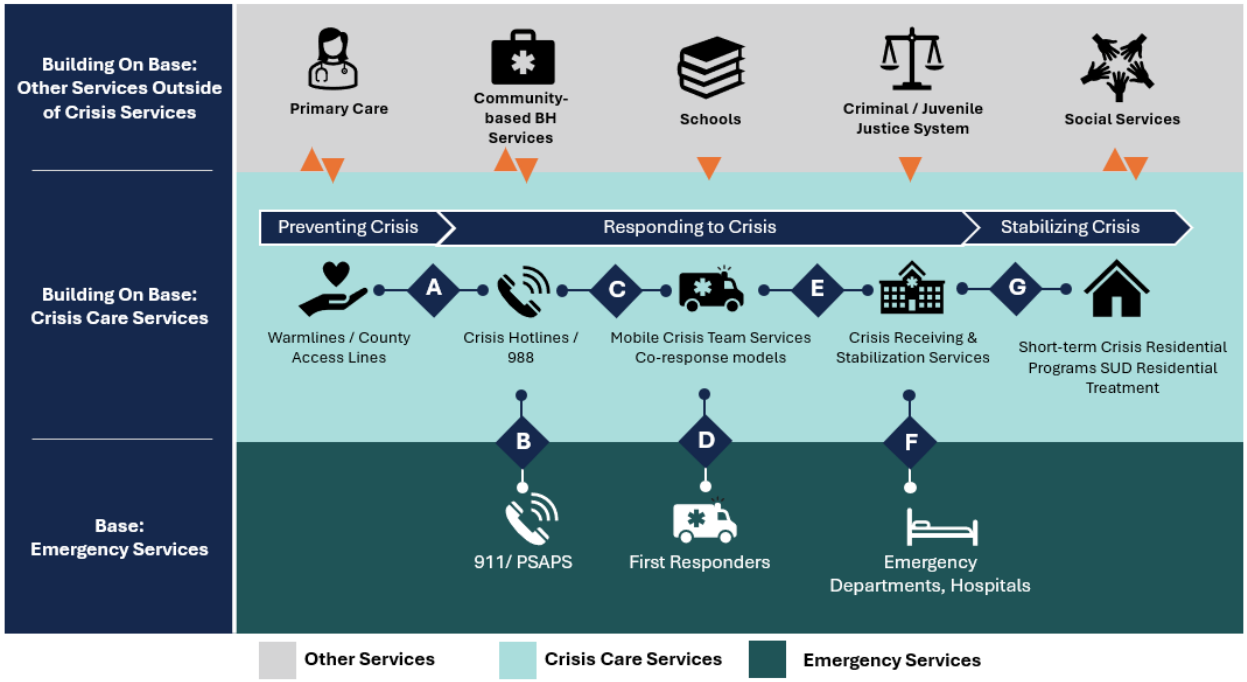
Properly connected and coordinated crisis services can offer timely services in the least restrictive setting, reduce unnecessary use of emergency departments and hospitals, and reduce unnecessary law enforcement involvement in mental health and substance use crises. System coordination can also help 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

Reducing unnecessary law enforcement involvement and the use of emergency departments and hospitals were key topics discussed in the lived experience focus groups. 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



988 services today are not fully connected to the broader behavioral health crisis care delivery system. Several counties do not have formal relationships with the 988 Crisis Centers that receive calls from help seekers in their respective counties. 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.[80]

The state has already invested significant resources into mobile crisis. The BHCIP program, for example, awarded $202 million to 78 behavioral health authorities and Tribal entities since the first round of funding in October 2022 to create or enhance 403 CCMUs.[81] 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.

"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, Centers for Medicare & Medicaid Services (CMS) formally approved California's mobile crisis services as a Medi-Cal benefit.[82] This benefit went live in January 2024 and is helping to ensure 24/7 mobile crisis service access for Medi-Cal members.[83] As of September 2024, 45 counties had been approved to provide services under the benefit, covering 97 percent of Medi-Cal members.[84] 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.

The state also has invested in crisis receiving and stabilization facilities/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.[85] These investments will continue to open 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.[86] In addition, Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (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.[87] BH-CONNECT will further help in a state bed tracking pilot program to track behavioral health facilities and general acute care hospital beds.

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

Recommendations

1. The state should 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, or others. 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.

Coordination should include guidance at the initial point of contact with a help seeker regarding the appropriate response and when additional support from EMS or other first responders might be appropriate.

#	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 BH, Tribal behavioral health, Emergency Medical Services (EMS) and others	CalHHS, Cal OES	DHCS, EMSA, PSAPS, Local EMS providers, County/ Tribal BH, 988 Crisis Centers	●	●	○	○

#	Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
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 [88] (see B.1.d.)	Cal OES, DHCS	EMSA, 988 Crisis Centers, County/ Tribal BH	●	●	●	●
D.1.c.	Align coordination efforts with technology solutions (*See Goal Area B1*)	Cal OES, CalHHS	988 Crisis Centers, County/Tribal BH, Mobile Providers, PSAPs	●	●	●	●

2. The state should support connection, coordination, and referrals of 988 help seekers to timely and effective community-based, culturally competent 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 $202 million award to county, city, or Tribal entity behavioral health authorities. It has further supported counties in standing up CMS-approved mobile crisis services as a Medi-Cal benefit. 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.[89] Other community-based responses, sometimes funded at the local level, are also operating throughout California.[90] 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.

