988 APPROPRIATIONS REPORT

December 2021

SAMHSA
Substance Abuse and Mental Health
Services Administration

CONTENTS

INTRODUCTION

As directed by Congress from the enacted budget for Fiscal Year (FY) 2021, the Substance Abuse and Mental Health Services Administration (SAMHSA) is responding to congressional questions regarding the National Suicide Prevention Lifeline (Lifeline). The following report language was included in the FY 2021 Labor-Health and Human Services Appropriations Bill:

> *The agreement includes an increase and requests that SAMHSA provide a report to the Committees on Appropriations of the House of Representatives and the Senate within 180 days after enactment of this Act on the level of funding required to meet the needs of the Lifeline, and includes updated data on suicide rates and attempts. In addition, SAMHSA is directed to provide a report to the Committees on Appropriations of the House of Representatives and the Senate and post such report on SAMHSA's website within 180 days of enactment of this Act detailing call and text volume over the past three years as applicable.*
>
> *The report shall also include an assessment of whether other services such as emails, videos, or other digital modes of communications would improve service of the Lifeline. As SAMHSA considers expanding this service, the agreement encourages SAMHSA to leverage existing infrastructure to the extent practicable. The agreement further urges SAMHSA to provide specific training programs for counselors to increase competency in serving at-risk youth through the utilization of existing specialized resources.*

The creation of 988 is a once-in-a-lifetime opportunity to strengthen and expand the Lifeline and transform America's behavioral health crisis care system to one that saves lives by serving anyone, at any time, from anywhere across the nation. Preparing the Lifeline for full 988 operational readiness will require a bold vision for a system that provides direct, life-saving services to all in need *and* links them to community-based providers uniquely positioned to deliver a full range of crisis care services. SAMHSA sees 988 as the linchpin and catalyst for a transformed behavioral health crisis system in much the same way that, over time, 911 spurred the growth of emergency medical services in the United States. Over time, the system that SAMHSA envisions will aim to:

- Provide enhanced access for people in behavioral health crisis through the use of an easily remembered three-digit number;
- Reduce reliance on the police by linking Lifeline/988 centers with mobile crisis teams (when the person in crisis requires services beyond what the call center itself provides);
- Reduce the deadly gaps in the existing fragmented behavioral health crisis care system by enabling Lifeline/988 centers to stay in contact and follow up with those in crisis;
- Relieve emergency room boarding by providing needed evaluation and crisis intervention in the community whenever possible; and
- Better meet the behavioral health needs of all people experiencing crises in a way that reduces stigma and encourages people at risk and their family members to seek help in the future.

This report addresses the congressional requests above in the following seven sections:

- Section 1: Introduction and context
- Section 2: Updated data on suicide rates and attempts
- Section 3: Lifeline call/text volume data
- Section 4: 988 Lifeline funding needs
- Section 5: Assessment of whether other services would improve services of the Lifeline
- Section 6: Training to improve service for at-risk youth
- Section 7: Conclusion

1. INTRODUCTION AND CONTEXT

Overview of Lifeline Program

In 2019, the Federal Communications Commission (FCC) proposed 988 as the three-digit number for suicide prevention and mental health crises. The following year, the National Hotline Designation Act (Public Law 116-172) was signed into law, incorporating 988 as the new Lifeline and Veterans Crisis Line number. This new number will become available using any cell phone, land line, or voice-over internet device by July 16, 2022.

The new three-digit hotline (988) builds directly on the original Lifeline that was established in 2005. The Lifeline is currently accessible through the toll-free number 1-800-273-TALK and operates 24 hours per day, 7 days per week. The Lifeline program contains three primary elements:

- A network of over 180 independently operated and funded local call centers, including 38 chat/text centers and three Spanish language centers;
- Nine national backup centers; and
- A single national system administrator.

Local call centers are located throughout the country and often are part of behavioral health organizations or other health systems. The current system administrator is Vibrant Emotional Health (Vibrant), which oversees the Lifeline program through a cooperative agreement, a closely coordinated grant support mechanism, administered by SAMHSA. In this role, SAMHSA provides assistance, oversight, and performance monitoring through operations meetings and data review. The system administrator guides and bridges the network of independent centers, onboards centers into the network, sets training and performance standards, provides technology infrastructure, and collects data on center performance. Most of these centers receive minimal direct Federal funding to support their operations (typically a yearly stipend of $2,500–$5,000), relying instead on local, state, and private funding, as well as the significant utilization of volunteers. This funding mix varies considerably across local centers, with no consistent pattern of investments across states and localities.

Process of Lifeline Response to People in Crisis

When an individual is experiencing a mental health crisis and calls the Lifeline, the caller is routed to the nearest local crisis center (based on area code). If local crisis centers are unable to answer incoming calls from individuals in distress, the Lifeline utilizes a subnetwork of contracted national backup centers to ensure capacity can meet the demand. There are also centers that receive Federal funding specifically to respond to text and chats, as most local centers do not currently have the capacity to address text and chat. Within the 38 chat/text centers, 19 core centers receive $250,000 per year each in Federal support to maintain dedicated chat/text response, with further adjustments for increased volume. The other 19 chat/text centers respond only on an ad hoc basis and receive a limited Federal stipend of $2,500–$5,000 to answer chats and texts. Despite the backup system and designation of specialized chat and text centers, current Lifeline capacity is only sufficient to address approximately 85 percent of calls, 56 percent of texts, and 30 percent of chats (analysis as of December 2020).

988 Implementation Considerations

SAMHSA has identified two overarching goals that must inform 988's launch and future operations:

- Strengthen and expand the safety net capabilities of the Lifeline, providing life-saving service to all who contact 988; and
- Transform our country's behavioral health crisis care system, so that services are available to anyone, anywhere, anytime.

SAMHSA's near-term priority is to ensure all Americans have access to a suicide Lifeline that can provide timely, high-quality crisis response. This will include several primary areas of focus, including enhancing Lifeline network operations, strengthening local crisis call center capacity, improving messaging and public awareness, and expanding federal support through the formation of a 988 & Behavioral Health Crisis Coordination Office.

A primary consideration for implementing 988 is having a sufficient number of paid staff at the local centers to address the contact volume. This is particularly an issue with respect to chat response, where encounters typically take longer and involve higher levels of clinical acuity. In addition, ongoing data infrastructure upgrades are necessary to expand access and provide a consistent user experience. Examples of upgrades include more efficient routing technologies and data collection to track response times, as well as more consistent demographic data collection to identify population needs and any disproportionality in service delivery and outcomes.

