NAMI Ask The Expert
National Alliance on Mental Illness

NAMI Ask the Expert:
More Than a Number:
The Impact of 988 on Reimagining Mental Health Crisis Care
Featuring David Covington and Hannah Wesolowski
July 20, 2023

Dr. Ken Duckworth (00:00:01):

I appreciate all your support. So this is an important conversation. We're one year in to the 988 Suicide Prevention Lifeline and we have two amazing people today who will be sharing what they've learned and what they've done. One is our own Hannah Wesolowski, our chief advocacy officer here at the National Alliance on Mental Illness. She also, in her spare time, leads our government relations team. A lot of advocacy, a lot of work on the Hill, and a lot of important public policy. And I'm delighted to introduce David Covington, who's really a national leader in crisis prevention and alternatives. He's a lead at RI International. And in a measure of his creativity, he runs a weekly session called the Crisis Jam, J-A-M as in jelly, and I think he's going to tell you about that.

(00:00:58):

As a reminder, National NAMI has a helpline. If you want to talk to people, cry, do a text or a chat, we have more than 150 trained volunteers with lived experience. And if you want to call them that number's right there on the screen, info@nami.org. Our community is here to support people. This is not an emergency lifeline. So there's Hannah, chief advocacy officer. There's David, CEO and president of RI International. So I'm delighted to welcome the two of them. The way we'll do it, they'll present kind of a formal presentation. I want your questions and I'll do my best to organize the questions in the Q and A section and we can have a conversation where we will get to your questions. Thank you, Hannah, and thank you David, and thank you everybody for attending.

Hannah Wesolowski (00:01:55):

Thanks so much, Ken. As Ken said, I have the honor and privilege of leading the government relations team at NAMI National and for the last several years I've worked on 988 quite a bit with many of you, I'm sure, and many others in the NAMI Alliance. And there's been so much great progress and there's still so much great work to do. I'm going to kick things off today, giving you a little bit of context. And as Ken said, David is really a national leader in this space, so he is going to provide more intensive information about the type of services that we want in our crisis continuum because while 988 is the start of our work, it's not the end of our work. We are committed to reimagining crisis response and really building a continuum of crisis care that's available in every single community across the country.

(00:02:47):

So just high level at the very start, what is 988? Well, it's a three-digit dialing code. Similar to what you have for 911, we now have 988. And that means that anyone who is in a suicide, substance use or mental health crisis or emotional distress can call 988, can text 988, or can chat online at 988lifeline.org. And what happens is that you'll be connected to a crisis counselor, ideally somebody local in your community who can provide resources, support de-escalation, help formulate next steps and connect you to other resources that might be available in your community.

Hannah Wesolowski (00:03:29):

This builds on and replaces the previous 1-800 number that was the suicide prevention lifeline. And now the scope of that lifeline is much broader. To not just be suicide prevention, although the lifeline always dealt with many more instances than just suicidal ideation, but a whole range of crises and situations where people are in emotional distress. And now you don't have to remember a 10-digit number. It's a three-digit number that you can call anywhere in the United States to get connected to this network. It's about 200 call centers across the country answering these calls, texts and chats and providing the services that I mentioned before.

(00:04:12):

This was created by Congress and believe it or not, it was unanimous bipartisan action by Congress, which has not happened very often these days. I can say as somebody who lives in the Washington, DC world. The National Suicide Hotline Designation Act created this number and set forward the purpose. It provided a mechanism for states to fund it and really gave an indication that 988 is the start, but it really should be the entry point to an entire crisis continuum of care. That was signed into law in October 2020 and 988 became available nationwide last July. This past weekend we just celebrated the one-year anniversary of 988's nationwide availability. So as you can tell, 2020 to 2022, not a whole heck of a lot of time to get everything into place. And we'll talk about some of the progress that's been made nationwide and it's really remarkable to see what's happening, not that the work is done, but so much happening across the country. So Ken, if you can advance the slide.

(00:05:19):

I've talked to a lot of folks in the NAMI Alliance and a lot of our partners about why NAMI has leaned in so significantly to 988. There aren't many opportunities to fundamentally change part of the mental health system and the availability of 988 gave us that opening. And we know that this is desperately needed. 5,500 times a day, people with mental illness are booked into our nation's jails about 2 million times a year. We know that there are about 3,300 suicide attempts made every day in the United States. We also know that suicide deaths exceeded 100,000. Sorry, overdose deaths exceeded 100,000 the last few years. And suicide deaths are over 48,000. Both of those are at near record highs.

(00:06:11):

And we know that millions of mental health crisis calls are made to 911 every year. There is an urgent need to provide better care to people in crisis. We at NAMI believe every single person in a mental health crisis deserves a mental health response, but tragically that's not what has traditionally been available to people in crisis. Far too often we've relied on law enforcement to provide that response. People go to overcrowded emergency departments and wait hours, days, sometimes weeks to get access to psychiatric care. And we let people cycle in and out of incarceration, hospitalization and homelessness rather than getting the care they need and deserve. And that's not acceptable. Next slide please.

Hannah Wesolowski (00:06:56):

So what we're aiming for, as I said, 988 more than a number, is that every single person has access to the continuum of care that gives them someone to talk to. That's the 988 component. That's connecting immediately with trained crisis counselors, a warm and helping hand to really help an individual in crisis. And we know that the vast majority of people who reach out to 988, that their immediate acute crisis can be resolved over the phone and connected to additional resources in the community that help them in their recovery and help them get well and stay well. But we know not everyone can get the help they need over the phone. And so for those individuals, we shouldn't be relying on law enforcement to provide that response and we shouldn't be criminalizing mental health crises. Instead, we need someone to respond, and that's mobile crisis teams that provide a behavioral health response that can be dispatched to an individual where they live.

(00:07:54):

And for those individuals that still need an additional layer of support, we need to provide a safe place to go. As I mentioned, emergency departments are often not the best resource for an individual in crisis. Many don't have access to psychiatric professionals. Many are overcrowded and then individuals often get stuck there because there's no other avenue for them to go. There may not be a bed available and they'll be stuck in that situation for hours or days. Our goal is simply that a person in crisis or their loved one can receive compassionate, accessible care and support from trained crisis responders. Again, 988 has given us the opening to do that. Next slide.

(00:08:36):

And this is one of my all-time favorite graphics. This comes to us from the Connections program based in Tucson, Arizona, Dr. Margie Balfour, who is just a brilliant leader in this space. And it really shows that when we have all aspects of a crisis continuum, it can make a remarkable difference in the lives of the people in the community. We can see that in Tucson where they have all aspects of this, they resolve 80% of crises on the phone. When they dispatch that mobile crisis response, they resolve about 70% in the field. And for that smaller portion, they have crisis facilities where 23-hour facilities where they can help stabilize an individual, determine what's going on and provide additional care. And I know David will speak much more about that.