Focus group participants were aligned in their view that crisis response is best conducted by someone with lived experience and/or with specialized training, rather than law enforcement. This is consistent with the community-based crisis response investments being made by the state.

"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 call is key to the development of a comprehensive 988-crisis system. CalHHS recommends further assessment of gaps in 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

#	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	○	●	●	○

#	Implementation Activities	State Lead(s)	Implementation Partners	Year 1	Year 2	Years 3-4	Years 5+
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. The state should 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).[91]

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 recognizes the need for more treatment facilities and programs. A 2021 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.[92] RAND has also cited bed shortages (acute, sub-acute and community residential) for children and youth in several related studies.[93] 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

PAG members encouraged ongoing investments in peer respite services, sobering centers, and additional crisis residential treatment facilities (particularly for children and youth with significant mental health and substance use disorders). Focus group participants also expressed the need for such services. 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.[94]

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 Five-Year Implementation 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

#	Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
D.3.a.	Coordinate efforts to inventory BH 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	○	○	●	○

#	Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
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 E2)	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. The state should 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 ED after screening by the Community Paramedic.[95]

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 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.[96]

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 identified by the PAG as well as related implementation activities are relevant to the aims of AB 988. They also seek to build on some of the state's broader efforts that are focused on behavioral health transformation. Where applicable, the related required AB 988 areas are included in the description.

E1. Equity

The state should 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 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 identity, 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 and in Workgroup and PAG discussions. Population-level disparities

among some groups and communities were further highlighted in the Comprehensive Assessment as a critical gap in the crisis system.[97] 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 benefit or need particular accommodations.

Discussions in the PAG and Workgroups highlighted many of the challenges to and opportunities for enhancing equity within the crisis care continuum. The state plans to embrace principles of targeted universalism in its approach to equity, recognizing that universal goals established for all groups are pursued through targeted processes and approaches.[98] Notably, feedback shared in the Policy Advisory Group, Workgroups, focus groups and by the community on the need to address equity and access through targeted approaches was consistent across populations and communities.

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. Across the state, Californians speak 220+ languages, and more than 44% of residents speak a language other than English at home (most commonly, Spanish).

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

- 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 (e.g., American Sign Language, languages other than English)
- Older adults
- System-impacted youth
- Individuals who are Black/African American, Latino/Latina/Hispanic, and Asian American/Pacific Islander (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 988 PAG/Workgroups and through the Comprehensive Assessment. These include the following additions:

- Justice-impacted youths
- Reentering justice-involved populations
- 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 duty to veteran status
- Undocumented individuals
- Perinatal populations
- Individuals who use drugs

As part of the planning process, a community engagement process was organized to uplift some initial findings and inform the PAG's recommendations for ensuring an equitable 988 behavioral health system. While that process included information gathering from many of the populations of focus and communities outlined above, the PAG and the state recognize that ongoing engagement will be critical to advance many of the recommendations and implementation activities described in the Plan.

Below are initial findings, drawn from the Community Engagement Report, as well as Workgroup and the PAG discussion. These findings and related implementation activities are embedded across each of the Plan's goals areas.

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

Transparency, cultural competency, 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. PAG and Workgroup members 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 center that contains marketing tools for promoting 988.[99] 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 increase utilization among different populations in California. 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.[100]

Seek to lower barriers to accessing 988 and other BH services across the crisis care continuum (Goal B: Statewide Infrastructure and Technology; 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 identity, sexual orientation) should have timely access to quality crisis care.

Doing so will require helping to lower barriers to access across different populations of focus whose access might be limited. The PAG and Workgroups began to explore access challenges for some, but not all populations that faces such barriers, as described below:

- Rural communities in California and throughout the nation have higher rates of suicide and depression compared with more urban communities.[101] While there are myriad reasons why these rates may be higher, one reason is access to care.[102] 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.

Less is known about levels of awareness and utilization of 988 in rural communities but it – and other telephonic options –may serve as 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.[103]

> "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.[104] The highest rates of death by suicide in California are males aged 85 years and older (46.1 per 100,000).[105] 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 CalHOPE warmline, and ensuring older adults have access to housing and related supports.[106]
- Youth, particularly young people who are Black/African American, have higher rates of depression and higher rates of suicide compared to other youth.[107] 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 received age specific, person-centered and culturally competent services.
- Many cultural, ethnic, and linguistic groups — Native American, Black/African American, Latino/Latina/Hispanic and Asian American/Pacific Islander 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 build trust among historically marginalized communities focused on ensuring that 988 and related crisis services are culturally and linguistically appropriate 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 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

The national 988 network offers translation services in more than 240 languages. It also offers a Spanish subnetwork with a dedicated dial pad, text, and chat option for individuals whose preferred language is Spanish.[108] For d/Deaf and Hard of Hearing populations, 988 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. In addition, several CA 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 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 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 standards that were responsive to California's diverse cultural and linguistic needs, including cultural competence trainings, along with implicit bias trainings, across the 988 and crisis care continuum. These trainings should cover topics including appropriate terminology, historical and racial trauma, and trauma-informed care. The Peer Supporter Workgroup further highlighted the critical importance of employing people from the communities they serve as a core strategy.

"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. Although the need for all marginalized communities to receive specialized care and services is great, 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.[109] According to the Centers for Disease Control and Prevention, it is now well understood that "AI/AN communities experience an elevated suicide rate" and that most of these communities "…lack access to suicide prevention programs that meet their cultural needs."[110]
- *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…"[111] 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."[112]
- *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. Additionally, disparities between Medi-Cal and commercial insurance coverage exacerbate inequities in service access. 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.

