

At the point of dispatch

How technology-enabled coordination builds trust
between 988 contact centers and mobile crisis teams



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Dispatch is the moment when crisis care either holds together or starts to fragment. When coordination fails, people in crisis repeat traumatic stories, mobile teams arrive without context, clinicians lose visibility into outcomes, and communities default to higher-acuity interventions that could have been avoided.

With the right workflow platform, geo-aware dispatch, secure information exchange, and shared dashboards, a contact center can turn a referral into a clinically reliable handoff.

That expectation is now reflected in national guidance. Substance Abuse and Mental Health Services Administration's (SAMHSA) 2025 crisis guidance frames contact centers, mobile crisis response, stabilization, and follow-up as one coordinated system. It also recommends established protocols and formal agreements between crisis lines and local mobile crisis teams.

988 Lifeline's current standards add a complementary clinical posture: support-centered conversations, warm transfers, required follow-up for certain high-risk contacts, and the least invasive clinically appropriate intervention.^{1,3,4}



Trust at dispatch is not a soft skill. It is clinical reliability that people can feel: one coordinated response, not repeated assessment, delay, or avoidable escalation.^{1,4}



Reduce retelling

Capture information once, share it appropriately, and spare the person in crisis from repeating their story. Dispatch workflows should support trauma-informed care by reducing retelling, increasing transparency, supporting collaboration, and minimizing avoidable escalation.



Use location proportionately

Use general-area routing as the default. Reserve exact geolocation for situations where it is policy-bound, clinically justified, and privacy-aware.



Measure the whole continuum

Track the handoff from contact center to mobile response to stabilization, linkage, and follow-up.



Design for human judgment and failure modes

Build clear escalation, downtime, no-team-available, and unable-to-locate protocols into the workflow rather than treating them as exceptions outside the system.



Executive summary

A strong dispatch process does three things at once: protects the therapeutic alliance created by the crisis counselor, gives the field team enough context to respond safely and effectively, and creates the structured data leaders need to strengthen the full crisis continuum.

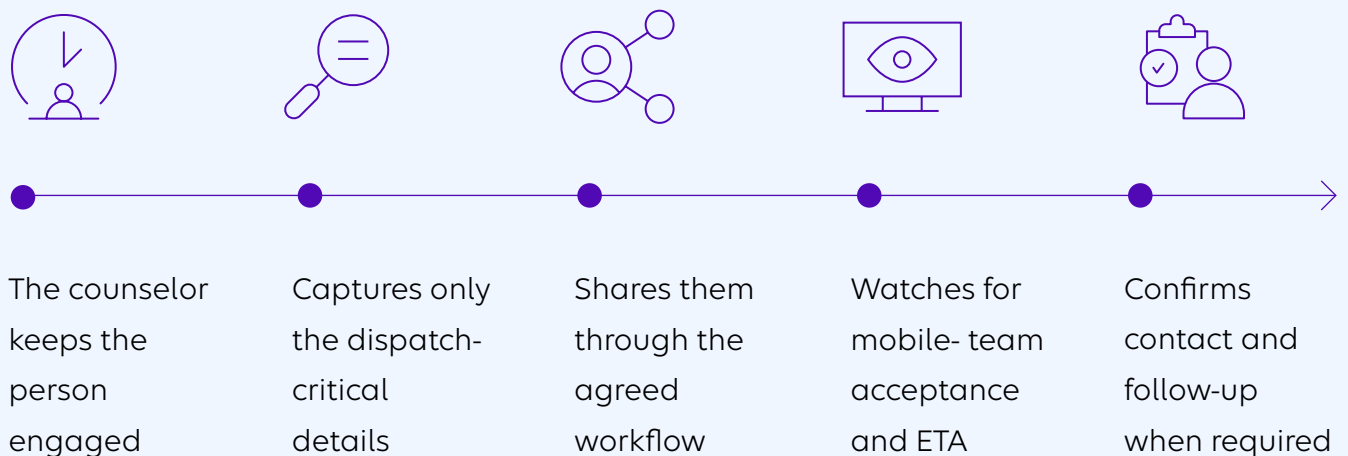
Technology, in this context, is clinical infrastructure. When it is thoughtfully governed, a shared contact-center and dispatch platform can reduce retelling, show mobile-team availability in real time, support warm handoffs and follow-up, and produce dashboards that reveal whether people are being stabilized in the community or lost between services.