Delivering on the second goal—which involves transforming our nation's broader behavioral health crisis care system—will require longer-term structural changes and investments. These include strengthening core behavioral health crisis care services, ensuring rapid post-crisis access, enabling advanced data integration, enhancing the behavioral health crisis care workforce, and establishing sustainable sources of funding for the broader crisis system. Beyond the current Lifeline functionality, it is critical that individuals experiencing a behavioral health emergency have access to a coordinated crisis system of care. Effectively responding to people in crisis who are experiencing a behavioral health emergency has three main components as outlined in SAMHSA's National Guidelines for Behavioral Health Crisis Care: providing someone to talk to, providing in-person response, and providing a place to go. Implementing 988 successfully will be a critical first step in evolving the broader crisis continuum. Current research suggests that many crises can be effectively addressed through a call alone. In addition, call centers that have follow-along capacity and/or access to local outpatient treatment resources can provide enhanced crisis care. A robust crisis system, including 988 access through the Lifeline network, will decrease suicides, reduce arrests and criminal justice involvement for individuals with behavioral health needs, and will facilitate linkages to care that reduce unnecessary emergency department boarding and hospitalization.

As one example, the crisis system in Tucson, Arizona—which covers the southern Arizona service are—highlights the potential effectiveness of a robust crisis system. A FY2019 analysis provided by Arizona Complete Health revealed that 80 percent of crisis line calls were resolved without dispatching mobile crisis teams, law enforcement, or emergency medical services. Of the crisis line calls that resulted in a mobile crisis team being dispatched, 71 percent of face-to-face encounters were resolved without the need for transport to a higher level of care. Of the calls that resulted in a mobile crisis team or crisis facility encounter, 68 percent did not have a subsequent emergency department visit or hospitalization within 45 days.[1]

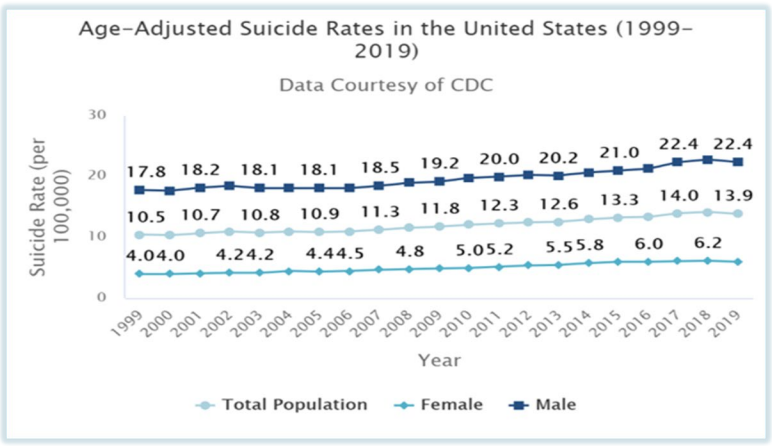
Enhancing the Lifeline and strengthening behavioral health crisis services will help decrease adverse outcomes and save lives. This report addresses each of the above requested items in the FY 2021 Labor-Health and Human Services Appropriations Bill. This report is aligned with, though distinct from, the two SAMHSA reports required through the 2020 Hotline Designation Act: (1) A Report to Congress with recommendations on training and access for populations at high risk of suicide; and (2) A Report to Congress, submitted jointly with the Department of Veterans Affairs, detailing the resources to make 988 operational and effective across the United States.

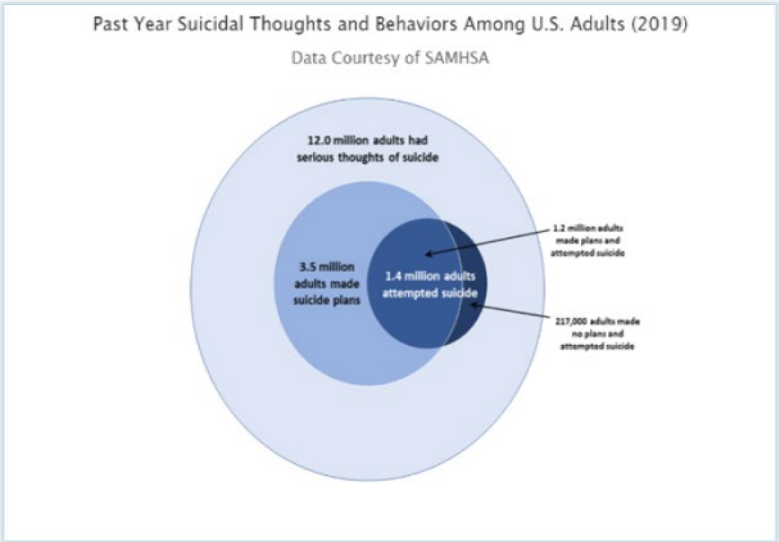
2. UPDATED DATA ON SUICIDE RATES AND ATTEMPTS

Over the past two decades, suicide rates have increased significantly. Recent Centers for Disease Control and Prevention (CDC) analysis highlights that, from 1999 through 2019, the suicide rate in the United States increased 33 percent.[2]

In 2019, there was approximately one death by suicide every 11 minutes in the United States. There were nearly two and a half times as many suicides (47,511) as there were homicides (19,141).

In addition, according to recent SAMHSA data, millions more individuals consider, or attempt suicide each year. In 2019, 12 million adults reported that they seriously thought about suicide. Of these individuals, 3.5 million reported that they made a plan for suicide, 1.4 million reported they had made a nonfatal suicide attempt, and 217,000 people reported that they attempted suicide without a suicide plan.[3]





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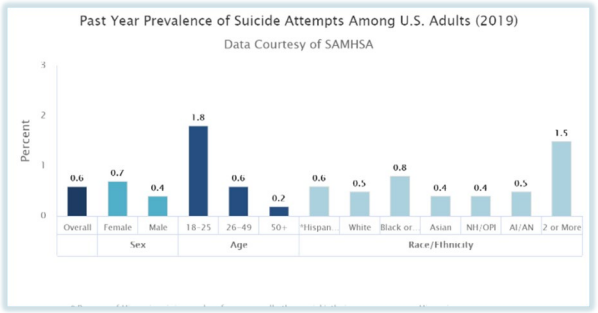
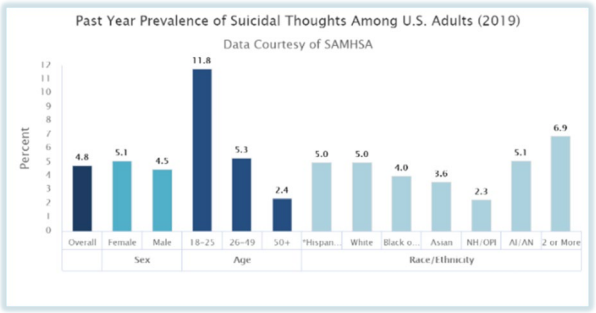
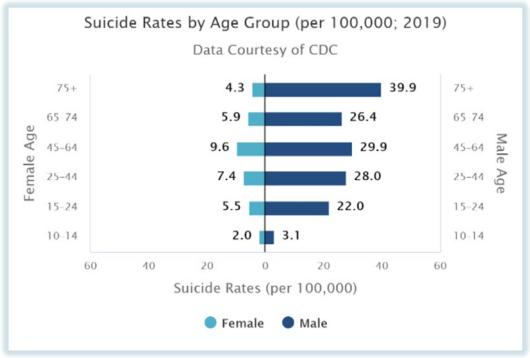
No community is immune from suicide; however, certain demographics are more at risk. Suicide rates vary by age, sex, and ethnicity.

