Public Health Actions That Support Implementation of the 988 Suicide and Crisis Lifeline

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Abstract

The 988 Suicide & Crisis Lifeline (988) took a bold step in July 2022 and launched an easy-to-remember three-digit number for accessing around-the-clock behavioral health crisis care. The 988 lifeline will connect those experiencing a suicide or behavioral health crisis to crisis counselors, provide timely referrals to treatment, and reduce reliance on law enforcement for behavioral health crisis response. In 2021 APHA adopted Policy Statement 20213, A Comprehensive Approach to Suicide Prevention within a Public Health Framework, which calls for public health actions to address suicide in the United States. This late-breaker policy statement builds on that call for action by responding to the July 2022 activation of 988 as a significant advancement in the national suicide prevention strategy. Public health actions support 988 implementation and the federal government's significant funding commitments and efforts to employ broad-based interventions and public health approaches to reduce suicide. This policy statement identifies action steps that embody the 10 Essential Public Health Services (EPHS) and illustrate the broad range of actions across core functions of assessment, policy development, and assurance. These actions infuse public health tenets into the 988 implementation and into development of expanded crisis response services. The action steps reflect the 10 EPHS framework's centering principle by explicitly integrating equity across the EPHS domains. The 988 implementation intends to accelerate transition to a more robust and comprehensive system of behavioral health crisis response nationwide. These action steps will inform the implementation by incorporating critical public health approaches in large-scale national-level suicide prevention efforts.

Relationship to Existing APHA Policy Statements

This proposed policy statement addresses how public health might support crisis services in general and the 988 Suicide & Crisis Lifeline in particular. In 2020, Congress designated 988 as the new dialing code to be operated through the existing National Suicide Prevention Lifeline to address situations involving people in suicidal crisis or emotional distress. This policy statement builds on the recognition in 15 current policy statements that suicide and suicidal ideation are socially determined and, in six statements, that there are specific groups at high risk of suicide. The statement extends Policy Statement 20213, A Comprehensive Approach to Suicide Prevention within a Public Health Framework, which calls for adoption of evidence-based suicide care practices and policies that support those in crisis, including a

strategic plan to support the implementation of 988 as a behavioral health crisis line. The additional 22 existing policy statements listed below are also relevant to this policy statement.

Policy Statements Related to Suicide Prevention in a Public Health Framework

- APHA Policy Statement 201415: Support for Social Determinants of Behavioral Health and Pathways for Integrated and Better Public Health
- APHA Policy Statement 20179: Reducing Income Inequality to Advance Health
- APHA Policy Statement 20184: Reducing Suicide by Firearms
- APHA Policy Statement 20185: Violence is a Public Health Issue: Public Health is Essential to Understanding and Treating Violence in the U.S.
- APHA Policy Statement 201912: Addressing Alcohol-Related Harms: A Population Level Approach

Policy Statements Related to Suicide and Social Determinants of Health

- APHA Policy Statement 200712: Toward a Healthy Sustainable Food System
- APHA Policy Statement 20095: The Role of Public Health Practitioners, Academics, and Advocates in Relation to Armed Conflict and War
- APHA Policy Statement 200914: Building Public Health Infrastructure for Youth Violence Prevention
- APHA Policy Statement 20101: Public Health and Education: Working Collaboratively Across Sectors to Improve High School Graduation as a Means to Eliminate Health Disparities
- APHA Policy Statement 20123: Cessation of Military Recruiting in Public Elementary and Secondary Schools
- APHA Policy Statement 20178: Housing and Homelessness as a Public Health Issue
- APHA Policy Statement 201810: International Food Security and Public Health: Supporting Initiatives and Actions
- APHA Policy Statement 201811: Addressing Law Enforcement Violence as a Public Health Issue
- APHA Policy Statement 20196: Addressing the Impacts of Climate Change on Mental Health and Well-Being
- APHA Policy Statement LB20-04: Structural Racism is a Public Health Crisis: Impact on the Black Community