The following table highlights how these findings have been embedded as specific implementation activities elsewhere in the Plan.

#	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 using principles of targeted universalism[113] 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 benefit or need accommodations	CDPH	DHCS, 988 Crisis Centers, Tribal/CBO Partners. County/Tribal BH	●	●	●	●

#	Implementation Activities	State Lead(s)	Implement-ation Partners	Year 1	Year 2	Years 3-4	Years 5+
A.2.b.	Engage populations of focus as well as those with lived experience to support development of tailored public health messages (translated appropriately and accessible in California's threshold languages) and dissemination strategies[114]	CDPH	DHCS, 988 Crisis Centers, Tribal/CBO Partners	●	●	●	●
A.2.c.	Engage community-based organizations (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/ Trbal BH, Tribal/CBO Partners	●	●	●	●
B.1.b.	Explore the development of a dedicated Native American line/dial pad option	CalHHS	Cal OES, DHCS, Tribal/CBO Partners	●	○	○	○
C.1.e.	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[115]	CalHHS,	DHCS, Cal OES 988 Crisis Centers,	●	●	○	○
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 and cultural competence	DHCS	EMSA, 988 Crisis Centers	●	●	●	○
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, DMH	○	○	●	○

E2. Funding and Sustainability

The state should 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): 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): 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.[116] 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 work is needed to develop a transparent funding process, including a clear process through which mobile crisis teams can access funding.

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.[117]

Several laws and subsequent implementation guidance issued by the California Department of Managed Health Care and the California Department of Insurance[118] govern reimbursement of behavioral health services in California for health plans and insurers licensed by the California Department of Insurance and the Department of Managed Health Care. A landmark piece of legislation, SB 855, requires health plans that cover hospital, medical, or surgical care to also provide coverage for of medically necessary mental health or substance use disorder (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 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.[119]

Additional efforts are needed to put this legislation into practice. The state needs to do more to ensure that counties and providers can bill commercial insurance for BH crisis services and

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.

#	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 BH 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	●	●	●	●
E2.e.	Develop and disseminate clear information about funding procedures for 988 Crisis Centers, the process for determining the 988 surcharge fee and he 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	●	●	●	○

E3. Data and Metrics

The state should 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): 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): 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."[120] This recognition of data as an enabling factor in supporting a person-centered approach to service delivery was central to the development of the Five-Year Implementation 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.[121] 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 speak to levels of effort (the quantity and the quality of the work done) and the third to 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.[122] 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 to be considered may include reasons for referrals and consumer /third party satisfaction rates.

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, state leads, and policymakers during implementation. The dashboard should also include user experience data. 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, 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 the crisis system influencing behavioral health outcomes. 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.

#	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, CalOES, 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, and percentage of calls resolved without 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.	Determine population level outcome measures and quantifiable goals to support assessment of the broader crisis care continuum	CalHHS CDPH Cal OES	DHCS, DMHC, EMSA	○	○	●	●

E4. Peer Support

Peer support should be integrated 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.[123] 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. 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.[124]

"If you haven't been through what I've been through, how can you help me through?" – Focus Group Participant

#	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	CalOES, 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): A state governance structure to support the implementation and administration of behavioral health crisis services accessed through 988.

Process

AB 988 requires the California Health and Human Services Agency (CalHHS) to recommend "a state governance structure to support the implementation and administration of behavioral health crisis services accessed through 988."[125] A robust governance structure with clearly defined roles and responsibilities is necessary to ensure ownership and accountability and to successfully execute the state's five-year implementation plan for a comprehensive 988 crisis system. 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 is as follows.

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

- CalHHS
- California Office of Emergency Services (Cal OES)
- California Department of Health Care Services (DHCS)
- California Department of Public Health (CDPH)
- California Department of Managed Health Care (DMHC)
- California Department of Insurance (CDI)

Second: As work progressed, the California Emergency Medical Services Authority (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 CalHHS Crisis Care Continuum Plan (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 988-Crisis Policy Advisory Group.

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**.