(00:09:24):

For many of those individuals, they can discharge them back in the community and those individuals stay stable in the community. And that means far fewer people ending up in jail, far fewer people ending up in the ER and hospitals. And at any point, the critical element of this is that 911 and law enforcement should have close relationships with 988 and our mental health crisis system so that we can always provide people the best possible care no matter how they come in contact with any type of emergency response. That they can be handed off to the mental health crisis system. We know where this is in place, it works, and this illustration shows us that data. Next slide please.

Hannah Wesolowski (00:10:09):

So just a little context on 988 and what you can expect from it. Like I said, leverages the previous National Suicide Prevention Lifeline, which was launched in 2005. It's free. It's confidential. It's available 24/7 every day of the year. There's about 200 local call centers across the country. You can access it via phone, text or chat. And the vast majority of calls can be deescalated over the phone. So this is what happens if you call 988. It's a little bit different with text and chat. But if you call 988, you're going to have an option to press one if you're a veteran. You can press two if you want to connect to the Spanish subnetwork, Spanish-speaking crisis counselors. And you can press three for a new subnetwork for LGBTQ youth and young adults up to the age of 25.

(00:11:00):

If you don't press anything, you'll be routed, currently based on your area code, to your local crisis center. If that local crisis center has a backup and can't answer, there are backup centers across the country to answer calls. And while we want calls answered locally, those backup centers are still trained crisis counselors that can provide support and information and resources to callers and give them the resources that they need. So this is what happens when you call 988. As I mentioned, text and chat are slightly different, but same general principle. It's giving people options for some specialized services for at-risk communities, but also trying to connect people locally as often as possible. Next slide please.

(00:11:45):

So I mentioned 988 just turned one. This past weekend, we celebrated the one-year mark of 988 being available nationwide. And here's what's happened. We've had about 5 million contacts to 988 in this first 12 months. It's a 2 million increase over the previous year with the National Suicide Prevention Lifeline. So it's about a 40% increase year over year. There's been over an 1100% increase in texts, 141% increase in chats, 46% increase in calls. About 1 million contacts have been made to the Veterans Crisis Line in that time. That's that first option when you call 988 to press one to be connected to the Veterans Crisis Line. Despite this increase in demand, we're seeing that more people are getting through much higher answer rate and the average speed of getting answered, the speed at which you talk to somebody, has decreased dramatically. So the system is holding up. Is the system perfect? No, there's a lot of work to do, but there's a rapid scale up of capacity across the country. Next slide please.

(00:12:53):

NAMI just did some public opinion polling that we released last Thursday, so a week ago, and we found a few interesting things. First, a lot of people still don't know about 988, so it's important that all of us continue to share this as a resource. Only 4% of Americans are very familiar with 988 and 17% are very or somewhat familiar, so there's a lot of work to do in educating Americans about this. Two in five Americans said they don't know what to do if someone they love is experiencing a mental health crisis or suicidal, and that's exactly what 988 is intended for. It's intended to help people and their loved ones in the midst of a crisis get connected to the help they need. So there's certainly a desire for this as well as a need to make broader awareness possible. Next slide please.

Hannah Wesolowski (00:13:48):

I mentioned that when Congress passed legislation to create 988, they gave states a few options. They said 988 should be kind of an entry point to a crisis continuum of care. But they didn't fund these services through that legislation. What they did say is that states could implement a small fee on monthly phone bills that is similar to how we fund 911. Many of you probably don't realize that if you looked at your phone bill, whether it's a landline or a mobile phone, you probably pay a small fee every single month for 911. It averages about a dollar a month across the country. Some are much lower, some are much higher.

(00:14:32):

Since 2020, when that option became available to do something similar for 988 to fund not just call centers, but the whole range of crisis services through this fee, we had eight states pass legislation and two of those were just in the last few weeks. So shoutout to any of our callers in Oregon or Delaware. Those were just passed by your legislature. Delaware is the first state to pass one of these fees. That parity with their 911 fee. They passed a fee of 60 cents per phone bill per month, and that's how much their 911 fee is. What this all means is that it raises tens of millions of dollars for states to implement crisis services. Again, our goal is that every community has access to mobile crisis response and crisis stabilization options, but we need funding to do that. And these fees give us the opportunity to sustainably develop those resources so any of us are in crisis have access to them whenever we need them.

(00:15:34):

NAMI tracks state legislation nationwide. You can see that at reimaginecrisis.org/map. And there's lots of other mechanisms that states are working on to build out this crisis continuum of care. And if you're not engaged with your state NAMI organization, we encourage you to reach out to find out what's the status of this effort in your state and what can I do to help. We always need stories. We always need support. So if you haven't been involved, there's likely a role that you can play. So encourage you to reach out to your NAMI state organization. Next slide please.

(00:16:16):

So just a little bit more context about what we're seeing in the national conversation. I mentioned that we released a poll just last week, and what we found is that three in four Americans are not content with the state of mental health treatment in the United States. Not surprising data because mental health services are far from sufficient to meet the demand and the need across the country. I hear from NAMI advocates on a daily basis, so their struggle to find the care that they need or that their loved one needs. And so we are seeing that at a high level that this data shows people are struggling to get the care that they know they deserve.

(00:17:00):

And a lot of people say that mental healthcare should be a high or the highest priority for funding in Congress. I mean, that's pretty significant. Nearly two in three people said that mental healthcare should be among the top priorities for Congress, and we couldn't agree more. One in two Americans said that funding for 988 in particular should be a high or the highest priority for funding in Congress. I mean, that's really significant. That says that people will believe that this is something that should be available to everyone and it's a system we need to invest in.

Hannah Wesolowski (00:17:34):

We also saw that people overwhelmingly believe that everyone deserves a mental health response to a mental health crisis. 85% of Americans want a mental health response first to somebody in a mental health crisis, not a police response. We know that law enforcement response can often lead to trauma and tragedy, and we want to make sure that we're prioritizing sending out mental health resources to anybody in crisis. We also know that concerns vary across communities and Black and Hispanic Americans are more likely than white Americans to agree that they would not feel safe calling 911 for a loved one having a mental health crisis because of the very real experiences many people have had. We also found that LGBTQ+ Americans were more likely to agree with that sentiment than non-LGBTQ+ Americans. So a lot of important data to make sure not only that we're building these systems, but that we're building equitable systems across the country. Next slide please.

(00:18:42):

Before I hand things off to David, I just want to reinforce a few things. One, we need a consistent response to mental health crises. A lot of what we hear about 988 is that, what will happen? Will police come? Who's going to come to my door? There's a few things I want you to know. One, 988 call centers don't have your location and they can't track you. They can't dispatch law enforcement. What does happen in a very small number of cases? If an individual meets what's called the imminent risk standard, where the crisis counselor is worried that an individual's life may be at risk, they go through an extensive protocol to try to find the individual to send lifesaving services. In a very small number of cases that could be police, but again, that's not a guarantee and it certainly doesn't happen very frequently.