Policy Statements Related to Suicide and Administrative Data and Language

- APHA Policy Statement 20086: Patients' Rights to Self-Determination at the End of Life
- APHA Policy Statement 201513: Improving Availability of and Access to Individual Worker Fatality Data

Policy Statements Related to Suicide and Vulnerable Populations

- APHA Policy Statement 20142: Reduction of Bullying to Address Health Disparities Among LGBT Youth
- APHA Policy Statement 201411: Removing Barriers to Mental Health Services for Veterans
- APHA Policy Statement 20169: Promoting Transgender and Gender Minority Health through Inclusive Policies and Practices
- APHA Policy Statement 20192: A Global Call to Action to Improve Health Through Investment in Maternal Mental Health
- APHA Policy Statement LB-18-01: APHA Opposes Separation of Immigrant and Refugee Children and Families at U.S. Borders

Problem Statement

On July 16, 2022, the 988 Suicide & Crisis Lifeline was activated in a transition to a three-digit, easy-to-remember, around-the-clock access number for suicide and behavioral health crisis care, replacing the former 10-digit National Suicide Prevention Lifeline number.[1] Improved behavioral health crisis response in the United States has become imperative. There are alarming statistics that call for evaluation of how current crisis response activity has affected behavioral health treatment. Between 2015 and 2020, one in every four fatal police shootings involved a person with a mental illness. The rate of incarceration is also higher for this population, with an estimated 2 million people with mental illness jailed and imprisoned each year.[2] In addition, overutilization of emergency health care services for behavioral health crises often results in poor-quality care, longer wait times to access treatment, higher health care costs, and forced medical treatment.

The 988 Suicide & Crisis Lifeline seeks to provide immediate and trauma-informed crisis intervention and support. When people contact 988 via call, text, or chat, they will reach a crisis counselor who is trained to understand how their problem is affecting them, provide support, and share resources as needed. For most, 988 contact will be the intervention. Crisis counselors are expected to resolve the urgent needs of most 988 callers, thereby reducing the overall need for an in-person response.[2]

Suicide is a major public health problem in the United States, with nearly 46,000 suicide deaths in 2020 and suicide ranking as the 12th leading cause of death overall. Suicide was the second leading cause of death among individuals 10–14 and 25–34 years of age, the third leading cause among those 15–24 years of age, and the fourth leading cause among those 35–44 years of age. In addition, there were nearly twice as many suicides (45,979) as homicides (24,576).[3]

In 2021 APHA adopted Policy Statement 20213, A Comprehensive Approach to Suicide Prevention within a Public Health Framework, which calls for public health actions to address suicide in the United States. Within the policy statement's 23 action steps, five call for adopting evidence-based suicide care and policies that support those in crisis.[4] Thus, a significant number of actions in APHA's policy statement to advance public health contributions to suicide prevention address gaps in responding to those in suicidal crisis. One of the action steps specifically addresses 988 by calling for the "creation of a strategic plan for implementing the 988 mental health crisis line through a collaboration of public health agencies, health and behavioral health care systems, and advocates." This late-breaker policy statement elaborates public health roles that support 988 implementation.

Public health approaches to suicide prevention apply public health tenets and principles while fostering novel and innovative interventions and methods developed within public health science.[5] Although the federal government has identified best practice guidelines for behavioral health crisis care, they are clinically oriented; indeed, the term "public health" appears only twice within the 80-page guidelines.[6] Many of the best practices actions and concepts will be familiar to public health professionals, but the guidelines do not explicitly represent a public health perspective. As 988 implementation proceeds, it will be important to utilize public health methods to strengthen U.S. suicide prevention efforts. The 988 Suicide & Crisis Lifeline is expected to significantly increase demand for crisis call support even though many 988 crisis centers are currently falling below the 90% answer rate goal.[7] Transparent monitoring of data such as these embodies public health principles of assessment to identify needs for program improvement and resourcing for sustainment that will be critical for 988 success.

