

FAQ for Understanding 988 and How It Can Help with Behavioral Health Crises

What is 988?

In July 2020, the Federal Communications Commission (FCC) designated 988 as the new three-digit number for the National Suicide Prevention Lifeline. The number will have trained staff to answer calls from individuals at risk for suicide as well as those experiencing other mental health and substance use related emergencies. Specialized services will be available for veterans, LGBTQ+ individuals, and other groups. By July of 2022, all telecommunications companies will have to make the necessary changes so individuals can access the National Suicide Prevention Lifeline using the 988 dialing code. As of early 2021, the FCC is still taking comments and deciding about how to handle text messages and other aspects of 988 implementation.

How did 988 come to be?

According to the [National Institute of Mental Health](#), suicide rates have been steadily increasing in the United States and suicide is the second leading cause of death in the U.S. for people ages 10 – 24 years old. Key leaders understood the difficulty of remembering a 10-digit number to connect to the existing suicide prevention line and the lack of adequate crisis services in communities. After Congress passed legislation directing the FCC to [study](#) the feasibility of creating a three-digit number to help people in mental health crisis connect to crisis services more easily, the FCC released a [report](#) in August 2019 recommending 988 as the best number for a national three-digit suicide and mental health crisis hotline. The report was in conjunction with the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) as well as the U.S. Department of Veterans Affairs. With the support of the mental health community, the FCC issued a final rule and order in July 2020 to start the process of getting 988 operational. With broad, bipartisan support from Congress, President Trump signed the [National Suicide Designation Act](#) in October 2020. One aspect of the Act allows states to assess a fee on cell phone bills to recover the costs of the three-digit number and associated crisis services provided to individuals in crisis. A similar fee on cell phone bills supports 911 in most states.

How will 988 differ from 911, 211 and the current suicide hotline number (1-800-273-TALK)?

211 is a non-emergency number for finding community resources, such as food banks and shelters. 911 is currently used for all emergencies, including mental health emergencies. Mental health crisis calls may result in potentially dangerous and traumatizing outcomes when police are called, especially in historically marginalized communities. Despite their best efforts, 911 dispatchers usually have not received specific training on how to handle mental health and suicide related calls. Although law enforcement response is often not necessary or appropriate for mental health crisis situations, police are typically the first responders activated by 911 calls.

988 will be a mental health crisis number, and calls will be handled by National Suicide Prevention Lifeline counselors. These counselors are highly trained to assist people in emotional distress or suicidal crisis. In fact, based on data provided by Lifeline call centers, approximately 98% of answered Lifeline calls do not require an emergency response. Of the 2% of the calls that do require emergency response, over 60% of those calls are ones where the caller agrees that emergency services are needed and collaborates with the Lifeline counselor to receive those services.

Vibrant Emotional Health, an MHA affiliate and administrator of the National Suicide Prevention Lifeline, has provided [recommendations](#) and defined the vision and mission of 988 as follows:

- Vision: 988 serves as America's mental health safety net. We will reduce suicides and mental health crises and provide a pathway to well-being.
- Mission: Everyone in the US and its territories will have immediate access to effective suicide prevention, crisis services and behavioral healthcare through 988.

How can 988 improve the lives of people with mental health and substance use conditions?

For many people with mental health and substance use conditions, particularly people of color and people in the LGBTQ+ community, a law enforcement response to a mental health emergency has ended in tragedy or poor outcomes, including death and incarceration. Just as current calls to the Lifeline are answered now, calls to 988 will be answered by someone trained in mental health crisis response, who can often resolve the situation by phone, text, or chat.

The new Lifeline number, 988, holds the promise of an equitable healthcare response to a healthcare issue with better outcomes as people receive the services and supports they need to remain in their communities and thrive. This promise will only be fulfilled if adequate resources are available to accommodate increased call/chat/text volume, as well as the continuum of crisis care services that can stem from the 988 call. Crisis care services are more impactful when they include and are informed by individuals with diverse backgrounds, including lived experience, who are trained to respond in an empowering and culturally responsive manner. For example: 988 presents an opportunity to invest in mobile crisis teams that can be deployed to respond instead of police. People in crisis may need an appropriate place to go for assessment that is not jail or a hospital emergency department, which are often the only options for law enforcement to offer. 988 provides the opportunity to invest in resources, such as crisis stabilization centers, crisis beds, or peer respite centers, which allow for individuals in need to receive mental health evaluation and resources.

What are some of the key features of a strong 988 system to keep in mind?

Vibrant Emotional Health, the administrator of the Lifeline, has identified three key themes to guide 988 implementation:

1. Universal and Convenient Access, including omnipresent public awareness and varying modalities for individuals to access 988 through their preferred method of communication;
2. High Quality and Personalized Experience that is tailored to the unique needs of the individual while also in line with identified best practices;
3. Connection to Resources and Follow Up to ensure all persons contacting 988 receive additional local community resources as needed.