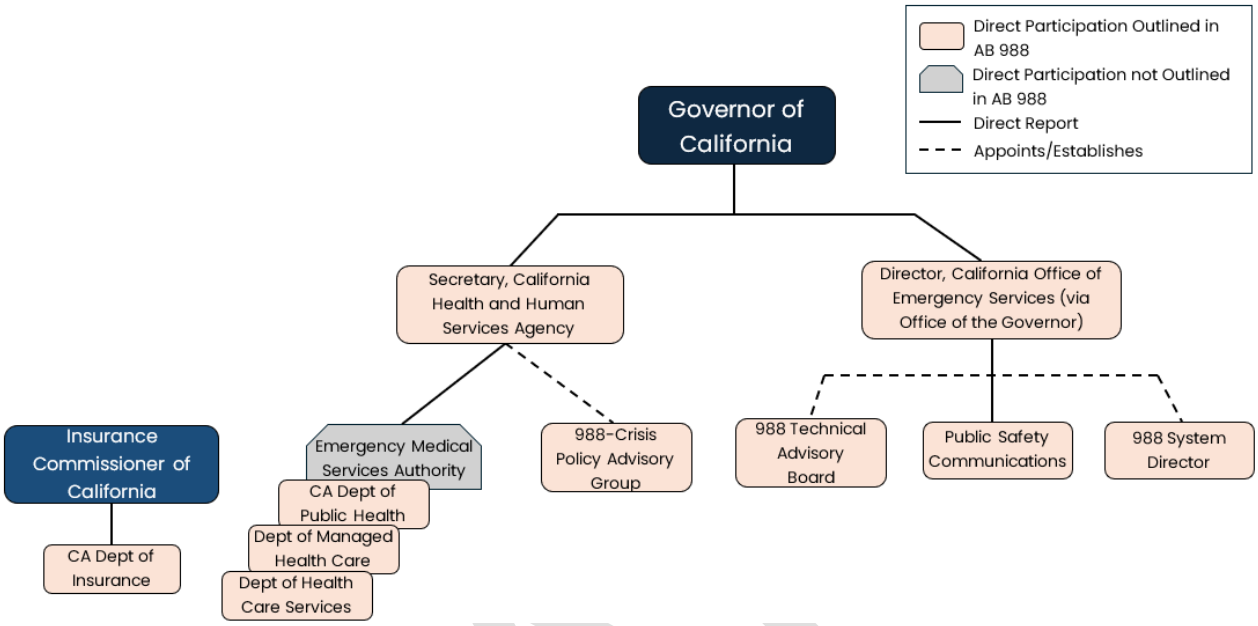
Governance Structure Overview

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 five-year plan.

CalHHS and Cal OES both are required to establish advisory boards—the CalHHS 988-Crisis Policy Advisory Group and the Cal OES 988 Technical Advisory Board (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 988-Crisis Policy Advisory Group to advise on the creation of the five-year implementation plan for a comprehensive 988 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.
- 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 recommendation goal D, recommendation B.1, and implementation activity E.2.f).
- Connect the five-year implementation 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 substance use disorder 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 implementation activity C.2.e)
  - Oversee 988 crisis counselor training, including clinical protocols and triage for behavioral health services (see implementation activity C.2.d)
  - Oversee the behavioral health aspects of clinical quality assurance of 988 Crisis Centers (see implementation activity C.2.e and C.3.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.d)

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, 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 activity C.2.d)
  - Oversee the medical aspects of clinical quality assurance of 988 Crisis Centers (see implementation activity C.2.e).

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).

[2] See glossary for definition.

- 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 Public Safety Answering Points (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 (see implementation activities B.1.c through B.1.e, B.2.b, B.2.c, D.1.c, D.2.d, and D.2.e)
  - The development of technical and operational standards for the 988 system that allow for coordination with California's 9-1-1 system (see implementation activities B.1.c and B.2.b)
  - The creation of standards and protocols for when 988 Crisis Centers will transfer 988 calls into the "9-1-1" PSAPs, and vice versa (see implementation activity B.2.b).
- 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 recommendation B.1 and implementation activity B.2.b)

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 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, 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 implementation activities C.2.d and C.2.e)

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 implementation activity A.1.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 recommendations A.1 and A.2)

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[126] as a state guidance document (see implementation activity B.2.b)

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 recommendations B.1 and B.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