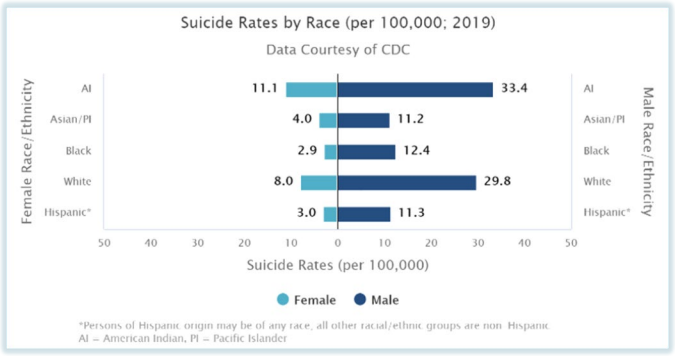
While suicide rates are higher among older adults, the prevalence of serious suicidal thoughts and past-year suicide attempts is highest among young adults aged 18 to 25.[4] Further, suicide is the second leading cause of death for ages 10 to 34.[5] Suicide risk among Black youth is increasing, with Black children aged 5 to 12 dying by suicide at nearly twice the rate of their White counterparts. Black youth also have higher rates of past suicide attempts than their White counterparts.[6]





As the charts below demonstrate, suicide rates are significantly higher among males than among females. Among males, the suicide rate is highest for adults aged 75 and older. Among females, the suicide rate is highest among those aged 45 to 64. In addition, when examined by race/ethnicity, suicide rates are highest for American Indian/Alaska Natives and White (non-Hispanic) males.[7]





Suicide rates also vary by geography. Individuals living in rural communities have the highest rates of suicide. In 2019, the suicide rate in the most rural counties (noncore, nonmetropolitan) was 1.8 times higher than the suicide rate in the most urban counties (large central metropolitan areas).[8]

Other high-risk groups for suicide include lesbian, gay, bisexual, queer, and questioning (LGBTQ+) youth, and veterans. Lesbian, gay, and bisexual (LGB) youth have higher suicide risk than heterosexual youth—with the most recent CDC Youth Behavioral Risk Survey data estimating 23 percent of LGB youth made suicide attempts within the past year compared to 5 percent of heterosexual youth.[9] Veterans are also at heightened risk compared to the civilian population. The suicide rate for veterans is 1.5 times the rate for non-veteran adults, even after adjusting for population differences in age and sex.[10]

The data are overwhelmingly clear that suicide remains persistently high in the United States and that more resources are needed to address the growing public health crisis.

3. LIFELINE CALL/TEXT VOLUME DATA

Given the most recent data on suicide in the United States, the launch and full implementation of 988 will be critical to saving lives. The National Suicide Hotline Designation Act of 2020 requires that the current Lifeline's 10-digit number be replaced by the new three-digit dialing code (988) for suicide prevention and mental health crisis services. The 988 code, an easier number to remember, will be available nationally by July 16, 2022. 988 is currently available to approximately 95% of cellphone customers.

As required in the National Hotline Designation Act, all 988 calls will flow through the Lifeline system. This national structure contrasts notably with the 911 system, which is managed at the state and local levels. Unfortunately, most crisis centers currently face funding challenges. As noted previously, most centers receive only $2,500–$5,000 per year from the Lifeline grant to support the Lifeline's calls, texts, and chats, and many rely on unpaid staff to manage Lifeline service demands.

While the Lifeline has increased the size of its network, expanded training, and improved response rates since its inception—and now comprises over 180 crisis centers across the country—demand exceeds capacity. Based on Vibrant' s internal analysis of data as of December 2020, Lifeline capacity is sufficient to address approximately 85 percent of calls, 56 percent of texts, and 30 percent of chats.

Without proper resourcing, the supply-demand gap is likely to be exacerbated by the creation of 988. Extensive volume estimates have been conducted by a third party in coordination with Vibrant, and assumptions and modeling have been reviewed by SAMHSA to forecast expected volume growth as 988 goes live in July 2022.

Lifeline Call, Chat, and Text Volume, 2018–2020

Over the past 3 years, the overall volume of Lifeline contacts -- including calls, chats, and texts -- has remained above 3 million each year. The chart below contains annual Lifeline contact volume between 2018 and 2020.

Annual Lifeline contact volume (excluding VCL)			
	2018	**2019**	**2020**
Calls initiated	1,726,916	1,731,603	1,832,003
Chats initiated[1]	1,528,957	1,573,577	1,456,295
Texts initiated	0	0	34,166
Total contacts initiated[2]	**3,257,891**	**3,307,199**	**3,324,484**

Lifeline calls: The Lifeline began fielding calls when it was established in 2005. In 2020, approximately 1.8 million calls were initiated. Of these total estimated calls, as of December 2020, the Lifeline maintained an 85 percent call answer rate.

Lifeline chats: In 2013, the Lifeline began incorporating chat service capability in select centers. Since the service's inception, the chat system has gone through several technology platforms to improve the queue system, enhance data collection and facilitate quality improvement. The new chat system put in place in June 2020 allows for a more reliable view of overall demand.

[1] Chats initiated in 2018, 2019, and the first half of 2020 may be somewhat inflated; during this time period, chats initiated were measured based on user-initiated web page sessions, rather than actual chats initiated.
[2] Calls are initiated when a caller presses 1,2 or waits past the greeting; chats and texts are initiated once the user completes (or opts to bypass) a pre-chat/text survey.

In 2020, over 1.4 million chats were initiated. Of these total estimated chats, as of December 2020, the Lifeline maintained a 30 percent chat answer rate.

Lifeline texts: The Lifeline began answering texts on August 10, 2020. Therefore, the number of texts is only available for approximately 5 months of 2020. There were approximately 34,000 texts initiated during this time period. Of these total estimated texts, as of Dec 2020, the Lifeline maintained a 56 percent text answer rate.