The 988 Suicide & Crisis Lifeline is recognized for its important promise in addressing suicide risk among historically underserved and marginalized populations.[8] Ensuring that key public health concepts of diversity, equity, and inclusion are central to implementing 988 throughout the United States will be needed to optimize access for those experiencing a suicide or behavioral health crisis. Likewise, efforts to address barriers that limit access to crisis care for those who are referred from 988 for services must include assessments of disparities in behavioral health and crisis care interventions. Principles of inclusion are also evident when planning 988 implementation among American Indian and Alaska Native indigenous populations to address their unique crisis care challenges and barriers.[9] Trust in the 988 response system will be critical to gain the confidence of 988 callers across the country; employing trauma-informed strategies and reducing reliance on 911-style law enforcement responses to behavioral health crises are key goals for a more effective crisis response system.[10] Community engagement in implementing 988 is another key public health tenet to ensure that crisis care is culturally sensitive and

equitably accessible. Effective messaging about suicide, grounded in public health communication research, has been developed by the National Action Alliance for Suicide Prevention and applied to a framework for 988 messaging to facilitate reach across communities.[11]

Given that suicide is a major public health problem, APHA is committed to supporting a comprehensive public health approach to suicide prevention, and 988 implementation is intended to be a significant component of U.S. national suicide prevention efforts, it is incumbent upon APHA to explicate public health tenets and principles that map to 988 implementation and expansion of the suicide and behavioral health crisis response system.

Evidence-Based Strategies to Address the Problem

The 10 Essential Public Health Services (EPHS) as a best practice: Historically, suicide and crisis response has predominantly been viewed as a clinical behavioral health issue. However, evidence-based research supports the accompanying need for public health interventions to mitigate upstream factors that contribute to suicide risk. APHA Policy Statement 20213 recognizes that suicide is a public health challenge and recommends addressing root causes that adversely affect mental and behavioral well-being and exacerbate health inequities.[4] The public health profession's 10 EPHS inform best practices for the public health community to respond to emerging and persistent public health threats.[12] This framework is applicable to suicide prevention efforts, including those that reduce the prevalence of behavioral health crises. By utilizing this framework, the public health community can identify intersectional activities that complement and strengthen the efforts of 988 and the existing crisis response network.

Equity as an overarching guideline of best practices in crisis services: In 2020, the 10 EPHS were revised to place equity at the center of the framework and ensure that all essential services address health disparities.[12] With a reenvisioned framework to guide public health practice, efforts to address public health challenges should immediately follow the updated guidance to ensure that consistent equity efforts are present throughout the public health arena. A public health response to 988 will require an equity-centered approach for serving all communities, especially historically underserved populations, and achieving better health outcomes. The Kennedy-Satcher Center for Mental Health Equity at the Morehouse School of Medicine and Beacon Health Options have drafted recommendations to embed equity into 988 and crisis response.[13] This toolkit outlines where crisis response inequities exist and recommends strategies to reduce adverse impacts. Key strategies include prioritizing historically invisible communities, limiting law enforcement interactions during crisis response, and delivering comprehensive training to grow and sustain a strong and equitable crisis response network.

Core functions of the 10 Essential Public Health Services: The 10 EPHS span three core functions, assessment, policy development, and assurance, that inform the action steps of this policy statement. These action steps are organized around the 10 EPHS framework core functions and call on relevant entities to apply core public health principles for implementing the 988 Suicide & Crisis Lifeline.