Why dispatch is where crisis systems prove themselves

SAMHSA describes an effective behavioral health crisis system as comprehensive, integrated, coordinated, person-centered, trauma-informed, and continuous from the onset of crisis through stability and follow-up. That system-level frame matters because dispatch is where the promise of "no wrong door" becomes visible - or breaks down. A strong phone intervention can lose force if the next step is delayed, too thin clinically, or confusing operationally.¹

A typical workflow makes that visible: the counselor keeps the person engaged, captures only the dispatch-critical details, shares them through the agreed workflow, watches for mobile-team acceptance and ETA, and confirms contact and follow-up when required.

A typical workflow makes that visible





Current field capacity remains uneven. The National Association of State Mental Health Program Directors Research Institute (NRI) reported that, in 2023, 38 states used 988 contact centers as one component for dispatching mobile crisis teams. Within that group, only 18 states reported that all 988 centers could dispatch mobile crisis teams when needed.

Twenty-six states reported statewide mobile crisis availability, and fewer than half reported 24/7 statewide coverage. At the same time, the median state reported that 68% of mobile crisis encounters were resolved during the contact without more intensive immediate follow-up.⁶



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NRI State Profiles



18 states

reported that all 988 centers could dispatch mobile crisis teams when needed.

NRI State Profiles



24%

of mobile crisis teams reported integrated electronic health records (EHRs) for information sharing during care transitions.

National Mobile Crisis Survey



13 states

were operating data systems that monitored flow across the crisis continuum.

NRI Dashboards brief

High-trust dispatch therefore has four dimensions:

Clinical trust, operational trust, data trust, and person/community trust.



Clinical trust means the mobile team receives a concise, meaningful picture of risk, acuity, and the least restrictive response plan.*



Operational trust means the contact center can see who is available, who accepted the referral, and whether contact was made.



Data trust means leaders can review the handoff later without reconstructing it from disconnected systems. Data trust also depends on data integrity standards and governance processes that support quality-of-care review.



Person and community trust means the process is transparent enough for people and partners to understand how decisions are made and how information is protected.^{1,2,4}

* In this context, least restrictive response means matching risk and acuity to the lowest-intensity intervention that can safely stabilize the person, with clear criteria for when to escalate to EMS, law enforcement, or a blended response.



What high-trust dispatch looks like

A shared definition of which types of crises mobile teams can lead and which require emergency medical services (EMS), law enforcement, or a blended response.

A minimum dispatch dataset that is clinically useful without creating a duplicate intake process. Dispatch data should be purpose-built for actionability and continuity of care, not administrative completeness or exhaustive documentation.

Closed-loop handoff: The mobile team accepts the referral, the ETA is visible, and the contact center can confirm contact when required.

Post-event review based on common metrics rather than parallel narratives from disconnected systems.

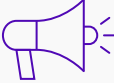
These are relationship practices, but they depend on technology and governance. SAMHSA's recent 988 and 911 interoperability guidance makes the broader point directly: relationship building, documentation, and communication are practical risk controls, not optional culture work.⁸

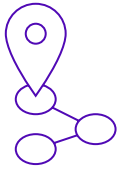
How technology connects clinical intent to action

SAMHSA's 2025 national guidance explicitly names technology as an enabler of high-quality crisis care. It highlights GPS-enabled mobile team services, real-time bed registries, centralized appointment scheduling, EHR integration with partner services and health information exchange networks, and centralized platforms that allow crisis contacts to flow through one coordinated system.