(00:19:35):

And so what we need is to make sure we have mobile crisis response in every single community so we can tell people exactly what to expect. That if you're in crisis and you need more help than can be provided over the phone, you will get a mobile crisis response. That's rapidly scaling up nationwide. It's not available everywhere, but just from a six months ago, a year ago, two years ago, the number of communities that provide mobile crisis response teams has expanded dramatically. And our goal at NAMI is to make sure every single community has access to those resources. So we can say just like if you have a heart attack and call 911, you know you're going to get an ambulance, you know you're going to be brought to a hospital, you know that there's a standard of care that's going to be implemented. You have the same expectation for what kind of services you'll get if you call 988.

(00:20:28):

The other thing is we need to expand our mental health crisis response workforce. There's a lot of work that needs to be done to make sure we have enough capacity. We are scaling up crisis services in every corner of this country, and we need the workforce to do it. Our country is in the midst of a mental health workforce shortage. [inaudible 00:20:49] specific to crisis. So there's a lot of effort being done to expand mental health crisis response workforce. We also need to invest in these crisis services. If we slow down now, we miss an incredible opportunity to make sure every single person gets the response they need and deserve. And in many communities, they have this range of crisis services. Where it's not available, we are working diligently to make sure that every person has this. We need to make sure the resources are there to keep these sustainable so that they're here not just tomorrow, but for every day in the future.

Hannah Wesolowski (00:21:24):

And finally, we need to expand awareness of 988. So anyone who is in this crisis can reach out and build those connections. We know that 988 saves lives and that so many people have gotten the resources they needed from 988. Again, there's work to be done. There's certainly areas of the system that need to continue to improve, but we know that this is saving lives. We always hear that it took decades to build the 911 system, but if we wait decades to build up 988, we will lose lives. And so we have to move with as much speed as humanly possible to make sure that this is built up in every community.

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And then finally on the next slide is just a number of resources, and you can find a link to all of these at nami.org/988. You can also always reach out to me. This is something we are committed to. We're committed to working with NAMI leaders and partners across the country to ensure that in the future, 988 is just part of our lives and that everyone knows what to expect and gets the resources and support they need when they reach out to 988. So with that, I'll turn things over to my colleague, David. David.

David Covington (00:22:46):

Thank you so much, Hannah, and wow, thanks for all the terrific work that you and NAMI are doing to lead this discussion nationally. And when some folks last year at the launch were saying, "Okay, we did the 988 thing," you were saying this journey is just beginning. We're at the starting line and maybe we've made it to base camp and now the march up to the summit is underway. So really love the work that you're all doing with Reimagine Crisis and the map that you keep around legislative changes has really created a lot of momentum and we'll continue to see states invest.

(00:23:30):

It was a day like any other day for 30 Chilean miners nearly a decade ago, but a collapse and crash led to them being trapped in utter darkness. We didn't know whether they were alive. But after 17 days, we made contact. Hard to believe they stayed alive, but they did. And we dug a hole, drilled a hole, thousands of feet deep, that was four inches in diameter. We made contact. We connected with them. We engaged, realized they were alive. Actually, as we were drilling down, the drill came back up and they'd attached a note to the drill that they were still alive. It took quite a while, longer, a weeks actually, for us to drill a larger hole that a person could go to them. But along that way, we kept them alive and supported them through that contact we had through that small hole. And then we went to them.

(00:24:31):

But in this case, we had to bring them to us. And ultimately we got them to a safe place and brought every last one of them out. The 11th one who came out and was interviewed by CNN and media globally said, "Thank you so much for believing we were alive." There was no shame, no blame. It was a multinational effort. We all collectively came around them and we save them with a really simple approach that we've started to say over and over again. You heard Hannah refer to it. We just want in every community someone that you can call, text or chat. And that engagement, sometimes that's enough. For those miners, it wasn't. For people with the most significant needs, it may not be. But for many individuals, a caring person on the other end of a keyboard or the computer or on the phone with their voice can be enough to walk you through the crisis that you're in and resolve the danger for right now.

David Covington (00:25:35):

Sometimes you got to have somebody come to you, someone to come. Someone to come to you, not have you go somewhere else, but come to where you're at, to your kitchen table. If you're a homeless individual, maybe under the bridge where you're at, if to your apartment or the school where you are, your job, maybe you just got booked into or not yet booked into jail, meet you there. That's the idea of someone to come and for those who need more, a safe place to go and one that they can get in directly. So it's three simple concepts, and we're going to talk about how those concepts can be deployed in a way that can revolutionize care for individuals in a behavioral health, a mental health, a substance use, or a suicidal crisis.

(00:26:25):

Now, we might say, okay, those Chilean miners, that was 30 people one time. There are people in a mental health or substance use or suicidal emergency continuously in our communities. We just don't have the capacity to respond to that. And yet we as a nation decided that that's exactly what we were going to do. Just as Hannah said, if the emergency is a medical one, a heart attack, stroke, a car accident, tragic gunshot wound, all of those, on your worst day, if that's the worst day of your life or of the year, as horrible as it is, the moment it happens, things start to get better.

(00:27:06):

They step-by-step start to get better because someone's going to engage 911. If required, there's going to be medical professionals on the scene generally in six to seven minutes if you live in a metropolitan area, in 12, 14, 15 minutes, if you live in a rural area. They're going to be there with standardized and caring engagement, and they're going to get you to someplace like an emergency department where you can get more intensive care if that's required. And not only is that care effective, but it frequently comes with a fair amount of love and support, a caring word, a touch on the shoulder. So that system is in play.

(00:27:43):

Now, I want to spend just a moment on what Hannah said. Hannah said it took 30 years to build that system. But actually I think we take that system so for granted, it's hard for us to imagine that it wasn't there before. So I went back and found the phone book. This is in 1966. This is actually right as the first 911 call is answered. That we're just within a few months of this. But before that, this is the inside of the Atlanta phone book.

(00:28:16):

And I'm going to just highlight, if you look, this is the top right of that inside front page. And for those of you who, well, for all of you who don't know what a phone book is, trust me, there was a time when we couldn't Google what the number was. We had a big white book, not that thick, dropped on our front doorstep and we would hold that book in the house as a paperweight. But that book had this, and you can tell this is important, it's got this big exclamation point here, emergency numbers in the upper left, and it's got this really helpful fire, police, doctor. And then you can tell there's no number there. There's no number. I had to look twice to figure this out. But if you look in the upper right, it says, "Write in the telephone numbers you will need in case of emergency."