To gather ongoing estimates of the proportion of callers with a suicide attempt in progress, Vibrant collects aggregate data from a selection of centers in the network at monthly intervals. The sample of centers includes the 9 national backup centers and 81 centers that agreed to provide these data for a stipend (as of December 2020). Each month, these centers report the total number of Lifeline calls they answered and the total number of calls where suicide was the primary presenting concern, and a suicide attempt was in progress. These calls may occur when the caller has already made a suicide attempt before the call, or a third party (such as a family member) has called because a loved one is in the process of making a suicide attempt. Many of these callers are considered to be at "imminent risk," which is defined by the Lifeline as:[11]

> *"A Caller is determined to be at 'imminent risk' of suicide if the Center Staff responding to the call believe, based on information gathered during the exchange from the person at risk or someone calling on his/her behalf, that there is a close temporal connection between the person's current risk status and actions that could lead to his/her suicide. The risk must be present in the sense that it creates an obligation and immediate pressure on Center Staff to take urgent actions to reduce the Caller's risk; that is, if no actions were taken, the Center Staff believes that the Caller would be likely to seriously harm or kill him/herself. Imminent Risk may be determined if an individual states (or is reported to have stated by a person believed to be a reliable informant) both a desire and intent to die and has the capability of carrying through his/her intent (see Lifeline Suicide Risk Assessment Standards for further clarification)."*

In 2020, of the more than 940,000 calls answered by the sample of 90 Lifeline centers, 22.57 percent (*n* = 213,075) of callers had experienced thoughts of suicide within the past 24 hours, 4.03 percent of callers (*n* = 38,068) were assessed as being at imminent risk, and 0.90 percent (*n* = 8,526) of calls occurred where a suicide attempt was in progress (i.e., the caller had already made a suicide attempt before the call, or a third party such as a family member had called because a loved one was in the process of making a suicide attempt).

In 2020, there were 1,509,920 total answered Lifeline calls (including Lifeline, Spanish, and backup subnetworks but excluding the Veterans Crisis Line). Based on the available data from the sample Lifeline centers (above) and applying those proportions to the total number of Lifeline calls answered by a counselor, it is estimated that in 2020 there were 340,789 individuals who called with current suicidal ideation, 60,850 individual callers who were determined to be at imminent risk, and 13,589 individuals who called while a suicide attempt was in progress.

Current Suicidal Ideation, Imminent Risk, and Suicide Attempts Among Callers to the Lifeline Calendar Year 2020

	Lifeline Answered Calls	Callers with Current Suicidal Ideation (within the last 24 hours)		Callers at Imminent Risk		Calls with Suicide Attempts in Progress	
		Number of Callers	Proportion	Number of Callers	Proportion	Number of Callers	Proportion
Sample of 90 Lifeline Centers	944,063	213,075	22.57%	38,068	4.03%	8,526	0.90%
Estimates for All Lifeline Calls Answered	1,509,920	340,789	22.57%	60,850	4.03%	13,589	0.90%

Limitations: The aggregate nature of the reported data does not allow for additional exploration, nor for verification against individual call reports. Centers may collect information concerning these questions using somewhat different underlying definitions. Data are reported by about half of the centers in the network, and more complete reporting might result in different estimates. These data come due on the 15th of each month for backup centers and the 15th of the month following each quarter for centers that received the stipend. As these data rely

on manual entry, data entry problems can sometimes occur, and reporting can at times be delayed. These data are regularly reviewed, and inconsistencies are addressed when they are identified. Thus, numbers may vary somewhat from report to report. The numbers reported here are based on the calendar year 2020 as a whole and were last reviewed and corrected in February 2021.

Forecasted 988 Growth

Given that full 988 launch will not occur until the last quarter of FY 2022, volume forecasts for FY 2022 predict a relatively modest increase of 25 percent in call volume, while text and chat volumes are assumed to hold constant. Details regarding the volume modeling for 988 implementation are noted in the Appendix. Lifeline volume estimates highlight an expected increase in demand for calls, texts, and chats in the years following the full implementation of 988. These estimates include three categories of calls:

- Continued annual trend for call volume at a growth rate of 14 percent per year, based on historical trends in volume;
- Expected migration of calls diverted from 911 or other mental health crisis lines, including warm lines, peer support lines, local crisis providers, and population specific call centers; and
- New crisis service users who now use the 988 call because it is easier to remember.

Volume estimates were projected for the first 5 years of the project and across three scenarios using a modest, middle, and high range. Using the middle-range estimate, the volume of encounters with the Lifeline, excluding VCL “press 1” option, is expected to increase to 7.6 million by the end of the first full year of 988 implementation in July 2023, more than a two-fold increase over 2020 volume.

The future year model did not factor COVID-19 specifically but did include people impacted by traumatic events as part of the market analysis. Lifeline volume declined slightly in the initial weeks of the pandemic but since has exhibited volume consistent with typical historical year-over-year increases. There was more notable impact of COVID-19 on the Disaster Distress Helpline (DDH), which is maintained as a separate number from the Lifeline.

4. 988 LIFELINE FUNDING NEEDS

Since the Lifeline's launch in 2005, the network administrator and centralized network functions have been funded through SAMHSA operations, while local Lifeline crisis centers have received funding through a mixture of Federal, state, local, and private funding.

To help ensure a smooth transition to 988, SAMHSA has significantly increased Federal resources for both network operations and local crisis call center capacity. Below, SAMHSA has outlined expected FY 2022 Federal resources. Also included below is SAMHSA's estimate of total future resource needs, which is expected to be addressed through a combination of Federal and non-Federal funding sources.

FY 2022 Federal Resources

Planned Federal funding for the 988 Lifeline in FY 2022 is $282 million and includes two primary sources: (1) $102 million in the Continuing Resolution; and (2) $180 million in crisis workforce funding through the American Rescue Plan Act. These funds are allocated as follows:

	FY 2022 resources (expected contact volume of 3.6 million)
1. Strengthening network operations	$177 million
2. Strengthening local crisis call center capacity	$105 million
Total	**$282 million**

1. **Strengthening network operations ($177 million):** Historically, Federal funding for the Lifeline has been dedicated to supporting the Lifeline administrator and centralized network functions. In FY 2022, SAMHSA has allocated $177 million to help shore up network infrastructure and scale up centralized network capacity. This funding will strengthen the key functions of network operations, such as:
    - Expanded paid and trained staffing for backup, specialized services, and chat and text centers;
    - Data and telephony infrastructure;
    - Standards, training, and quality improvement; and
    - Evaluation and oversight.
2. **Strengthening local crisis call center capacity ($105 million):** As additional information about volume expectations and system response capacity has become available, additional funding is needed in FY 2022 for local crisis centers. As of August 2021, most states have not passed 988 state cell phone fees—the primary vehicle identified in the Hotline Designation Act of 2020 for states to build 988 capacity. Sufficient local crisis call center capacity is crucial to ensuring higher overall 988 answer rates. Mature call center networks—such as 911—aim to address 95 percent of calls within 20 seconds. This funding will support capacity building within local crisis centers, which is essential to driving significantly higher answer rates. While it may take time for the Lifeline to achieve answer rates comparable to those of 911, it is essential to engage states and local centers to accelerate resourcing the network with the capacity required to address incoming calls, texts, and chats.

The additional $105 million will help states and local call crisis centers:

- Expand capacity to increase local response rates;
- Provide follow up and follow through so that individuals are effectively engaged with local behavioral health crisis services;
- Have sufficient funds to pay staff (e.g., mental health professionals, peer support workers); and
- Have sufficient resources to train staff/volunteers in providing evidence-based interventions, including for high-risk populations.

While state funding streams may increase (e.g., through the passage of state cell phone fees authorized in the Hotline Designation Act of 2020), as of now, there are limited sources of dedicated funding. This $105 million identified above will support a Federal partnership with states to develop local center capacity, with a focus on sustainability and service integration in order to avoid continued fragmentation with disconnected systems of care.