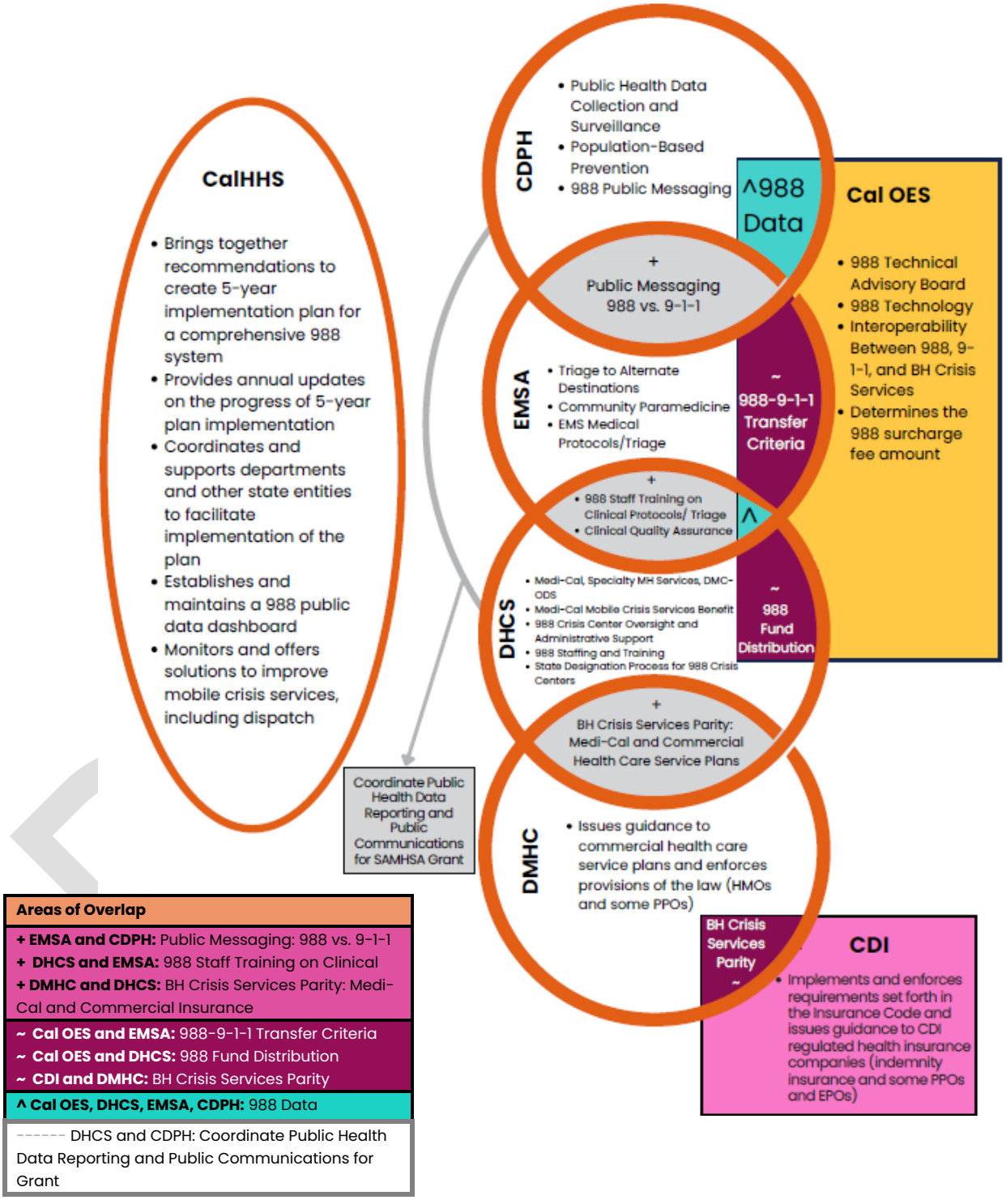


Figure 7 outlines the state entities' 988-related responsibilities with federal partners, including the Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), Federal Communications Commission (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 National Suicide Prevention Lifeline.
- 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.

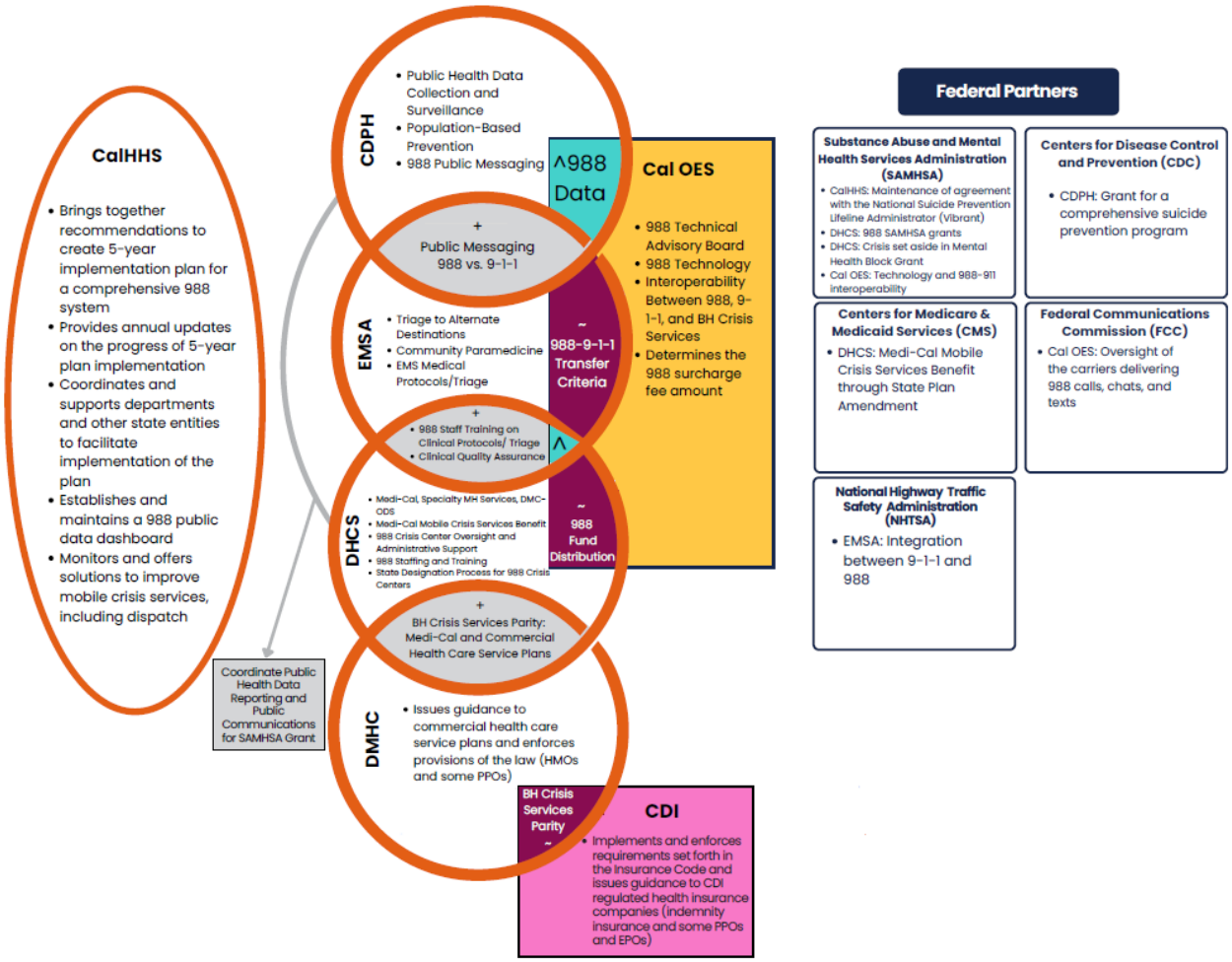
FCC

- 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 five-year 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 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 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. 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

Once approved, and 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/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.** Both DHCS and DMHC oversee health care coverage in California. DHCS administers Medi-Cal, including both non-specialty and specialty mental health services, while DMHC regulates commercial health plans operating in the state. Numerous implementation partners are also involved, including County Behavioral Health, community-based organizations, providers, associations, and others. It is essential for CalHHS to coordinate with these departments and implementation partners to maximize Medi-Cal and commercial health plan reimbursement for behavioral health crisis services, with the goal of achieving parity in behavioral health crisis care and sustainable funding for crisis services.