Assessment as a core function: Ongoing assessment of 988 outcome data will be critical to understanding the success of the system and identifying gaps in service capacity and equity. Evidence-based research is needed to improve data on behavioral health crises. Important lessons learned from research into the existing 911 crisis system support the need for improved crisis response data for decision making, system improvement, transparency, and accountability across the crisis response network. A 2021 survey showed that while 911 can record calls as related to behavioral health or substance use in its electronic data system, there are no overarching policies to guide consistent data collection.[14] For example, some centers rely on National Incident-Based Reporting System or Unified Crime Reporting codes, which provide only limited information on behavioral health crises. Others indicate whether a call is related to behavioral health or substance misuse in a text field, making this information challenging to aggregate. Without consistent data that can be aggregated and compared, little can be known about the full scope of behavioral health crises or 911 crisis system response in any given community.[14] Consistency can be established through the use of standardized tools that identify calls related to behavioral health crises. Codes such as “suspected suicide” have been associated with a greater likelihood of a person being transported to treatment than codes such as “suspicious person” and “calls for assistance.”

Consistency can also be established through standardized data collection, ensuring that systems record quantitative data on behavioral health crises. Aggregated national data can provide a more accurate account of system functioning, allowing for better directed quality improvement efforts. To this effect, consistent data collection must account for and acknowledge factors that substantially contribute to inequities, including race, ethnicity, and zip code, to preserve and foster equity-informed and equity-centered data collection, assessment, analysis, and policy development. Consistent data would also improve public-facing reporting, an essential element to build trust in an accountable crisis system. Building upon the lifeline’s suicide risk assessment standards,[15] assessment of a caller’s risk at the point of connection can help provide an understanding of which levels of crisis present to the lifeline and which strategies have proven most effective during crisis intervention. Research also indicates that upstream prevention strategies are critical for mitigating crisis risk, especially in the case of strategies targeting youth.[16] Identifying which upstream measures are most effective at reducing suicide risk can

help inform the public health community about the prominent intersectionality between social health determinants and suicide and crisis intervention. In addition, assessing barriers that prevent callers from accessing continuing care can help identify gaps in services.[17]

Policy development as a core function: Effective policy directives ensure that the public is informed about critical health services, and consistent communication about 988 is key to public acceptance. The Substance Abuse and Mental Health Services Administration (SAMHSA) has published information for 988 messaging including a toolkit, key message guidance, fact sheets, and outreach materials.[18] While these resources serve as important backbones for communication about 988, more resources will be needed to tailor messages to diverse communities, especially those that may be reluctant to use 988 services. Effective communication about a culturally responsive 988 system is key to building trust in communities, especially those with previous traumas related to 911 interactions. The National Action Alliance for Suicide Prevention has produced the evidence-based 988 Messaging Framework for effectively communicating about suicide.[11] The framework, which is grounded in public health communication research, evidence from studies of suicide contagion, and public opinion polls, outlines principles of effective communication campaigns, safe messaging guidelines, and the importance of promoting hope, healing, and recovery through positive narratives. The framework builds on previous best practices guidance and stresses the importance of developing strategic goals for 988 messaging and the need to engage community members, especially those with lived experience, in message development.[11] It also provides guidance on working with local media to ensure that their coverage of 988 and suicide is informed by consensus guidelines for safe reporting on suicide.[19]

Many individuals who reach out to crisis hotlines find that the services provided are helpful in reducing suicidal ideation, feelings of hopelessness, and other psychological pain without the need for further engagement with other crisis care.[20,21] When crisis hotlines have offered follow-up services to callers, research has shown that these services can be effective in positively influencing clients with suicidal ideation.[22] These findings highlight the important role of crisis hotlines in the pathway to crisis services.