Future Annual Costs

SAMHSA estimates future resource needs in a few key areas. Much of this need will depend on anticipated contact volume. SAMHSA assumes that a continued Federal and state partnership will be critical in ensuring the sustainability of the 988 system and does not distinguish what proportion of these needs will be addressed Federally. Federal resources for 988 for FY 2023 and beyond will be detailed in future President's Budgets. SAMHSA's assumptions of potential future needs of the Lifeline include:

1. **Strengthening network operations ($110 million per year):** Assuming that contact volume increases to 7.6 million in FY 2023 and that the backup centers/specialized services are responsible for responding to contacts which local and state contact centers cannot handle, SAMHSA estimates an annual resource need of approximately $110 million for the network. Network operations also include telephony and data infrastructure, training, quality improvement and evaluation.
2. **Strengthening local crisis call center capacity ($560 million total of Federal and non-Federal funding per year):**

   SAMHSA anticipates an increase in resource needs for the local and state crisis call centers, under the assumption that contact volume increases to 7.6 million in FY 2023 (excluding VCL "press 1" option). Resources will be necessary to:

   - Expand capacity to increase local response rates;
   - Provide follow up and follow through so that individuals are effectively engaged with local behavioral health crisis services;
   - Have sufficient funds to pay staff (e.g., mental health professionals, peer support workers); and
   - Have sufficient resources to train staff/volunteers in providing evidence-based interventions, including for high-risk populations.

   The estimated average cost per contact is $82 for a Lifeline call center. This estimate of cost per contact accounts for:

   - Dedicated resources (i.e., crisis workers and their supervisors);
   - Shared resources (i.e., Center director, HR manager) that support other programs in addition to 988;
   - Dedicated capital (assets employed for the sole use of 988);
   - Shared capital (assets used by multiple programs administered by the network center);
   - Dedicated expenses (expenses incurred to support 988, AAS conference);
   - Shared expenses (expenses incurred to support the network center, e.g., rent,); and
   - Common contact center processes are also calculated in the model (refresher training, quality, debrief sessions, attrition).

3. **Improving public awareness:** The 988 code will provide a universal, easy-to-remember, three-digit phone number and connect people in crisis with life-saving resources. As 988 launches, SAMHSA also anticipates the need and additional costs to educate the public on services covered by 988.
4. **Improving 988 and behavioral health crisis coordination office ($10 million per year):** Coordination will help support 988 implementation and broader crisis system transformation. Coordination activities include technical assistance to states

and crisis centers; strategic planning, performance management, evaluation, and oversight; and formal partnerships, convenings, and cross-entity coordination.

Sources of Funding for 988 Call Centers

Multiple sources of funding could potentially be utilized to support the anticipated demand for Lifeline services. SAMHSA is the responsible entity for 988 implementation in contrast to the 911 system, which is managed by local entities. The potential funding sources include:

- **SAMHSA Suicide Lifeline.** Annual SAMHSA Suicide Lifeline funding supports the infrastructure of network operations, including backup, specialized services and chat and text centers; data and telephony infrastructure; standards, training, and quality improvement; and evaluation and oversight. The FY 2022 President's Budget includes $102 million for the Suicide Lifeline.

- **Mental Health Block Grant (MHBG) funds.** SAMHSA has been actively engaging with states on the use of MHBG funds, including the crisis set-aside ($35 million in FY 2021, $75 million in FY 2022 President's Budget). This coordination has included technical assistance on the use of funds, requests for information on specific allocations of funding across the crisis continuum of care, and recommended changes to the data reporting system. States are at different stages in their implementation of core crisis services and currently use the funds to expand existing core services or develop new services. Funding regional or statewide crisis centers is an allowable, but not required, use of the funds. There is significant variation in the degree to which states are using MHBG funds to support 988 crisis call centers; this variation could result in unequal service access in some areas.

- **Certified Community Behavioral Health Clinic (CCBHC) funding.** SAMHSA has invested significantly in the expansion of CCBHCs across the nation. Crisis services are a required component of the CCBHC model, and some CCBHCs already serve as part of the Lifeline call center network.

- **Medicaid and Payer coverage.** Some states have pursued plan amendments, waivers, and demonstrations to support elements of the crisis continuum. As with the MHBG program, there is wide variation across states in this area, and only Arizona has a state plan to fund part of the call center response. Medicaid managed care payers often cover aspects of crisis services—more typically crisis intervention and stabilization services, not call response. To date, private payers have provided limited coverage of crisis services.

- **State cell phone fees.** The Hotline Designation Act of 2020 allows states to impose and collect cell phone fees to support 988 operations. As of August 2021, four states have passed legislation related to 988 involving a user fee. Three other states have passed 988 legislation not involving a user fee. While other states may follow, most states have no pending 988 legislation. SAMHSA will continue to track state legislative activity in future years.

Based on planning grant data from states for the period July 2020–June 2021, existing public funding (Federal, state, and local) accounted for a small fraction of call center costs. States are showing more investment through the multiple recent funding streams for the MHBG. For example:

- **Georgia** currently has a statewide, 24/7 Crisis Access Line; mobile crisis teams with statewide coverage; and crisis stabilization units for adults and children. Georgia will spend approximately $3,756,750 on 988 Lifeline implementation with $996,008 for other crisis-related services over the next 4 years in MHBG, MHBG-COVID, and MHBG-ARP funds.
- **Kentucky** currently operates 24/7 crisis hotlines (in all regions) that provide mobile crisis intervention and stabilization units. The state plans to use $3,286,740 from MHBG-COVID/ MHBG-ARP for the implementation of 988 Lifeline response. Kentucky will also allocate a portion of its crisis set aside to implement text/chat abilities in preparation for 988 Lifeline implementation.

- **Missouri** runs six crisis hotlines currently. The state plans to use all its FY 2021 appropriations crisis set-aside funding, $605,348, to support these call centers in preparation for the implementation of 988 Lifeline. In addition, Missouri will use the MHBG-COVID crisis set aside, broken into two parts: 988 Mental Health Crisis Line–Initial Infrastructure Development ($1,000,000) and 988 Call Center Support ($2,647,500). The MHBG-ARP will supply $4,400,000 toward the implementation of 988 as well. Missouri will be spending a total of $8,652,848 on 988 Lifeline from these three sources.

Not every state has yet been able to provide this level of detail. It is also important to emphasize that given the flexibility in MHBG language and the range of crisis services, it is not possible to draw generalizable conclusions from these few examples.

5. ASSESSMENT OF WHETHER OTHER SERVICES WOULD IMPROVE SERVICES OF THE LIFELINE

SAMHSA recognizes that many youths in crisis prefer to utilize digital approaches to access care. Text and chat modalities are increasingly used to access Lifeline services. Through ongoing coordination and convening activities, SAMHSA will assess the potential use of emails or other digital modes of communication to improve access to the Lifeline. Recent developments can serve as a basis for further analysis. The Disaster Distress Hotline, which is managed as part of the Lifeline using a different call-in number, recently launched two new digital communication programs, and the potential utility of these services for the Lifeline will be assessed.