David Covington (00:29:01):

So if we go to the bottom of that page, it has all kinds of numbers. It's not even clear. These columns aren't labeled, so I don't know what they are. And some of these locations overlap. If you know Atlanta, there are people who live in both Atlanta and DeKalb County because Fulton... Anyhow, it's confusing. So I guess what you were supposed to do is do some homework, make calls, try to figure this out. Then do as they said, write your individual numbers in to this piece of paper, rip this out of the phone book, tape it to the refrigerator, and then make sure your emergencies in the kitchen. That's literally what we had. And what we realized is lives were lost because of the time when there's a fire, when there's a medical emergency. That first hour around a stroke, you've got millions of brain cells dying per second. We can change lives by a rapid and thoughtful response.

(00:29:56):

But it's not just that there wasn't 911. 911 begins to be answered '67, '68. We've now got people answering 911. And guess what? They had no one to send to you. It's striking. But if you go forward 14 years later in 1980, John Lennon is shot in the back five times in the largest city in the [inaudible 00:30:19] right off of Central Park, and he is transported to the hospital in the back of a police car. We still were building out the capacity of ambulances to be able to be to you rapidly. So this is a coroner's car. I'm not making this up. We used coroner's cars. We used coroner's vans. We used hearses. But it was common to just get you to the hospital any way we could. The back of a police car, a family member throwing you in the station wagon, that's what we had. So it took years for us to build out, but we did it because we said that is going to make a difference and it's going to save lives.

(00:31:03):

But the last thing is the emergency department itself. That wasn't like what we have today. We decided that what we had previously wouldn't work. And what we had previously was you would go to the hospital emergency department. We're used to just walking in the door. You didn't walk in the door. It was locked. The way it was described to me by folks who were leading there then, Sandy Schneider, the past president of the American College of Emergency Physicians, described to me that there would be a... She called it a dongle, a little button that you'd push that would ring a bell in the emergency department. And if staff were available, they'd come to that door, but they didn't just let you in. They sort of opened the door and started asking you some questions. Was your physician on panel with the hospital? Were they going to serve you or not? They did not consider you a patient until you were admitted. Totally different world that through legislation and investment we changed.

(00:31:59):

Now, why did we change that? Well, ultimately, we changed it because of this paper in 1966, Accidental Death and Disability. And it argued that if you were on the streets of a major metropolitan city in the United States and were in a car accident, had a heart attack, you had a less chance of surviving than on the front lines of Vietnam. Because in Vietnam, we had medics in the field who were rapidly on the scene. Remember those MASH helicopters that would transport you to a unit where trauma surgeons stood ready to engage? It laid out the roadmap. And then again, this is the '60s and '70s and '80s, and we continue to make improvements to that system as we go forward.

David Covington (00:32:44):

So someone to call, someone to come, a safe place to go. We've got the equivalent of the coroner's vans to transport and the emergency department you can't get in. We don't have enough capacity and they aren't deployed in the right way. There's not an approach that says that anyone, anywhere, anytime, should get care in a crisis that feels like care to them. We've got a system that's very different than that.

(00:33:09):

Now, let's talk a little bit about the way it's rolling out. Now, this is before 988 launched. But right before 988, about two and a half to three million calls, texts a year were going through to that old 800-273-TALK number. The lifeline. Most crisis calls were still going through to local, county and state crisis lines. Those are the same crisis lines that answer the lifelines. So in the state of Georgia, if you call 988 or you call the Georgia Crisis and Access Line, it goes through to Behavioral Health Link, one of 220 crisis centers in the network that are the backbone of that 988 infrastructure nationwide.

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What's going to change as 988 rolls out and more and more Americans are aware of it, is more people are not going to call 911. We conservatively estimate that there's another 24, 26, maybe even 30 million people who are calling 911 in a mental health, substance use or suicidal crisis because they don't remember, or they don't know about a local crisis line. They don't remember the 10-digit number in emergency. And some are actually not calling anywhere. They're simply... They want to bypass this system altogether and they're going to a hospital emergency department directly. So we think there's somewhere between 40 and 50 million contacts of people that are in these types of emergencies every year. And as 988 gains traction, they're going to be reaching out.

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And look, the difference between the pre-medical emergency system and the behavioral health one is we didn't actively punish people who had a medical emergency ever. That's just not been what we've done. But we still haven't approach that there's a culture of you ought to figure this out on your own. And if you don't, our response is frequently going to be a punitive one. We're going to have law enforcement on the scenes. We're going to spend long hours or days in a hospital emergency department. I think people continuously miss how much psychiatric boarding goes on in the United States. It just doesn't get enough media attention. The Seattle Times in 2014 did an investigation for a year and found that in that Washington State area that people who were waiting in a hospital emergency department for substance use referral or mental health referral on average, on average, we're waiting three days.

(00:35:41):

Now that seems hard to believe, and in fact, if you're an adolescent, you may wait longer. At the beginning of 2020, Kana Enomoto, she was previously the acting director at SAMHSA, the top federal official for mental health in the United States. Her daughter, Reina, was having a suicidal crisis, landed up being referred to emergency department, and they were there over the course of a couple of visits. They were there for 10 days. The first stay, they were there for three days. This is the top administrator of the United States who had networking connections and insurance. This is the system we have in place today.

David Covington (00:36:18):

The Seattle Times found that people were frequently handcuffed to a gurney in the hallway because they didn't have either the attending space or the room space. It's been a very punitive approach at times. And the organizations that do provide services to psychiatric inpatient crisis, residential and other kinds of detoxification and providers, they again, remember that locked door in the emergency department, are the ones who get to say who they will and who they won't serve, when they are open and when they're not open. It's the old system that we still have as opposed to a new vision. Again, the same one we decided as a country we had to have for medical emergencies. Humane, thoughtful. This is the investment we make in each other. That we're going to respond when somebody has a heart attack, when they break a bone, when they're in an accident, when they are shot by a gun. We're going to have that system available to make that better, to save pain and to save lives. And let's do the same thing here. Everyone in crisis gets care that feels like care to them when and where they need it.

(00:37:28):

So that paper that came out in 1966, that blueprint, SAMHSA put out the blueprint for these services in 2020, the National Guidelines for Behavioral Health Crisis Care, a Best Practice Toolkit. And it laid out this someone to call, someone to come, a safe place to go. In our weekly learning community, the Crisis Jam, we lay out every week this vision of SAMHSA that Hannah was leaning into as SAMHSA works with communities to build out this resourcing and why it's so important. So let's talk just a little bit about what makes this system different. It's not just having a call, text, chat center and mobile teams and crisis receiving, but those services are deployed in the same set of values and spirit as our ambulances and emergency departments. So let's talk about what that means.

(00:38:20):

First of all, those call agents in the call centers, the text, chat centers, are using a level of technology. The SAMHSA guidelines talk about those 988 centers being able to dispatch mobile crisis, being able to use electronic bed inventories to see the current real-time capacity for detox or crisis beds, being able to schedule electronically appointments into behavioral health providers, [inaudible 00:38:46] health information exchange coming to your call contact center. So the caring engagement and collaboration with that live human being is the key, but they're not doing this without the technology of, call it air traffic, call it care traffic control, to wrap around and deploy these resources.