Accountability/Transparency

CalHHS should provide accountability so that all systems and entities responsible for the care of individuals who are in crisis are delivering 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 CalOES, 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.

Community Engagement

Achieving accountability requires community engagement with Californians most impacted by the behavioral health crisis care system and those who experience the deepest inequities. Ongoing community engagement is important to improve public awareness of and to build trust in 988 services. CalHHS recognizes that more community engagement is needed to successfully implement the Plan, many of which are laid out in the Plan's implementation activities.

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

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 are still navigating a complex behavioral health landscape, which can make integrating 988 services into the broader crisis care continuum challenging.

Several key issues remain unresolved at the state level and would 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 a toolkit by the end of 2024 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 release a toolkit 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.

Like other states, California faces similar challenges and acknowledges that addressing them will require time and coordination. The Plan outlines recommendations to address these obstacles and sets ambitious goals for achieving a comprehensive 988 system in the state. To make this vision a reality, it is essential that state agencies and departments have the authority and resources necessary to fulfill the roles and responsibilities outlined in AB 988 and the Plan.

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 CalHHS Behavioral Health Crisis Care Continuum Plan (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 implementation activities to support the CCC-P's vision and AB 988's goal of creating a comprehensive 988 system in California. It also aligns with the Governor's mission to transform California's mental health and substance use disorder 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 the most significant 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: 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.

(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

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:

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
AI/AN	American Indian /Alaska Native
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 ERQO	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 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
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
COD	Co-Occurring Disorders
CP	Community Paramedicine
CSAC	California State Association of Counties
CSU	Crisis Stabilization Unit
CYBHI	Children and Youth Behavioral Health Initiative

Abbreviation	Definition
DDS	California Department of Social 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 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	988-Crisis Policy Advisory Group
PSAP	Public Safety Answering Point
PSS	Peer Support Specialist
RBA	Results Based Accountability
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbances

Abbreviation	Definition
SFY	State Fiscal Year
SMHS	Specialty Mental Health Services
SMI	Severe Mental Illness
SUD	Substance Use Disorder
TAB	State 988 Technical Advisory Board (Organized by Cal OES)
TAD	Triage to Alternate Destinations

Glossary of Terms

TERM	DEFINITION(S)	SOURCE
Abandonment	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 competent 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.	California Department of Public Health
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 substance use disorders	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.	California Department of Health Care Services 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 substance use disorder 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.	Crisis Care Continuum Plan
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 Units (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)
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
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

TERM	DEFINITION(S)	SOURCE
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
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

TERM	DEFINITION(S)	SOURCE
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.	California Department of Social Services
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
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.	Harm reduction framework
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)

TERM	DEFINITION(S)	SOURCE
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
Interoperability	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
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.	California Department of Health Care Services
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

TERM	DEFINITION(S)	SOURCE
Mental Health Parity (SB855)	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.	SB855
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.	California Department of Health Care Services
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.	BHCCCP *Definitions for crisis services* (Page 79-81)

TERM	DEFINITION(S)	SOURCE
National Suicide Prevention Lifeline (NSPL) or 988 Suicide & Crisis Lifeline	The National Suicide Prevention Lifeline or 988 Suicide & 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)
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 individual 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

TERM	DEFINITION(S)	SOURCE
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)
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 Asian American/Pacific Islander (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

TERM	DEFINITION(S)	SOURCE
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) CDC Health Communications Playbook CDC National Prevention Information Network Health Communication Strategies and Resources
Public Health Messaging	A component of a larger communication 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.	-

TERM	DEFINITION(S)	SOURCE
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)
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 Department of Social Services; however, DHCS is responsible for the oversight of the mental health program approval. Although DHCS has oversight f or the mental health program approval, some counties have been delegated the authority to issue a mental health program approval to STRTPs within their borders.	California Department of Health Care Services
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)

TERM	DEFINITION(S)	SOURCE
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 the Department of Public Health 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.	California Department of Health Care Services
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 the Centers for Medicare & Medicaid Services 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).	California Department of Health Care Services
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

TERM	DEFINITION(S)	SOURCE
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)
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

TERM	DEFINITION(S)	SOURCE
988 Center or 988 Crisis Center	988 centers operate on a county or regional basis in California and participate in the National Suicide Prevention 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, *Steinburg Institute*

Tasnim Khan, Western Health Advantage

Taun Hall, *The Miles Hall Foundation*

Uma Zykofsky, California Behavioral Health Planning Council (CBHPC)

An asterisk (*) signifies a workgroup lead; *italics* indicates a PAG Member
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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 (CalOES)*

Casey Heinzen, Department of Health Care Services (HCS)

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*, Steinburg 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 (CHCS)

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 Office of Emergency Services (CalOES)

***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, *Steinburg 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, UCDS Mobile Crisis

Blanca Gutierrez, Contra Costa Crisis Center

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

Casey Heinzen, Department of Health Care Services (HCS)

Curt Guillot, California Office of Emergency Services (CalOES)

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, *Steinburg 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, Children Now

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

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

Casey Heinzen, Department of Health Care Services (HCS)

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, *Steinburg 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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End Notes

[i] Some PAG members identified delegates to support meeting attendance; these individuals included: Budge Currier, California Governor's Office of Emergency Services (original 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] California Health and Human Services Agency, Behavioral Health Crisis Care Continuum Plan, May 2023

[3] Ibid, page 23

[4] 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"

[5] 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."