As of June 1, 2021, the Disaster Distress Hotline offers online peer support via Facebook Groups and 24/7 crisis support with Facebook Messenger. As of May 3, 2021, videophone services are now offered for people who are American Sign Language users, either via a videophone-enabled device or via the SAMHSA Disaster Hotline website. The nonprofit crisis center DeafLEAD staffs and responds to these calls. Adding other virtual mechanisms to link individuals in real time to crisis services would represent further progress in system development; however, this must be evaluated along standards for data integrity and response benchmarks. Additional mechanisms to promote direct access via virtual means could be further explored over the long term and further study is needed to evaluate the impact on volume, response rates, and timeliness.

At the moment, SAMHSA is primarily focused on phone, text, and chat to 988; however, these additional forms of communication may facilitate awareness of 988 itself as well as provide enhanced opportunities for prevention efforts.

6. TRAINING TO IMPROVE SERVICE FOR AT-RISK YOUTH

Suicide is the second leading cause of death for children, adolescents, and young adults,[12] and certain groups are at heightened risk. For example, LGB youth seriously consider attempting suicide at almost three times the rate of heterosexual youth.[13] In order to increase the competency for Lifeline crisis counselors in serving these at-risk youth, the Lifeline Standards, Training, and Practices Committee has begun collaborating with the Trevor Project. The Trevor Project is a nonprofit organization focused on suicide prevention efforts among LGBTQ+ youth. It operates the Trevor Lifeline, a national 24/7 crisis intervention and suicide prevention lifeline for LGBTQ+ young people under age 25. SAMHSA, the Lifeline, and the Trevor Project aim to align best practices, noting where practices differ due to cultural needs (and evidence/rationale underpinning distinctions). Once practices are aligned and differences are understood, future work would include:

- Updating network counselor training materials and resources for serving LGBTQ+ youth;
- Adapting Lifeline network center membership processes to incorporate organizations providing specialized services for high-risk populations;
- Designing and implementing seamless Lifeline-to-Trevor Project facilitated transfer processes for LGBTQ+ youth contacting Lifeline (who are not at imminent risk and who consent to being connected with the Trevor Lifeline); and
- Organizing and planning webinars for the Lifeline network to review basic practices, including warm transfers.

The *LGBTQ Youth Guidelines* document (only accessible within the network training materials) is one example of this partnership in action.[14] This six-page document was originally published in July 2020 and updated in August 2020 and examines data from the Trevor Project's 2020 National Survey on LGBTQ Youth Mental Health (https://www.thetrevorproject.org/survey-2020/). The document also reviews vocabulary and common presenting concerns for the LGBTQ+ population and provides specific guidance on how to best support specific needs.

SAMHSA also is aware that there are other high-risk youth groups, including American Indian and Alaska Natives; individuals in rural communities; and, increasingly, Black youth. SAMHSA recognizes the need for competency of all call center staff to address crisis and suicide needs of all high-risk youth. Thus, through the Lifeline, SAMHSA has continued to update and develop critical training resources that can help crisis counselors better address the needs of high-risk youth populations. These training resources are designed with diversity, equity, inclusion, and cultural competency in mind and include:

- **Online Crisis Chat Manual.**[15] This manual was updated in March 2021 and offers best practices to support youth chat users, including guidance on vocabulary, language use, self-harm, eating disorders, and other common presenting concerns.
- **Lifeline Crisis Chat and Text Training Module.** This module, which has been developed and distributed to Lifeline chat and text centers, reviews common themes present in chat and text conversations with younger age cohorts. This training provides detailed and practical guidance for counselors, with modules on specific topics and challenges. All current and new centers have access to this training via Lifeline's new learning management system, and counselors will have individual account access to complete the training and review information as needed.
- **Inclusive Language Tip Sheet.** This tip sheet, which has been developed and released to centers through the Network Resource Center, provides education and guidance on how to use inclusive language while supporting people in crisis. It also includes specific information on speaking to youth in at-risk communities, such as communities of color and the LGBTQ+ community. This was promoted via Facebook office hours and will be featured in upcoming training corners.

SAMHSA will continue to coordinate with Federal partners and external stakeholders to identify emerging trends and promising practices, promote research and evaluation, review data, identify gaps and inequities, and provide consistent technical assistance to ensure that Lifeline training adapts to changing needs and evidence. SAMHSA will also work with the Lifeline administrator to provide additional technical assistance to Lifeline centers to ensure compliance with the training expectations in working with high-risk populations. The Lifeline administrator may seek out additional agreements or memoranda of understanding to engage with experts in developing and disseminating training content. Finally, in recognition that members of certain high-risk groups prefer to seek assistance from specialized crisis care centers, the Lifeline will continue to publicize available supports for specialized care and will refine processes to facilitate access to specialized services while adhering to safety and risk assessment protocols.

7. CONCLUSION

In this brief report, SAMHSA addresses the four elements requested in the FY 2021 Labor-Health and Human Services Appropriations Bill. Further, SAMHSA recognizes that support for 988 and related crisis services is an opportunity to address our nation's long-standing problem with access to mental health crisis services. As is described in the *National Guidelines for Behavioral Health Crisis Care*,[16] an effective mental health crisis call center is a critical component of a national safety net that can address the needs of persons in crisis *anytime, anyplace,* and *anywhere.* A successful 988 program will ensure people across the country have someone to talk to, a mobile team to respond to them, and a place to go that offers safe and effective diagnosis and treatment.

Appendix: 988 Volume Projections

Currently, about 12 million people either call the National Suicide Prevention Lifeline (Lifeline), its local/regional crisis centers (through their local number in addition to the Lifeline), or 911 for mental health or suicidal crises each year. In addition to those who currently call because of a mental health crisis, the ease of access of 988 was designed specifically to lower the barriers to access for everyone, including and especially for those who haven't yet called a hotline while in crisis. While 988 will be universally available to everyone in the United States, it has the potential to benefit specifically about 39 million people annually—the estimated total number of individuals experiencing a suicidal or mental health and substance use crisis with means to contact 988. This estimate is based on the results of a comprehensive market analysis, conducted for Vibrant, to determine the likely number of people whom 988 would most directly benefit: the addressable and serviceable populations.

The results of this market analysis are as follows:

The potential addressable population for 988 is an estimated 150 million people (about 53 percent of the U.S. population age 12 and older),[17] which reflects the following estimates of the prevalence of mental and/or substance use disorders and exposure to potentially traumatic events:[18]

- About 70 million individuals with mental health and/or substance use disorders, or about 25 percent of the U.S. population age 12 and older. This 25 percent of the U.S. population includes 17 percent with a mental disorder(s) only, 4 percent with a substance use disorder(s) only, and 4 percent with a co-occurring mental and substance use disorder(s).
- About 80 million individuals with potential lifetime exposure to a potentially traumatic event(s) but no mental or substance use disorder, or about 29 percent of the U.S. population age 12 and older. Examples of potentially traumatic events include experiencing, witnessing, or being confronted with event(s) involving actual or threatened death or serious injury or threats to the physical integrity of self or others (e.g., violence).