Most crisis systems still operate across partially connected platforms, making governance and workflow design as important as technical integration itself. A core guardrail is avoiding automation bias: technology should make dispatch more reliable and transparent, but it should not replace clinician judgment. In practice, technology is not secondary to clinical practice. It is what helps clinical intent travel across settings without being diluted.^{1,2}



Capability	Clinical value	Operational value
 Integrated contact-center workflow	Supports support-centered conversations while capturing the minimum dispatch dataset and warm-handoff notes without restarting the assessment.	Standardizes triage, resource lookup, escalation pathways, and quality review across staff and shifts.
 Geo-aware dispatch	Helps match the person in crisis to local care and identify the fastest clinically appropriate mobile team.	Shows which teams are available, en route, on scene, or unavailable in real time.
 Live resource visibility	Helps the mobile team aim for the least intensive appropriate next step, not simply the next available opening.	Displays crisis beds, stabilization capacity, and appointment options for timely downstream linkage.
 Shared record and health information exchange (HIE) connectivity	Reduces retelling and gives responders context on history, risk, and recent encounters when lawfully available.	Supports secure messaging, documentation, follow-up prompts, and reporting across agencies.
 System dashboards	Make equity, safety, diversion, and continuity visible so leaders can intervene before failures become normal.	Turn time stamps and dispositions into service-level, system-level, and contract-level performance data.



Georouting

988 Lifeline currently routes voice contacts based on a help-seeker's approximate location. This connects people to local crisis resources while preserving more privacy than exact-device tracking.



Geolocation

Exact-device location can speed urgent deployment, but SAMHSA's toolkit notes that it does not preserve anonymity in the same way. Use should be governed by policy, justified by clinical need, and explained transparently whenever possible.^{2,3}