SAMHSA's 2020 National Guidelines for Behavioral Health Crisis Care emphasize how crisis hotlines can play a critical role in crisis services with state and regional crisis centers serving as a coordinating hub for additional services beyond clinical care from crisis counselors.[6] The implementation of 988 also serves as a potential catalyst for improvements in the overall crisis service system. For those who could benefit from additional services, crisis hotlines are a bridge to additional resources, although research has

shown that only half of callers given resource referrals actually use these services.[17] In the case of those needing emergency services, crisis hotlines can coordinate immediate trauma-informed responses with local mobile crisis teams, law enforcement, and emergency medical services. The 988 Suicide & Crisis Lifeline has imminent risk standards to which all 988 crisis centers must adhere, and these standards aim to provide the least restrictive care possible to those in crisis.[23] However, in areas where mobile crisis services are not available, law enforcement and 911 may respond to people in crisis, which can be traumatic for these individuals. Policies that build trust in communities, especially those with previous traumas related to 911 interactions, will be critical for creating an equitable trauma-informed crisis response system.

Services provided must respond to the unique needs of each respective community. The Kennedy-Satcher Center highlights the importance of placing mobile crisis units at local medical and behavioral health clinics.[13] Positioning mobile crisis units in settings where response teams reflect the population served helps achieve equitable access to crisis services. Data also show that placement of mobile crisis units in non–health care settings has been successful with respect to offering culturally responsive services to communities experiencing homelessness and tribal and LGBTQIA+ (lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual) communities. Response services must be cohesive for those seeking help during crises. The goal of these partnerships should be to extend the continuum of care beyond crisis response.

The implementation of the new 988 Suicide & Crisis Lifeline has already significantly increased and expanded demand for crisis response services and significantly expanded the venues for delivering crisis response care. Since 988's national implementation on July 16, 2022, the lifeline has seen a 45% increase in call volume, necessitating a scale up in crisis services.[24,25] To support the implementation, the U.S. Department of Health and Human Services and SAMHSA have announced grant funding to scale up response efforts. Specific grant actions include mobilizing crisis response services, specifically in tribal communities where access to 988 technologies may be limited. In addition, funding will support youth and school-based interventions and public health strategies to bolster the impact of comprehensive services. Continued legislation and policies that ensure 988 sustainment and service expansion will be critical to support the increased volume of service provision.

Accessibility measures are essential to make the 988 Suicide & Crisis Lifeline an equitable system that serves all communities. The lifeline is actively working to address barriers present in the current system, including those that affect individuals with disabilities and non-English-speaking communities.[26]

Federal, state, and local government statutes, regulations, and institutional policies must also address barriers to accessing 988 and crisis response services when planning for crisis response system expansion and seeking continuous funding to support the lifeline. The World Health Organization has embraced the Institute for Human Centered Design's Principles of Inclusive Design as the best measure to incorporate accessibility measures into public health practice.[27] Through adoption of these principles, 988 and the crisis response network can build equitable strategies to ensure that accessibility is embedded in the operations of the lifeline, mobile crisis units, and policy development.

Assurance as a core function: Assurance surrounding 988 and crisis response is critical to building, sustaining, and continuously strengthening the 988 and crisis response network to ensure an informed and comprehensive system for years to come. In order to secure trust within communities, 988 and crisis response services must be immediately, effectively, and equitably responsive to those who need services.[28] Public health professionals involved in crisis response should be informed of the system's current equity gaps and should aim to close the gaps by responding to upstream preventable factors that contribute to crises. Centering equity measures within public health's 988 and crisis response operations includes building a responsive public health workforce that represents and reflects all communities, especially those that have been historically underrepresented, invisible, or excluded.[13]

Given that the crisis response network is rapidly growing to support the expanded need for a larger system, the lack of a sufficient number of crisis response workers remains a barrier and potential threat to providing immediate response to crises.[22,25] It is imperative for the lifeline and the crisis response network, including public health personnel, to quickly recruit and train a new workforce and identify strategies to retain workers. The 10 EPHS can inform best practices to build, support, and maintain a responsive, sustainable, and equity-centered public health workforce. Key parties in the crisis response network have defended the importance of having communities with lived experience lead suicide and crisis response efforts, including SAMHSA,[29] Vibrant,[28] and the Kennedy-Satcher Center.[13] Ensuring an existing platform for people with lived experience to guide 988 and crisis response system development and evaluation is a critical step for embedding equity and cultural awareness into quality improvement processes. The Suicide Prevention Resource Center explains why inclusion of communities with lived experience is important and provides user guidance on how to identify and include community members in suicide prevention and crisis response efforts.[30]