The potential serviceable population for 988 is a subset of the potential addressable population that may be vulnerable to a mental health or suicide-related crisis at a given time and is estimated at 39 million (about 14 percent of the U.S. population age 12 and older).

- The potential serviceable population excludes an estimated 7 million individuals who may not be able to access 988 because they may be overseas (e.g., active military duty personnel stationed abroad), lack telephone services (e.g., households lacking landlines and wireless phone service, unsheltered individuals lacking cell phones), or in institutions (e.g., nursing homes, correctional system).[19]
- The potential serviceable population also excludes an estimated 104 million people who may have a mental and/or substance use disorder(s) and/or may have exposure to a traumatic event, but may not be in crisis at a given time (defined as not experiencing suicidal ideation or serious psychological distress).[20]

A subset of the serviceable population is currently served by the Lifeline, the national network of crisis centers, 911, and other potential sources of support and services; in contrast, a share of the potential serviceable population for 988 may not be supported by any services today.

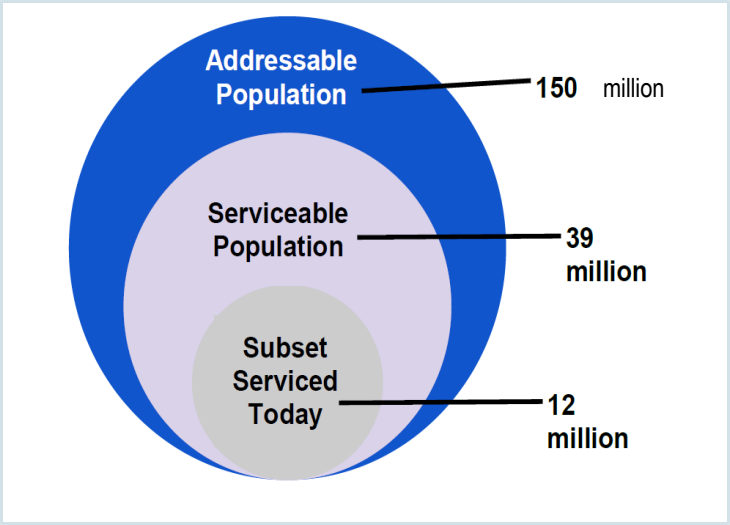
- The subset of the potential serviceable population served by existing crisis hotlines includes about 2 million currently served by Lifeline, about 4 million served by the broader local/regional crisis center network, and about 6 million served via 911.
- The remaining subset of the serviceable population is assumed to potentially be receiving support from providers, community services, family/friends, or other support systems. They also may not be receiving support.

Being able to serve this many people will require significant investments in education and marketing to ensure that every American knows what 988 is and when and how to contact 988; initiatives to change the public's attitudes about seeking help for mental health issues; and systems changes like standardized training for public safety professionals to ensure that contacts to 911 are diverted to 988 when appropriate.

Volume Projections (Call, Text, and Chat)

After 988 goes live in July 2022, call, chat, and text volume is expected to increase over time. While contact volume is not the sole driver of 988 crisis line costs, it is an important one.

To most accurately project the full scope of the projected volume increase, three broad sources of anticipated volume increase were analyzed: (1) historic growth trends, (2) projected new volume, and (3) projected diversion from 911 and other crisis lines.



Historic Growth Trends. Historic trend growth is growth that would have been anticipated even in the absence of the transition to 988. From calendar year (CY) 2007 to CY 2020, call volume to the Lifeline has increased an average of 14 percent per year, reflecting the near universal promotion of the Lifeline number by mental health and suicide prevention organizations that routinely include the Lifeline number on their websites and outgoing voice messages. Significant increases in call volume have also been observed in the wake of very public tragedies resulting in major media attention devoted to the Lifeline number. In each of these instances, call volume spiked in response to this increase in publicity, and in each instance, call volume did not return to its previous baseline. Lifeline call volume-has experienced a 10-year compound annual growth rate of 11 percent and a 5-year compound annual growth rate of 8 percent.

Lifeline chat volume has experienced an 8-year compound annual growth rate of 55 percent and a 5-year compound annual growth rate of 24 percent.

Below is the projected annual growth rate, based on historical trends alone, across three growth scenarios.

Annual Contact Volume Growth Rate, Based on Historical Trends Alone		
Low Growth	**Moderate Growth**	**High Growth**
1%	7%	14%

These projections suggest that based on historical trends alone, contact volume by Year 5 would reach more than 4 million in the low growth scenario, more than 6 million in the moderate growth scenario, and more than 9 million in the high growth scenario.

Projected New Volume. New volume is anticipated secondary to projected growth in adoption by the potentially serviceable population. The very existence of the number 988, akin to 911, would be expected to facilitate recall, which would render it more accessible. Availability of 988 will communicate to the public that, like for medical emergencies, there is a system to respond to mental health crises. In addition, the Hotline Designation Act and the FCC's order include this language: "national suicide prevention and mental health crisis hotline." Although the Lifeline already serves many individuals in mental health crisis more broadly (as many as 77 percent are not suicidal at the time of their Lifeline contact) and includes the language "emotional distress" in its marketing, the language in this legislation does create an expectation of inclusion of mental health crises beyond concerns about suicide, such as questions about a family member experiencing a psychotic episode. This broader definition will contribute to new contact volume as well.

The following estimates are based on the assumption that effective marketing will be the primary driver of these increases in new contact volume. These estimates also assume new volume growth rates of 2 to 5 percent in year 1, increasing to 5 to 15 percent in year 5 due to marketing (based on growth estimates from other similar crisis line services in Australia and the United Kingdom). Our projections suggest the following increases in 988 contacts secondary to new volume alone, across the three growth scenarios:

Additional 988 Contacts, Attributable to New Volume Alone Years 1 and 5, Post-988 Launch					
Low Growth		**Moderate Growth**		**High Growth**	
Year 1 1M	Year 5 4M	Year 1 3M	Year 5 8M	Year 1 4M	Year 5 12M

Diverted Contact Volume—911. Another expected source of increased volume is diversion of calls currently going to 911 to 988, when appropriate. 911 diversion is likely to have many benefits for persons in mental health crises. Not all persons experiencing mental health crises or suicidal thoughts are at imminent risk for suicide. Speaking with a caring and skilled Lifeline counselor adhering to Lifeline's Guidelines for Callers at Imminent Risk, the least restrictive, most collaborative intervention appropriate to the situation will be employed. Even in situations where a caller is assessed as being at imminent risk, the crisis worker can frequently deescalate the crisis over the phone to the point where law enforcement or ambulance dispatch can be safely avoided. Adherence to the Lifeline's Imminent Risk Guidelines not only reduces unnecessary law enforcement and ambulance dispatch; it also reduces the possibility of transporting an emotionally distressed individual in handcuffs.