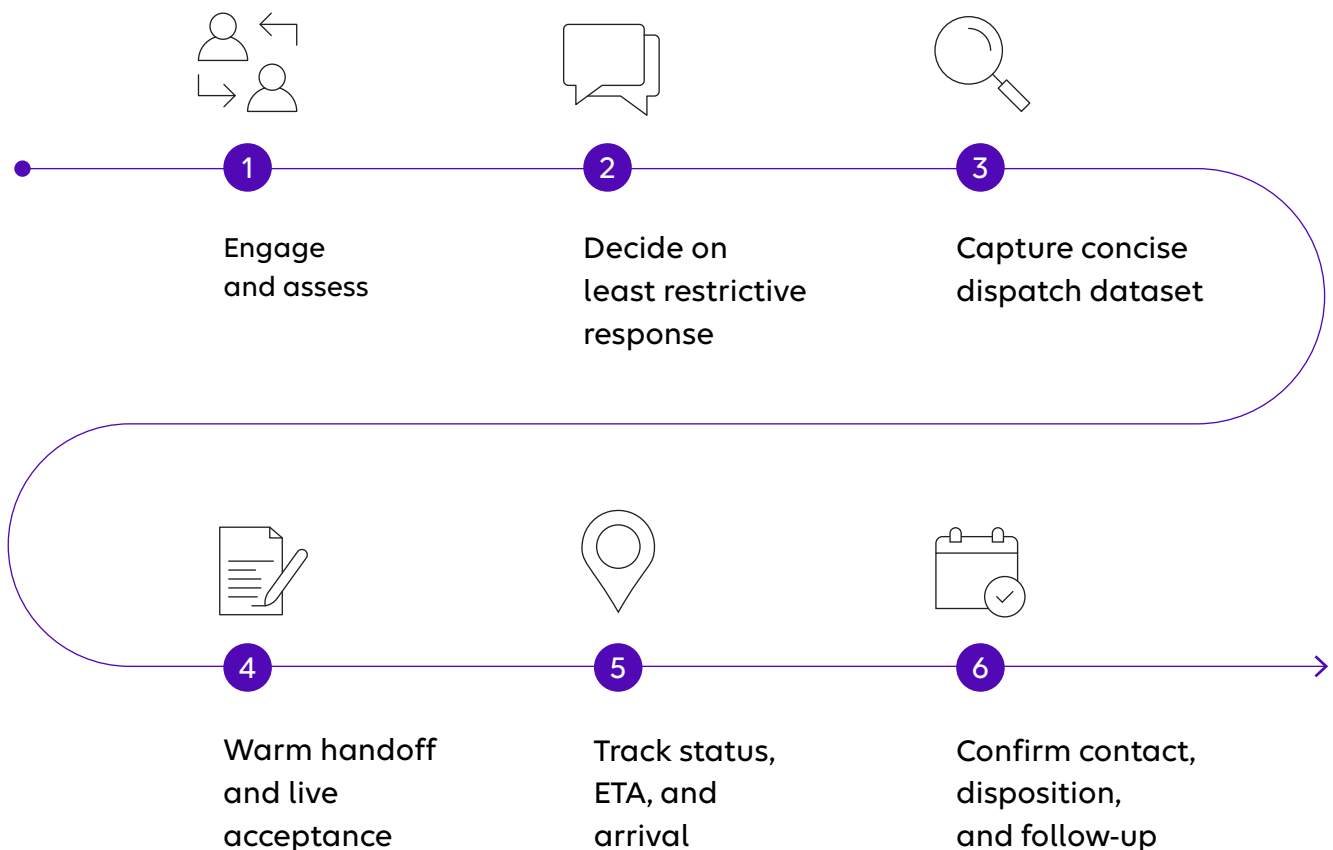
Crisis technology in practice

SAMHSA's Mobile Crisis Team Toolkit describes Georgia's Crisis and Access Line (GCAL) as using GPS technology to identify which mobile team can respond most quickly.* It also describes a live registry showing real-time withdrawal and stabilization bed availability. At the time of writing, SAMHSA noted that 33 states had established or were developing a live bed registry. The lesson is not about a single vendor. It is about workflow visibility: dispatch quality improves when contact centers can see mobile teams and downstream resources at the same time.²

*GCAL is operated by Carelon.

A dispatch model that protects clinical care

988 Lifeline's current standards are clear about the clinical posture that should govern dispatch. 988 conversations are centered on support, not intake. The person in crisis is not required to provide identifying information to receive services. Crisis counselors must ask about suicide, practice active engagement, use the least invasive intervention that can secure safety, and, in specified circumstances, confirm whether requested dispatch services made contact. When a mobile crisis response exists in the contact center's service territory, 988 Lifeline policy requires a formal relationship, such as a memorandum of understanding (MOU).^{3,4}



This model keeps the counselor responsible for the therapeutic frame until the handoff is accepted. Technology should show team availability, geography, hours, age capability, language support, and any special scope characteristics. Whenever possible, the handoff should be live; the mobile team should accept the referral in real time; and the dispatch record should generate time stamps automatically for activation, acceptance, en route, arrival, and disposition.^{2,3,4}

Always capture	Capture if known and clinically relevant
Presenting crisis and current safety concern	Suicide, self-harm, violence, substance use, or medical context
Location type and address, if available	Language, sensory, mobility, or cultural access needs
Who is with the person and who initiated the contact	Whether the person consents to or expects mobile response
Responder safety concerns and need for additional partners	Existing safety plan, prior crisis contacts, or trusted supports
Working disposition goal and immediate next steps	Preferred downstream options, such as crisis stabilization or clinic follow-up



Clinical rule

The dispatch dataset should make the next step safer and more person-centered. It should not replace therapeutic engagement or justify collecting unnecessary identifying information.^{3,4}



Operational rule

The handoff is not complete when a referral is sent. It is complete when the receiving team accepts the referral, the system records the transition, and the dispatching center can see what happened next.^{2,4}



Governance, privacy, and dashboards leaders can trust

Technology cannot build trust unless organizations define roles, thresholds, and lawful data-sharing pathways together. SAMHSA recommends data governance plans that address data sharing and transparency, data integration, and compliance. SAMHSA's mobile crisis toolkit adds that cross-agency agreements should formalize roles and responsibilities beyond technology alone.

In practice, a 988-mobile crisis partnership needs an MOU or operating agreement, a data use framework, clear platform ownership, and a written review process for sentinel events and dispatch disputes.^{1,2,4}

Privacy rules remain essential. At the same time, recent policy changes make coordinated architecture more achievable than many organizations assume. The 2024 final rule from the U.S. Department of Health and Human Services (HHS) on 42 CFR Part 2 better aligned aspects of Part 2 with Health Insurance Portability and Accountability Act (HIPAA).