[6] Ibid, page 23

[7] Ibid, page 20

[8] Ibid, page 21

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, Department of Health Care Services Behavioral Health Task Force: Existing California Medicaid Policies, proposed Medi-Cal Mobile Crisis Benefit, CalHHS; Tribal Indian Behavioral Health added August 15, 2024

[9] Section 53123.4.(b)2 of the Government Code 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

[10] "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 Crisis Care Continuum Plan page 73; additional terms included in this Plan are included in the Glossary

[11] Behavioral Health Crisis Care Continuum Plan, May 2023

[12] Ibid, page 37

[13] BHTF Task Force Meeting; April 2024 988 Comp Assessment Workgroup Meeting

[14] Ibid, page 34

[15] Ibid, page 22

[16] 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 crisis lifeline centers in California; 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; 2023-24 May Revision: Department of Health Care Services Highlights, May 12, 2023

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

[18] 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

[19] Section 53123.3(a)3 of the Government Code: "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."

[20] Section 53123.3(b) of the Government Code

[21] This document refers to 988 Crisis Centers throughout to connote National Suicide Prevention Lifeline (NSPL) designated 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

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

[23] 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

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

[25] Ibid.

[26] California Health and Human Services Agency, A New Mindset: California's Behavioral Health Transformation, Slide 5, April 17, 2024

[27] CalHHS Website – Crisis Care Mobile Units Program Grant

[28] CalHHS Website – Behavioral Health Continuum Infrastructure Program

[29] BHCIP Infographic, accessed October 27. 2024

[30] Represents funding from the past five fiscal years (FYs 2020, 2021, 2022, 2023, and 2024) and exclusive of funding the Department of Health Care Services (DHCS); 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

[31] BHCIP Round 1 Data Dashboard, accessed October 10, 2024

[32] Behavioral Health Infrastructure Bond Act of 2024, accessed October 10, 2024
[33] 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
[34] Section 53123.3 (a) (3) of the Government Code: "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."
[35] Details from the comprehensive assessment are included in the *AB 988 Chart Book*: *An Inventory of Needs, Services and Gaps of the BH Crisis System*.
[36] California Health and Human Services Agency, Behavioral Health Crisis Care Continuum Plan, May 2023
[37] California Department of Health Care Services, Assessing the Continuum of Care for Behavioral Health Services in California Data, Stakeholder Perspectives, and Implications, January 10, 2022
[38] Ibid, page 39
[39] KFF, Unmet Needs for Counseling or Therapy Among Adults Reporting Symptoms of Anxiety and/or Depressive Disorder During the Covid-19 Pandemic, 2022
[40] CA DHCS, Assessing the Continuum of Care for Behavioral Health Services in California, January 10, 2022
[41] PPIC Statewide Survey: Californians and Their Government, September 2023
[42] 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
[43] 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
[44] PPIC Statewide Survey: Californians and Their Government, September 2023
[45] 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
[46] PPIC, Californians' Mental Health Varies across Key Groups, October 4, 2023

[47]Blue Shield of California/The Harris Poll, BlueSky Youth Mental Health Survey, June 2023
[48] California Legislative Information – Text of SB-972
[49] Milbank Memorial Fund, Fifty Years of Trust Research in Health Care: What Does It Mean for Policymakers?, January 24, 2023
[50] Feedback letter from Disability Right California to CalHHS and the 988 Project Team
[51] NAMI/Ipsos 988 Lifeline and Crisis Response Research, July 2024
[52] HMA/KAI Community Engagement Report 2024; This 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
[53] Statement from a Native American participant in Focus Group 1
[54] De-identified summary data emailed from DHCS on June 17, 2024; DHCS CDO, CDO 24-1149
[55] Targeted Universalism Policy and Practice, May 2019
[56] 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."
[57] Cal Matters, Sosa A, 'A Lifesaving Tool': California's New Mental Health Crisis Line Sees a Surge in Calls, updated July 20, 2023, accessed May 10, 2024
[58] Vibrant monthly data
[59] Ibid.
[60] Ad Hoc Analysis conducted by AHP: Comparison of National and CA Annual 988 Call Volume, shared by DHCS via email, July 2024
[61] Additional benefits 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
[62] Gasior M, PowerDMS, Policing the Mentally Ill: How Changes in Tactic and Best Practices Impact Your Department, 2020, accessed May 10, 2024
[63] 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
[64] In 2022, this figure was 27 million calls, according to the Federal Communications Commission, approved OMB request (3060-1122), 2022
[65] These estimates are for illustrative purposes only. National data on behavioral health calls may be higher or lower than California estimates.