(00:39:07):

So one of the questions that was in the chat earlier was, do all 988 centers currently dispatch mobile crisis? If they have mobile crisis in that community, they may or may not. But that's the blueprint. That's the standard that we're working toward, that all of this is tied together. And that those mobile teams aren't saying, "Meet me at the community mental health center," or "Meet me at the hospital." They're saying, "I'm coming to you." They're getting in the car. And a team, some kind of professional, a licensed clinical social worker or counselor is pairing with some kind of, maybe a certified peer specialist as a team going out as two old friends in an unmarked vehicle. They're going straight to the home and going right in to sit down in that person's living environment. And they're spending the time to survey the assets, inventory their strengths, their resources, what's worked for them before, helping them deescalate that crisis, and collaborating with them in real time. It makes a huge difference. And this is how that slide that Hannah was showing of the impact of these services works as the mobile teams involved.

David Covington (00:40:18):

The other thing I want to say about this is it's deploying these services in this fashion at the volume required for the community's needs. This is another piece that we miss is how many individuals are in a mental health and substance use or suicidal crisis every day in the US. I was a little stunned myself when San Diego County started a mobile crisis initiative a couple of years ago, and at the press conference, the county police chief, she said, "Last year we had 45,000 interactions as police with people with a mental health, substance use or suicidal crisis." So this is about attending in scale because the vast majority of those did not require law enforcement involvement. There wasn't an active threat to public safety. There was not overt criminal activity. It was somebody in pain and a mobile crisis team going out.

(00:41:11):

This is the heat map of the 28,000 mobile crisis engagements that were done in Phoenix last year. So for years, the Arizona leadership, from the Medicaid Authority to the Behavioral Health Authority, its health plans and its provider networks have prioritized these services because of the humanity of it, but also because of the cost savings as we're deferring away from unnecessary law enforcement and hospital involvement. But some people are going to need more than that. They're going to need a facility that they can get into directly and facilities that are more humane. We at RI refer to the concept as the living room. Someplace you'd want to be served yourself, you'd want your mom to go to. This is our flagship location here in Arizona that we've operated since the mid-'90s. This is a facility in Washington State, in Baton Rouge, Louisiana.

(00:42:08):

But the key around these programs, so we're one of three organizations here in Phoenix. Hannah mentioned Connections. Connections operates the one right in the center of Phoenix. Another organization called Community Bridges operates the one in the East Valley. But you can see those, the geography is we've got coverage so that law enforcement can get to any one of these facilities in 15 to 20 minutes. Without this system, let's be honest about what happens, law enforcement is faced with a conundrum. They either do what they're supposed to do and take someone to a hospital emergency department where they can get caught in the chokehold, the choke point of this gauntlet to care that requires medical clearance first. And they'll be there for 18 hours. They'll be there for three days. If they're an adolescent, they might be there for five, six or seven days in a small room, often without windows, fluorescent lighting, without care, without treatment. They're waiting. It's inhumane, and we do it continuously.

(00:43:10):

So law enforcement is expected to take the person there, but the law enforcement themselves get caught. They can get stuck for 3, 4, 5 hours routinely or much more depending on the local situation. Law enforcement doesn't want to do that. So a lot of times they will instead take the person and book them into jail on some kind of nuisance crime or misdemeanor. They can be in and out of jail, typically within 45 minutes to an hour, or they try to drop them off at a park or move them around. I mean, this is the way that it works in the past as we are moving to a new situation. So Phoenix has for more than a decade, had these facilities where the person can go rapidly to them. And let me tell you what that means.

David Covington (00:43:59):

First of all, let me just say this. We have built systems in the United States around this sort of concept. Think about a light switch. If the light switch is up, they need inpatient care. It's a red light. They need acute care. They need inpatient. They need to be in a program for some days. If the light switch is down, they can get by, if you will, with the supports of follow up or outpatient care. A couple of years ago, I decided to look at how many of the people that are in crisis land up being in those two categories versus those that would be in the middle of that and need something more like mobile crisis services, a short-term crisis stay in something like a crisis receiving facility. So we use the LOCUS. I'm not going to go into all the detail about how the LOCUS works, but it's categories one and two or category six would pair with those specific types of services that communities tend to build out.

(00:44:53):

So we wanted to see how many people were in levels three, four and five that would again map to those core crisis services that the SAMHSA guidelines talked about. We looked at over a million records over a 10-year period of people who were in the back of a police car, who were seen by mobile crisis services, or were boarded in a hospital ED, and we found that 82% of them were in the middle. They actually would benefit more from these kinds of services, four out of five. And instead, what we have in most communities is all of these people at the upper end battling for limited acute care beds that really required resource that we have.

(00:45:30):

So what Phoenix has tried to do over the course of time is create a program where these facilities, the one in Tucson that Hannah mentioned, as well as the three in Phoenix, and we also have some in the outlying areas, that the law enforcement can come to directly. They don't call us. They don't chat or text. They don't go on a web portal. They just drive to the closest available facility. Again, generally about 10-minute or 15-minute drive.

(00:45:53):

Now, this is our facility in Phoenix. If you look to the right, you can't see in the picture, there are two spaces with sign that say police park here. They don't park there. They park right here where this car is sitting, which is closer to the door. And they get out and you'll see there's a sign there that says this is the police entrance. It's not a separate special door. It is actually attaches to, think about an airlock that connects to our 23-hour temporary observation and treatment unit directly. Many crisis programs across the country get into battles with law enforcement about storing their service revolver not being on the unit, et cetera. These law enforcement in Phoenix and in Tucson are never on the unit. They're in a connecting room attached to the outside that they can get directly in.

(00:46:40):

So the guarantee is at all of these facilities that they bring... we call the individual in crisis, the guest who's going to be with us. They bring that guest to the police door. They ring a bell. They knock. We come to that door quickly. And the guarantee is that they are in. This is the room. That door on the right is the one they're knocking on. The door on the left is the door directly connected to the unit. They're in this space for three to five minutes at none of these facilities across Arizona. Are they there more than 10 or 15 minutes? They are there. They make a handoff. They do an introduction. If they have paperwork, they share it. And then they're back on the street. So the concept nationally of everybody being choked through a hospital emergency department, we've just done away with that.

David Covington (00:47:28):

Now for the three to 5% who do have a medical issue that law enforcement didn't see, we get them the medical care, but we put that on the behavioral health system as opposed to putting on law enforcement. We want to make this system as easy as possible so that everyone, again, is getting care that feels like care when and where they need it. And then the facilities inside are, again, more focused on an environment of healing and support. And because the acuity of these programs is very high, we've got the medical, clinical and nursing resources around the clock to make sure we can support and engage. And there's a heavy engagement of certified peer supports and people with lived experience as part of these teams to really stack the deck that we're going to be able to help these individuals in crisis and support them on their first steps toward some kind of recovery journey. So the engagement of peers throughout the program really makes a huge difference when paired with the best in class medical, clinical and nursing leadership.