Collectively, a public health framework to support and augment the 988 and crisis response system should be informed by data, driven by communities, and adequately funded to support a continuous and

comprehensive system. An effective system of crisis response care must link clinical crisis interventions to a continuum of services spanning upstream prevention to postintervention maintenance. It is imperative for health equity to remain the centripetal force that drives public health interventions in crisis response and beyond.

Opposing Arguments/Evidence

Opponents of engaging the U.S. public health system in crisis response will be concerned about large and unnecessary costs for interventions that may not be effective in preventing suicide. Public health interventions would require resources to be applied to indirect and diffuse population-level factors embodied by a public health approach in contrast to clinical behavioral health interventions that directly mitigate an individual's known suicide risk.[4] A large body of research has described effective clinical behavioral health treatments for those in suicidal crisis, with considerably less evidence that public health approaches will yield cost-effective gains in reducing suicide.

Public health infrastructure is often a low funding priority at the federal, state, and local levels[31] and has not received consistent federal financial support.[32] At the same time, behavioral health services have been woefully underfunded.[33] As a result of chronic underfunding, both public and behavioral health fields struggle with demand for services, and this has been even more evident with the COVID-19 pandemic. The tremendous need for services has undermined public health and behavioral health system efforts to maintain a sufficient workforce, avoid service fragmentation, and address service inequities.[34] Opponents of a public health presence in crisis response will be concerned that pressure for an underfunded public health system to divert scarce resources to support 988 would be a misplaced priority that further limits its ability to prepare for and respond to unforeseen large-scale service emergencies.

A public health approach to crisis response is being developed in various forms across the country.[35–37] Conducting research and developing training for applying public health principles to crisis response would require valuable time and scarce resources to address an urgent problem. Opponents of a public health presence in crisis response will contend that the highest priority in terms of time and resources should be research on and development of evidence-based curricula that effectively train crisis counselors and crisis response teams.

Opponents of an expanded public health presence in crisis response will also be concerned about negative publicity related to poorly handled response. There is already skepticism regarding 988's ability to employ trauma-informed approaches during response.[38] Unnecessary deployment of law enforcement

or forced behavioral health treatment through crisis response will undermine public health credibility and risk public health's overall ability to build and maintain trust within communities.

In general, opponents of applying public health principles to 988 implementation will argue that there is little evidence warranting the cost and resources to engage the public health system in crisis response. In essence, such arguments seek to maintain the status quo for suicide and behavioral health crisis response. However, recent advances in public health methods that contribute to suicide prevention and increasing engagement by the U.S. public health system are consistent with the APHA policy statement for adopting a comprehensive public health approach to suicide prevention, including 988 implementation and more robust crisis response capabilities.[4]

Action Steps

APHA calls for public health actions reflecting cross-cutting principles of equity and aligned with the core public health functions of assessment, policy development, and assurance to support implementation of the 988 Suicide & Crisis Lifeline and improved crisis response services in the United States.

- APHA calls on federal, state, territorial, tribal, and local public health departments, agencies, and organizations to proactively engage with behavioral health and emergency response systems at all levels to fund, create, continuously strengthen, and sustain a robust, consistent, cohesive, and equity-centered infrastructure for crisis response nationwide. APHA urges parties at all system levels to use the Kennedy-Satcher Embedding Equity into 988 policy brief to ensure consistent elevation of equity priorities throughout 988 implementation.