[66] The Road to 988/911 Interoperability: Three Case Studies on Call Transfer, Colocation, and Community Response, June 2024
[67] California 988 Technical Advisory Board, last accessed November 22, 2024.
[68] 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
[69] Geo-routing directs phone calls to 988 to a nearby 988 Crisis Center based on the caller's general location and does not reveal the precise location of help seekers; SAMHSA and Vibrant have conducted testing, traffic study, impact analysis with two carriers (T-Mobile and Verizon) going live with geo-routing on September 17, 2024; an expected third carrier is expected to go live in October 2024
[70] California Department of Public Health, Crisis Hotlines, Warmlines & Resources
[71] California Department of Social Services Website – Family Urgent Response System
[72] CCCP Report
[73] Vibrant, 988 Suicide and Crisis Lifeline Suicide Safety Policy, February 2023
[74] Substance Abuse and Mental Health Services Administration. 988 Frequently Asked Questions, accessed May 10, 2024
[75] 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
[76] RAND Health Quarterly, Suicide Prevention Hotlines in California, 2017
[77] According to the California DHCS, "In July 2024, 1,913 988 contacts in CA were substance related, out of the 37,000 answered contacts reported by the BSMR, which is 5.17% of all answered contacts. Keep in mind not every center submits data points for every item each month, so this data's usefulness is limited."
[78] This examination will build on SAMHSA's language access plan, CalHHS Language Access Policy and existing language access policies and practices of implementation partners.
[79] https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf
[80] 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
[81] CalHHS, Crisis Care Mobile Units Program Grant
[82] Centers for Medicare & Medicaid Services, Approval Letter for California State Plan Amendment (SPA) 22-0043, accessed May 10, 2024

[83] 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

[84] The benefit went live in California in January 2024; however, the CMS approval date shows a retroactive date to the application date, January 2023; correspondence with DHCS: "The benefit is effective January 2023, but the first county was not approved to provide services until November 2023, and by December 31, 2023, 28 counties were approved to provide services under the benefit. As of August 28, 2024, 43 counties have been approved to provide services under the benefit. As of September 2024, 45 counties have been approved to provide services under the benefit." CalHHS Updates from PAG Meeting 6

[85] California Department of Health Care Services, Fact Sheet on Proposition 1

[86] Text of AB-531 The Behavioral Health Infrastructure Bond Act of 2023

[87] Department of Health Care Services, The California Behavioral Health Community-Based Continuum Demonstration: Concept Paper (Executive Summary), November 2022

[88] 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.

[89] National Library of Medicine, Knowledge and Skills for Social Workers on Mobile Crisis Intervention Teams

[90] 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

[91] See CYBHI Scaling Evidence-Based and Community-Defined Evidence Practices and DHCS EBP-CDEP-Grants as examples

[92] RAND Corporation. Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021

[93] RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Sacramento County, California, 2022; RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Santa Clara County, California, 2022 RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in California; Merced, San Joaquin, and Stanislaus Counties, 2022

[94] 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

[95] California Emergency Services Authority, Community Paramedicine and Triage to Alternative Destinations, 2024
[96] Evaluation of AB 1544: Community Paramedicine and Triage to Alternate Destination
[97] AB 988 Chart Book An Inventory of Needs, Services and Gaps of the Behavioral Health Crisis System, November 11, 2024
[98] Targeted Universalism Policy & Practice
[99] SAMHSA 988 Partner Toolkit, Accessed November 22, 2024
[100] Note that DHCS's 988 digital marketing materials will seek to comply with Section 508 of the Rehabilitation Act.
[101] For California suicide rates, see California Department of Public Health, California Injury Data Online EpiCenter; Psychiatry Online, The Changing Context of Rural America: A Call to Examine the Impact of Social Change on Mental Health and Health Care
[102] Suicide Trends Among and Within Urbanization Levels by Sex, Race/Ethnicity, Age Group, and Mechanism of Death, October 6, 2017
[103] Workgroup 1, Comprehensive Assessment meetings, Interviews with county behavioral health agencies
[104] See slides in the AB 988 Chartbook
[105] America's Health Rankings analysis of CDC WONDER, Multiple Cause of Death Files, United Health Foundation; America's Health Rankings; California Department of Public Health, California Injury Data Online EpiCenter
[106] The California Statewide Study of People Experiencing Homelessness, published in 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.
[107] See slides in the AB 988 Chartbook
[108] FAQ: Is the 988 Lifeline available in other languages for non-English speakers? - 988 Lifeline
[109] 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, 2022
[110] Centers for Disease Control and Prevention, 2014; Fatal injury reports, national and regional, 1999–2014
[111] State of California – Executive Order N-15_19
[112] State of California – Executive Order B-10-11
[113] Targeted Universalism Policy and Practice, May 2019
[114] 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."

[115] This examination will build on SAMHSA's language access plan, CalHHS Language Access Policy and existing language access policies and practices of implementation partners.
[116] Government Code: Section 53123.4(2)
[117] Discussion with CBHDA, August 2024
[118] Health and Safety Code – HSC 1374.724
[119] This information is also posted on the DMHC's website
[120] CalHHS, CalHHS IT & Data Strategic Plan, March 2024
[121] Clear Impact Website – What is Results-Based Accountability?
[122] AB-988 Miles Hall Lifeline and Suicide Prevention Act, as amended, SECTION 1. Section 53123.4 of the Government Code
[123] Substance Abuse and Mental Health Services Administration, Peer Support Services in Crisis Care, Advisory, SAMHSA Publication No. PEP22-06-04-001, June 2022
[124] CalMHSA Medi-Cal Peer Support Specialist Certification Data Dashboard, Peer Certification - California Mental Health Services Authority
[125] California Government Code: § 53123.3. Recommendation Area 4
[126] California Governor's Office of Emergency Services. 911 / 988 TRANSFER/HANDLING CRITERIA – DRAFT. 911/988 Interface Working Group for the 988 Technical Advisory Board. 2024.