(00:48:38):

And again, the other thing I'll say about this is that it is key that we think about the volume. So in order to make this work for many psychiatric inpatient and crisis residential and crisis stabilization programs across the country, they might have 16 beds. The average length of stay might be seven to 10 days. They might admit one person today. Maybe zero. Maybe two or three on a rare day. In Phoenix alone, we'll have 15, 20 people just at our facility who are dropped off by law enforcement and that law enforcement drives away. So it's really a vision of how we begin to get law enforcement and hospitals out of this behavioral health response unless there is a need for it.

(00:49:30):

And again, we know when we need those services. If I'm on the way to the airport, I'm going to be on a plane without medical professionals, I might be on that plane for four hours. But I don't get screened medically to make sure I should be on that plane. On the way to the airport, I'm going to be involved with medical or law enforcement only because of three things. That I have a medical emergency, I'm involved in a car accident, or I have some kind of medical emergency. I'm involved in some kind of threat to public safety, or I'm involved in overt criminal activity. And we do have, it's rare, but we do have situations where it requires a law enforcement and a behavioral health response where there is a threat to public safety, someone has a firearm and is threatening to harm themselves or someone else. We're going to have to jointly respond to that.

(00:50:20):

And this coordination, that was another one of the questions we saw in the chat text. The coordination between 911 and 988, between mobile crisis and law enforcement, between emergency departments and crisis receiving, and between all of the different iterations of that matrix, that's increasingly areas that we're trying to standardize. We're looking for how to make that work the best. And again, it comes back to the technology for the care traffic control of these centers being able to navigate all that together in a way that no one falls through the cracks. So it's a step-by-step process, but we are seeing communities nationwide prioritize this work and move forward. It's not a notion, it's not an idea that that is developed by people in a ivory tower somewhere.

David Covington (00:51:09):

Arizona, Georgia have been doing this work for 10, 15 years. The state of Colorado in 2013, Governor Hickenlooper at the time and the Colorado legislature were concerned about the impacts of Columbine and Aurora. And actually a policymaker by the name of Chris Habgood did an environmental scan of the nation and saw these key elements. And he thought about it very much in the way of the medical emergency response system and began to deploy what became this concept of someone to call, someone to come, and a safe place to go. But that vision of your worst day, a psychiatric crisis, a behavioral health emergency, being connected to a rapid response of caring individuals supporting you at the level of your need is one that is, we're watching it take shape.

(00:52:05):

Hannah's quote that was, not only that she used earlier, was in the NPR podcast here as we marked the one-year anniversary of 988. That idea that we've got to do this quickly. I think if you look at the 30 years that the bulk of that emergency medical system from 1966, '67, '68, when 911 is first answered, and you start to see that capacity built out, we're moving much more rapidly, but we've got to keep that focus on. We're now facing budget cuts as a country as the political wind shift. And keeping the momentum up of states investing in this capacity, ensuring that both Medicaid, Medicare and commercial insurance begin to fully reimburse for these services, these are the goals that we've got to work together on to ensure that caring response as we go forward. Thank you.

Dr. Ken Duckworth (00:53:03):

Thank you, David. And thank you, Hannah. We have about 450 people, so a fair amount of questions. Let's start with the basics. If you've registered for this event, you will get an email with the access to a transcript, the slides, and a certificate of attendance. You are welcome to share this with your local police department, hospital, CIT people. We encourage that. Let's go with the first question.

(00:53:30):

So 988 is a national mental health lifeline. How about funding the mobile crisis services? So looks like step A has been set. Anywhere in America can access a person to talk to on 988. But it sounds like there's a lot of variability in the services people will receive. So the question is, what's the advocacy plan for that? Is that all local? Is that local and national? And how do I track the progress of my community? Thank you.

Hannah Wesolowski (00:54:08):

Yeah. And David, feel free to jump in. It is local, in some respects. States are passing legislation on how they fund mobile crisis services, how it's connected to other emergency services, and much of it's being implemented locally. But there's also a federal component here related to resources.

(00:54:28):

Just today, the Centers for Medicare and Medicaid Services, CMS, at the federal level, announced a Medicaid waiver approval for... or Medicaid amendment approval for providing mobile crisis response as part of their Medicaid program in Kentucky and California, I believe. So this is something that is being supported at the federal level to provide resources, but being implemented at a state and local level.

Hannah Wesolowski (00:54:58):

You can go to our tracking map, which I dumped in the chat before, reimaginecrisis.org/map, to see what legislation has either passed or being proposed in your state to help expand this. And also realize that there were some states that were doing this or some communities that were doing this before. So there is a nationwide effort to make sure this is coming online in every community, but there are some that are going to move faster than others. So we are in different places across the country at the moment, but more and more mobile crisis teams are becoming available with every month and every year that this effort is ongoing.

Dr. Ken Duckworth (00:55:38):

David, you want to add to Hannah's answer?

David Covington (00:55:40):

Yeah. I'll add a couple of things. Arizona spends more than 300 million a year on these three core services, but that funding largely doesn't come from Arizona. It comes from the federal government, but by virtue of billing Medicaid. Medicaid is a payer. Now the call, text, chat services, we'll have to decide as we go forward. Right now, Congress has said, very much as Hannah said, that states should reimburse this or resource this, similar to the way that we resourced 911 with that small add-on cell phone fee. But mobile crisis, temporary observation and treatment for 23 hours, short-term crisis beds, these are medical services. In Arizona, they are covered services in the covered services guide. They are essential services that are reimbursed by Medicaid. Medicare and commercial insurance must follow suit. They have to provide payment on par with the medical emergency system and they're not yet doing that. So we see Medicaid increasingly coming to the table and Medicare and commercial insurance must also come to the table.

(00:56:56):

The other thing about this is just again, the federal government is putting more and more resource to this, and that's been terrific, but largely states are still the ones putting the funding. The block grant doubling and tripling during the pandemic still is a fraction. Our Medicaid budget here in Arizona's 12 billion and the block grant in its entirety is only about 3 billion for the whole country with SAMHSA. So the resources actually largely already exist for mobile and facility services. We've got to ensure that states pay for them. And there's work going on at [inaudible 00:57:34], Henry Harbin, who actually has worked with NAMI over the years around first episode psychosis services and making sure that they're standardized billing codes. We're doing that same work around mobile and crisis. So Hannah, to the extent that some of the legislation and the national stuff reinforces mobile and facility, that'll be great, but the payers are increasingly coming to the table and must come to the table for those medical services.

Dr. Ken Duckworth (00:58:02):

Let's transition from complex policy to swag. David, a lot of people like your T-shirt. How do they get a 988 T-shirt? [inaudible 00:58:11]. Very nice, very nice demo. And this also speaks to the issue of how do we get more people to learn about 988. Well, let's start with swag.