MHA and Vibrant advise carefully considering the following issues:

A behavioral health crisis needs a behavioral health response. Increased collaboration between 911 and 988 would provide more options for those in crisis, such as transferring mental health crisis calls to

988 call centers, dispatching mobile crisis teams to individuals in mental health or suicidal crises rather than police or EMS, and greater coordination around access to care options like crisis stabilization units. SAMHSA has issued [guidelines and a toolkit](#) for behavioral health crisis care that may be helpful in considering and evaluating your state's crisis system.

A robust behavioral health response is only possible with appropriate funding for the network, individual crisis centers, and the crisis continuum. In order to ensure a robust infrastructure, states should exercise their authority to implement a 988 fee, similar to the current 911 fee, that would be restricted to crisis center and service provider expenses. In 2018, fees for 911 generated \$2.6 billion to support that service; similar investment is needed for mental and behavioral health services. The fee revenue should supplement, not supplant, funding from diverse sources, including federal, state and local governments, Medicaid, and private insurance. States will need to look carefully at their current crisis systems, identify gaps and ensure adequate funding.

988 should be designed to provide an empowering, personalized, high quality and culturally responsive experience for individuals in crisis. The system should be designed to optimize and support services that ensure access and inclusion within 988 to meet the unique needs of at-risk groups, including youth, rural populations, BIPOC communities, and LGBTQ+ individuals. Multiple modalities such as text and chat should be available in addition to phone support. Crisis staff should reflect the communities served and engage people with lived experience at all levels of response. Individuals providing those services should be trained to be culturally responsive in order to ensure dignity for the person being served. Services should also be linguistically appropriate for the communities served. Data driven metrics, including performance and user experience by race and ethnicity, are needed to ensure quality service and positive outcomes for all members of the community.

Stakeholders should consider 988 and the crisis system as a part of their larger mental health service system and as part of their community resources. Data should be collected on why people get into a crisis and continual planning and analysis should identify ways to avoid crises. Some localities have added [peer teams](#) for unhoused people and others at high risk of crisis and police involvement. Supportive housing, Assertive Community Treatment (ACT) Teams and early psychosis programs may be helpful in avoiding crises and if crises do occur, ACT teams can be helpful in quickly resolving them and following up after crisis. People accessing the 988 system will need to be connected to community-based resources and follow up.

For more detailed suggestions for implementation, see Vibrant's recommendations [here](#).

Will there be any planning activities in the states, and how can I get involved?

Vibrant Emotional Health, which operates the National Suicide Prevention Lifeline, has issued a request for proposals for a non-competitive grant to states in order to fund their 988 planning activities. Applications are due January 8, 2021 and stakeholders may want to participate in the planning activities funded by Vibrant's grants. It is particularly important that people with lived experience and representatives of the communities served by the grant be included in planning.

How can I find out if my state assesses 911 fees?

[This chart](#) explains which states currently assess 911 fees. The National Suicide Hotline Designation Act allows states to assess a fee to fund call routing, personnel, and provision of mental health and crisis outreach services in response to 988 calls. Even if your state does not assess a 911 fee, legislation can be introduced for 988 assessments in state legislatures.

Are there any model laws or policies that can be helpful to enact state legislation for 988 funding?

The National Suicide Hotline Designation Act allows states to pass legislation assessing small monthly fees on cell phone bills to support 988, as is often done to support 911 services. Even if your state does not assess a 911 fee, legislation can be introduced for 988 assessments in state legislatures. The National Association of State Mental Health Program Directors (NASMHPD) developed a model law.

Here is MHA's [version](#) of the NASMHPD model law. We emphasized a behavioral health response to crisis first, as well as involving law enforcement in very limited circumstances as co-responders. We also added some provisions to ensure equity and expanded the partnership agreements beyond community mental health or behavioral health centers (CMHCs) because many MHAs do not have that designation.

It is important for advocates to enact state legislation assessing a fee because local member centers within the Lifeline network are currently underfunded and additional resources will be needed to meet the increased demand on call centers.

Assessing this fee is also critical as the law allows states to generate funding for “the provision of acute mental health, crisis outreach and stabilization services by directly responding to 988.” This means that this funding can be used in part to create a crisis response system that does not rely on law enforcement and provides the continuum of appropriate crisis care outlined in this document.

If you are working on state legislation, please email Debbie Plotnick at dplotnick@mhanational.org for technical assistance or questions. In addition to this document, we are working with other advocates to develop additional model legislation to ensure that Medicaid and private insurance adequately cover the crisis services in your states.