Assessment

- APHA calls on 988 and crisis response system funding entities, system proponents, and data owners at the federal, state, territorial, tribal, and local levels to ensure transparent processes for assessing and monitoring the implementation of 988, allowing the public access to data that indicate where the system is working well and for whom and where there may be gaps in services.
- APHA urges parties invested in 988 and the crisis response system to collect and apply 988 utilization data to identify salient social determinants and inequities contributing to crises and support development of effective upstream intervention strategies.
- APHA urges parties invested in 988 and the crisis response system to identify evidence-informed, culturally responsive, and person-centered strategies that support people recovering from crisis and continuously strengthen their emotional and overall well-being.

Policy Development

- APHA calls on parties invested in 988 and the crisis response system at the federal, state, territorial, tribal, and local levels to incorporate consistent, coordinated, culturally sensitive, and inclusive messaging to ensure widespread awareness of the 988 number and encourage all populations to access crisis services when needed. APHA urges messaging campaigns to use the SAMHSA Partner Toolkit and the Action Alliance 988 Messaging Framework to ensure accurate and consistent 988 public education.
- APHA calls on 988 and crisis response system proponents at the federal, state, territorial, tribal, and local levels to ensure consistent, coordinated, and culturally sensitive messaging that emphasizes alternative strategies to relying on 911 and law enforcement response to crises.
- APHA calls on 988 funding entities, legislative bodies, and policy proponents to ensure that 988 is seamlessly integrated into cohesive partnership collaborations with health care and nonmedical entities that provide robust crisis response services embedded in settings where people work, live, and play.
- APHA calls on public health entities to engage with community partners to create mobile crisis units and other strategies that strengthen 988 impact by reaching individuals in crisis in their cultural, linguistic, and unique environments.
- APHA urges federal, state, territorial, tribal, and local funding entities to commit robust resources for 988 implementation and sustained operation and adopt legislative and policy directives to scale up crisis response services within their jurisdictions.
- APHA urges health care systems and public health entities to enact policies and provide operational support to ensure that primary and emergency behavioral health services are evaluated for outcomes and achieve systemic parity with primary and emergency medical services.
- APHA calls on parties invested in 988 and the crisis response system at the federal, state, territorial, tribal, and local levels to employ trauma-informed strategies when responding to crises. These entities are called on to promote least restrictive care; to avoid actions that evoke or reinforce previous traumas, including those related to 911 law enforcement interactions; and to build a trusted 988 and crisis response system within communities.
- APHA urges legislative bodies and policymakers to apply principles of inclusive design in governing codes and organizational directives for 988 and crisis response services that address and mitigate physical, functional, psychological, cultural, or other barriers to full and inclusive access to services.
- APHA calls on state governments to utilize legislative authority, budgetary action, and governmental influence to ensure adequate funding to expand crisis call center networks that provide comprehensive statewide 988 and crisis response coverage.

Assurance

- APHA calls on federal, state, territorial, tribal, and local level authorities to resource the building of 988 and crisis response infrastructure in historically underserved communities. The workforce should include those with lived crisis experience and those who reflect and effectively respond to the linguistic and cultural needs of historically underserved populations.
- APHA urges all parties responsible for 988 and crisis response service implementation to immediately enact plans to recruit and train an expanded crisis care workforce.
- APHA calls on researchers and 988 and crisis response program developers to generate innovative evidence-based models for training and sustaining a crisis response workforce that is technically proficient, culturally sensitive to all communities, and emotionally sound in delivering crisis response services. Training and retention strategies should include specific crisis response training along with wellness strategies that prevent workforce burnout and retraumatization.
- APHA calls on federal and state governments, academic institutions, public agencies, and private enterprises to prioritize research grants that develop and test equity-centered crisis response interventions. Unified research strategies should identify diverse and inclusive protective factors, upstream prevention methods, and gaps in service capacity in the communities served.
- APHA calls on parties invested in 988 and the crisis response system to fully incorporate the perspectives of those with lived experience into all aspects of program evaluation, design, and development and continuous quality monitoring. In this process, valued recognition should be ensured and retraumatizing or exploitative exposures should be avoided.

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