David Covington (00:58:23):

Yeah.

Dr. Ken Duckworth (00:58:23):

People like your swag.

David Covington (00:58:25):

First of all, SAMHSA does have a store. You can get over 300 items for free from the SAMHSA store. They don't have shirts, but they have magnets and stickers and posters and a host of other things. But we actually, we took the logos. There are four SAMHSA logos that are in the public domain. We have six key quotes. You saw one of them on the back of mine, but there are five others you can choose from. And then you can choose English or Spanish. And the way to get to those, the easiest way is to go to talk.crisisnow.com, talk.crisisnow.com.

(00:58:59):

And every week, every Wednesday, from noon Eastern Time to 1:00, we have a learning community called the Crisis Jam, and we'll have 400, 500 people on every week. Another 100 to 200 watch on YouTube. We've got over 100 episodes, but Hannah's on most of the time. Steph is on from the NAMI team. We have SAMHSA updates. We have [inaudible 00:59:22] updates. We have a featured presentation, a trivia question. We spotlight crisis centers as well as a federal legislation view. And we always have NAMI's state map. So that call is constantly bringing people back to our swag website as well. We want to get the word out.

Dr. Ken Duckworth (00:59:40):

Hannah, you want to add anything on swag?

Hannah Wesolowski (00:59:45):

No. I mean, I love David's shirt and encourage everyone to get one. I have mine and love wearing it and having a chance to talk to people about what 988 is.

Dr. Ken Duckworth (00:59:54):

Let's go. Another question, a different angle. What is the training of the person who picks up the phone at 988? And other people are saying, "I'd like to work in mobile crisis work." How might I approach that? So let's start with the training of the people picking up the 988 line.

David Covington (01:00:16):

Yeah. So we have 220 centers across the network in every state, and these centers don't exist to answer 988. Not yet. They exist to answer their local county crisis line, their local city crisis line, their state crisis line, or a host of other things they do. They answer a domestic violence line or a gambling hotline or whatever. They'd answer 211. And so they have different policies, procedures, different funding, and the vast majority of their funding still does not come from 988. It comes from local resources and we sort of put all that together. So that means they have different sets of standards and expectations. They're generally accredited by somebody like the American Association of Suicidology and they are under the rubric of the expectations of Vibrant and SAMHSA for answering 988. But technically what 988 requires is those staff be three things. They'd be caring, competent and trained. And then that's up to the local organization.

David Covington (01:01:18):

So for many years, Behavioral Health Link, who operates the statewide center in Georgia, required full licensure to be on that phone. But most centers, many centers have volunteers who actually don't have... maybe don't have a high school diploma or any kind of college education. So we've seen a wide variety of approaches over time. I think what we're leaning into is in the best possible world, the individuals answering that call, text, chat are people with lived experience, their certified peers who've been appropriately trained, and there is clinical supervision of those teams.

(01:01:56):

Now going to mobile teams, the SAMHSA National Guidelines talk about someone who is licensed to do assessment in the state. Most states require a licensed clinical social worker or licensed counselor to do assessment. If you're going to engage the person and try to avoid a hospitalization or know that they need hospitalization, you need to be able to do assessment. The partner of that individual, again, the SAMHSA National Guidelines encourage a certified peer support staff, someone with lived experience. So that team is going in.

(01:02:27):

And the reason we do teams is because these people are going into the community. They're going to a non-secure setting. They're not going to the hospital emergency department. So it's about the safety of the individual in crisis, their family and of the staff members. So again, it varies by city and state, but I think someone who has a lived experience and is willing to get some training, they can work on mobile teams, they can work in call, text, chat centers, and we need you. We need you.

Dr. Ken Duckworth (01:02:54):

Hannah, you want to add anything to that?

Hannah Wesolowski (01:02:57):

No, I think David hit all the points. Let's get to some of the other questions.

Dr. Ken Duckworth (01:03:01):

All right, great. One of the question that's coming up is the relationship between 988 and police response. And this would be related to police training and crisis intervention training or CIT. So let's talk about 988, how it relates to 911, how information goes back and forth, and what's being done for the improve the police response when there isn't a mobile crisis team.

Hannah Wesolowski (01:03:29):

Yeah. I think that's a really important question. Even if we have the perfect system where you can call 988, they can dispatch mobile crisis response, mobile crisis responses available in every community, you're always going to have law enforcement in the course of their day-to-day work coming in contact with people in crisis. Many people, when they see somebody exhibiting certain behaviors, they don't know they're in a mental health crisis or police may just come upon somebody as they're doing patrol. And so we're always going to need CIT-trained officers.

Hannah Wesolowski (01:04:02):

And certainly right now where we don't have mobile crisis response everywhere, that becomes even more important. Crisis intervention teams are critical community partnerships between the mental health community providers and law enforcement, but also that law enforcement training so they better understand lived experience and what somebody might be going through. And NAMI has been involved with CIT from the beginning, helping provide a seed grant in 1988 to start CIT in Memphis. And we believe that it is always going to be critical and important.

(01:04:41):

Now, law enforcement and 911 and 988 and mobile crisis response all have to work together. And I saw a number of questions come in about what does that relationship look like? Well, law enforcement and 911 are very local as is mobile crisis response. And so it's really building that trust and process community by community to ensure that all systems are able to hand off to the most appropriate response in that community. We know that for other healthcare crises, we often don't rely on law enforcement to respond. And for the vast majority of mental health crises, law enforcement doesn't need to be involved. And so as David covered so beautifully, the time and demands and resources that responding to mental health crises have put on law enforcement are significant. And so we really need to shift that expectation that it's not law enforcement's responsibility to respond to a person in crisis nor does it give a person in crisis the best response.

(01:05:44):

However, we want to make sure if 911 operator is talking to somebody in crisis that perhaps they have some 988 crisis counselors co-located in their 911 call center, or they have a protocol so that they can transfer those calls to 988. Likewise, if law enforcement responds and realize a mobile crisis team is going to be better suited to help in this situation, they have protocol to be able to bring that mobile crisis team in. And if a mobile crisis team feels there's a safety issue, they should have a very quick and efficient conduit to be able to get law enforcement support if it's needed. So it's really important that these systems work together and that progress is happening community by community. And we agree that it's an absolute priority to make sure the system works for everyone.

David Covington (01:06:33):

I love all that, Ken. I just accentuate two points. Ron Bruno was the executive director for CIT International for many years. And the most popular thing we've ever done on the Crisis Jam has been his presentation on mental health, a mental health crisis care should not come in a police car. So yes, there are going to be maybe one out of 20 cases where we need law enforcement involved to some degree, either on the scene or to secure the scene first because there is a threat to public safety. But the vast majority of the time, again, 19 out of 20 times, the person is not in a medical emergency and shouldn't go to a hospital first. And 19 out of 20 times, they're not in some kind of situation that requires law enforcement involvement.