It allows a single consent for future treatment, payment, and health care operations uses and disclosures; permits redisclosure by HIPAA-covered entities under that consent; and expressly states that segregating Part 2 data is not required. Even so, crisis systems still need explicit policies for role-based access, redisclosure limits, patient notice, and complaint handling.⁹

Dashboard domain	Illustrative measures	Why leaders need it
 Access and flow	Time to answer; local answer rate; activation rate; dispatch-to-arrival time; unable-to-locate rate; no-team-available rate.	Shows whether handoffs are timely and whether community capacity exists when people need it.
 Clinical quality and safety	Safety assessment completion; least-restrictive disposition rate; emergency-service requests; contact confirmation; supervisory review timeliness.	Tests whether practice aligns with 988 Lifeline policy and local response thresholds.
 Continuity and follow-up	Warm-handoff completion; follow-up offered; follow-up completed within 24 to 72 hours; linkage to outpatient or stabilization service.	Shows whether the person was connected onward or simply transferred out of view.
 Equity and experience	Outcomes by age, race, language, geography, disability, and urban-rural status; interpreter use; consumer and family feedback.	Identifies whether access and outcomes differ across populations or settings.
 System impact	Emergency department (ED) diversion; crisis-stabilization use; law-enforcement involvement; hospitalization; repeat crisis contact.	Connects dispatch quality to downstream utilization and community-level performance.

This measurement discipline is not theoretical. The National Association of State Mental Health Program Directors Research Institute (NRI) reported 28 states had data-reporting requirements for crisis contact centers and 25 had requirements for mobile crisis services in 2023. Yet only 13 states were operating systems that monitored data across the full crisis continuum.

NRI's national mobile crisis survey similarly found that 45% of teams were not using metrics to inform incentives or payments, 44% measured point-of-service diversion, and only 23% tracked when a team could not locate the client. A dashboard is therefore not just a reporting tool. It is a mechanism for clinical accountability and capacity management.^{5,7}

988 Lifeline already directs its network to an interactive SAMHSA dashboard for network-wide performance metrics. Local crisis systems should bring the same transparency to the point of dispatch.¹⁰

Examples include targets for dispatch-to-arrival time, warm-handoff completion, contact-confirmation completion, no-team-available rate, unable-to-locate rate, and follow-up within 24 to 72 hours.



Implementation roadmap: How to make trust operational

Phase	Primary build activities	Leadership question
● 0-90 days	Convene 988, mobile crisis, stabilization, and key public-safety partners; define dispatch thresholds; finalize the minimum dispatch dataset; establish the contact-confirmation protocol; draft the MOU and quality assurance (QA) review process.	Do partners trust one another enough to write down roles and decision rules?
● 3-9 months	Deploy shared workflow technology, team-status visibility, geo-aware dispatch rules, and an updated resource directory; begin dashboarding access, flow, and follow-up metrics; train staff in warm-handoff practice.	Can staff see the same operational picture in real time?
● 9-18 months	Connect EHR, HIE, admission, discharge, and transfer (ADT), or secure messaging; add live bed or appointment visibility; audit equity and outcomes; align contracts or incentives with diversion, follow-up, and continuity goals.	Are technology and financing reinforcing the same clinical model?

Do not procure technology as a convenience layer around crisis care. Build and govern it as clinical infrastructure that protects dignity, reduces retelling, supports the least restrictive response, and makes the full continuum visible for improvement.^{1, 2, 3, 4}

In conclusion

At the point of dispatch, the question is not whether a contact center owns sophisticated software. The question is whether its technology, policies, and partner relationships help the person's story, the counselor's judgment, and the field team's response stay coherent from first contact through stabilization and follow-up. When that coherence exists, trust grows. When it does not, even highly skilled clinicians have to work against the grain of the system.^{1, 2, 8}



About Carelon Crisis Solutions

Carelon Behavioral Health partners with communities to strengthen crisis systems of care. Through our Crisis Center of Excellence, we provide flexible support tailored to each community's unique needs — from serving as an accountable entity and coordinating crisis system operations to delivering technology through our Crisis Safety Platform. Whether building new capabilities or enhancing existing programs, we help communities create more connected, effective crisis care.

Learn more:

carelonbehavioralhealth.com/solutions/crisis-center-of-excellence



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