David Covington (01:07:18):

We have today in Phoenix, it'll happen multiple times, is that someone was looking strange to someone in the community. They called 911, just as Hannah said, a police went out and they said, "You know what? This is a mobile crisis engagement." And we prioritize getting mobile crisis to that police officer on the corner of Thomas and 16th as quickly as we can. If we can get there in under 30 minutes, often the law enforcement officer will just wait and hand off and police drive away. So again, the engagement there. Hannah hit on all the tactics. But again, we're talking about swag earlier. Another quote we have on the back of the shirt says, "Mental health shouldn't come in a police car."

Dr. Ken Duckworth (01:08:00):

All services are local. There's a lot of questions. I want to make a difference in Kalamazoo, Michigan. I want to connect with law enforcement and mobile crisis in Houston. I want to work with professionals in Pinellas County. And I want to emphasize from my perspective, having been the commissioner of mental health in Massachusetts, how local services are.

(01:08:21):

Hannah, would you recommend people contact the NAMI connected to Kalamazoo, to Pinellas County, NAMI Houston? Because it seems to me that's a way to capture both the power of multiple people and the local culture and service world.

Hannah Wesolowski (01:08:39):

Yeah, absolutely. Contacting your local NAMI is the best way to go. And if you need help with that, I'm putting our Reimagine Crisis email in the chat and can reach out to us and we can help make those connections. We need everyone's voice as part of this. It's going to take all of us to continue the momentum that we've started to really build out this system and make sure everyone's getting the help they need. So if you know your local NAMI, definitely reach out to them. If you are with a local NAMI and you haven't been involved and want to get involved, reach out to us. Or if you need help connecting with that local NAMI, you can also reach out.

Dr. Ken Duckworth (01:09:17):

Interesting. NAMI gets very involved in these things. If you look at Massachusetts, which is my home state, the crisis intervention training is happening because of the local NAMI, right? They weren't a fast state to take this on and NAMI really brought it to the table. Hannah, you've conducted a couple surveys around 988. What are the big takeaways or things you want to share here?

Hannah Wesolowski (01:09:42):

Yeah. I think, one, people overwhelmingly agree with this concept that a person in a mental health crisis deserves a mental health response. Even if they are not a person themselves who has dealt with the mental health crisis or had a loved one with a mental health crisis, when you ask them what's the best response in this situation, they say a mental health response. So people are supportive of this concept. They support the federal government, state governments paying for it. They support an insurance payers paying for it. But we also found that just not enough people are aware of 988. So we're going to have a lot of work to do in, one, developing trust so people know what to expect and trust this as a resource. And part of that is building up this continuum of care, but also just letting people know it's there and it's for them. Like I said, less than one in five people are familiar with 988, so we have a lot of work to do.

Dr. Ken Duckworth (01:10:39):

David, any other perspective you have on those surveys?

David Covington (01:10:43):

I've watched the growth of crisis lines. When 1-800-SUICIDE was developed. When 1-800-273-TALK took its place. We took over the 40-year-old Fulton County crisis line in Atlanta in 2002 and we implemented our new number. And every time we've done all those, we've been watching the growth of the new number, but also we continue to answer the old number. And I'm shocked how long it's taken for some of those old numbers to extinguish, right? I guess they were on a refrigerator in the old world.

(01:11:16):

But I think everything is accelerated because of technology and social media and the kind of great work that you're doing at NAMI. So it's striking. It's not enough, but 20% over the course of one year. Again, it took decades for 911 to reach the ubiquity that we have now. So this is moving. This is really moving. And we were all had the emergency breakup until July 16th of last year because we were afraid of that influx and not being able to meet the demand. And I think now the training wheels are off. We're off and running and it's going quick. I think it's going to be moving.

Dr. Ken Duckworth (01:11:57):

If people have more questions, can they join the Crisis Jam Learning Community?

David Covington (01:12:03):

We have about 5,000 people who've been a part of one of those calls and 350 distinct presenters or major participants on the call. So if you haven't been on a Crisis Jam, Hannah, it's a little frenetic. We had in the Go Live event where Miriam Delphin-Rittmon presented last July. We had 20 speakers in the hour and Miriam spoke for 15. So it really moves. And the other thing we do is we operate without a safety net. The text chat is wide open. So we'll have 400, 500 people on the call and it just moves continuously because everyone's encouraged to jump in.

(01:12:47):

So if you go to talk.crisisnow.com, you'll see the Zoom link as well as you can get through to our YouTube channel and you can see all the past episodes. You can spend the weekend doing that. But we welcome you to join. And we're meeting every Wednesday except for the major holidays.

Dr. Ken Duckworth (01:13:05):

I want to close this-

Hannah Wesolowski (01:13:05):

Yeah. And I would say-

Dr. Ken Duckworth (01:13:05):

Go ahead, Hannah.

Hannah Wesolowski (01:13:10):

Yeah. I was just going to say if you want to learn more about the different strategies, tactics, programs, at-risk communities and how we address at-risk communities' needs, I mean, Crisis Jam is definitely the resource for that. Every week I learn new things and just amazing, supportive, brilliant community of people working to build up these crisis resources.

Dr. Ken Duckworth (01:13:31):

Well, we didn't get to everything, of course. We got to a substantive subset of the questions. But if you join the Crisis Jam, you can keep going and keep learning. I want to close by somebody saying, "I've been using 988 during periods of crisis and it's been incredibly helpful." And I just want to close with that note. I want to thank you both for your expertise and for the great work you continue to do. Crisis Jam is going to be in the slides so you can join that. David runs a weekly conversation. We're going to be talking about the criminal justice system and jail diversion on Thursday, August 31st, again with Hannah, our policy lead at NAMI, and please feel free to join us.

(01:14:26):

Oh, we wrote a little book at NAMI and all the royalties go to NAMI. As the author, I interviewed 130 real people who have shared their story with law enforcement, have been peer workers on crisis programs in Atlanta. You'll be happy to know David and many other first person as expert experiences. Book has sold about 40,000 copies, was a USA Today bestseller, and is NAMI's first book. And so if you're interested in learning more, anywhere you want to buy a book, You Are Not Alone is there. Go to the next slide.

(01:15:07):

And I just want to say you're not alone. We do our absolute best as a nonprofit to provide these kind of educational resources. If you're interested in donating to NAMI, bring it on. I want to thank you all for joining today and thank you for your continued efforts. I want to emphasize how local this is. 988 is a national triumph and we need to work locally in Kalamazoo, Pinellas County, Houston and everywhere else across the country. We have to up the game of the mental health crisis response and the sophistication when a police response is the first response. Thank you everyone. I hope to see you on August the 31st. We'll continue to discuss this kind of world, how to improve our service system, which is in great need of help.