Volume likely to be diverted to 988 from other services has been calculated utilizing National Emergency Number Association (NENA) call volume reports and interviews, internal call data including the 2018 Lifeline Crisis Center Survey, NYC Open Data regarding 911 emotionally disturbed person (EDP) encounters, the National Criminal Justice Reference Service report *Reducing Non-Emergency Calls to 9-1-1*, anecdotal provider reports, and scenarios depicting various outcomes dependent on local resources. Current examples of 911 diversion already exist within several Lifeline local call centers and localities.

The estimate below is based on historical patterns and assumptions with respect to individuals potentially choosing to use the three-digit 988 number over local numbers, and the volume of potential future 911 volume that may be serviced by 988 (instead of 911). Based on historical 911 data, academic literature, and considerations around systems change related to 911 diversion, approximately 6 percent of current 911 volume is considered within eligible scope for diversion, with assumed rates of diversion for that eligible population ranging from 1 to 2 percent in year 1 to 10 to 30 percent in year 5.

The projections suggest the following increases in 988 contacts secondary to 911 diversion alone, by year 5, across the three growth scenarios:

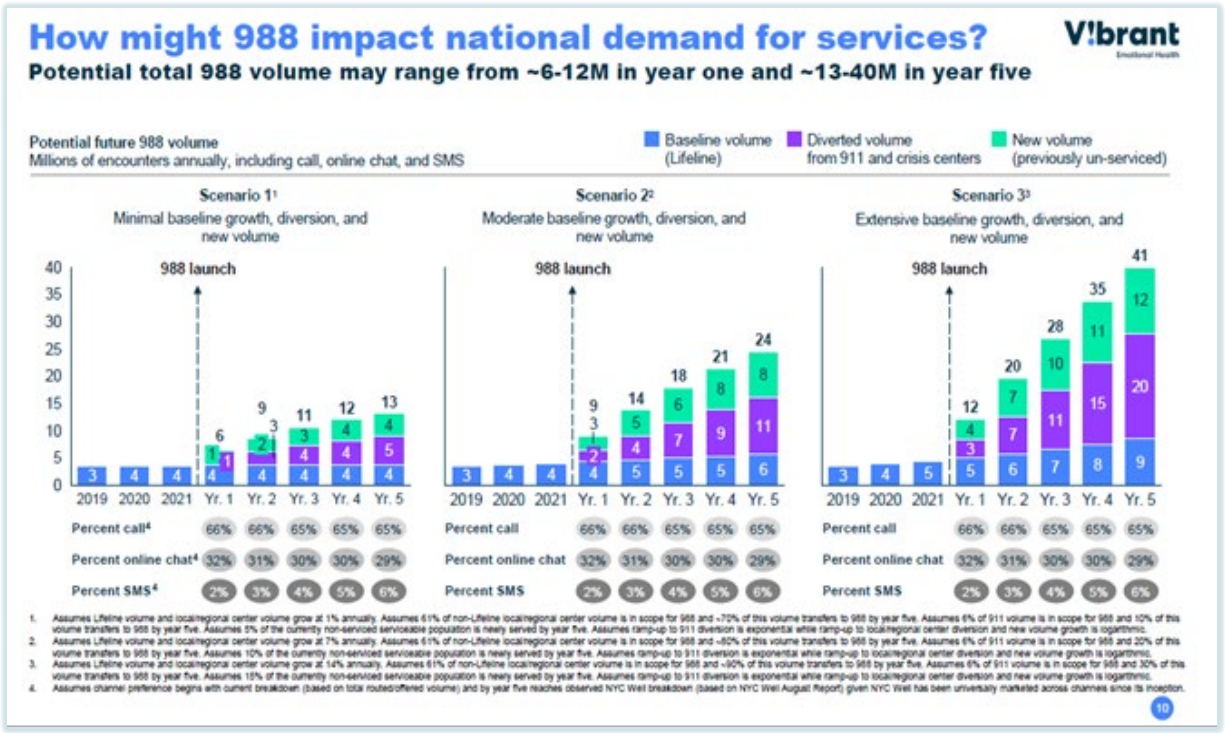
Additional 988 Contacts, Attributable to 911 Diversion Alone Year 5, Post 988 Launch		
Low Growth	**Moderate Growth**	**High Growth**
2 million	3 million	5 million

Diverted Contact Volume – Other Local and Regional Crisis Hotlines. There will likely be diverted contact volume from other local and regional suicide prevention and mental health crisis hotlines. As states plan for coordinated responses, it is likely that some centers will merge or be reconfigured. As the Lifeline is dependent on local centers that are funded by a variety of sources, the Lifeline will need to assure stability in answering calls with special attention to the impact of state and local system redesign on these local centers. This includes existing non-Lifeline contacts that may migrate to the 988 system. Assumed rates of diversion from current helplines range from 23 to 30 percent in year 1 to 69 to 90 percent in year 5.

Estimating Total Projected Contact Volume

Total projected contact volume was calculated by summing (1) historical growth trends, (2) new volume secondary to growth in penetration of the potentially serviceable population, and (3) diverted volume (from 911 and other hotlines). Based on low, moderate, and high-volume growth scenarios, the projected contact volume following one full year of implementation (July 2023) is 6 to 12 million in total volume of call, chat, and texts, and 13 to 41 million in contact volume by year 5 (July 2027). SAMHSA has relied on the moderate growth scenario to estimate cost and inform resource recommendations.

These estimates reflect total projected volume, including expected contacts routed to the Veterans Crisis Line (VCL). This is depicted graphically below:


How might 988 impact national demand for services?
Potential total 988 volume may range from ~6-12M in year one and ~13-40M in year five
Vibrant Emotional Health
Potential future 988 volume
Millions of encounters annually, including call, online chat, and SMS
Baseline volume (Lifeline)
Diverted volume from 911 and crisis centers
New volume (previously un-serviced)
Scenario 1[1]
Minimal baseline growth, diversion, and new volume
Scenario 2[2]
Moderate baseline growth, diversion, and new volume
Scenario 3[3]
Extensive baseline growth, diversion, and new volume
988 launch
2019 2020 2021 Yr. 1 Yr. 2 Yr. 3 Yr. 4 Yr. 5
Percent call[4] 66% 66% 65% 65% 65%
Percent online chat[4] 32% 31% 30% 30% 29%
Percent SMS[4] 2% 3% 4% 5% 6%
1. Assumes Lifeline volume and local/regional center volume grow at 1% annually. Assumes 61% of non-Lifeline local/regional center volume is in scope for 988 and ~70% of this volume transfers to 988 by year five. Assumes 6% of 911 volume is in scope for 988 and 10% of this volume transfers to 988 by year five. Assumes 5% of the currently non-serviced serviceable population is newly served by year five. Assumes ramp-up to 911 diversion is exponential while ramp-up to local/regional center diversion and new volume growth is logarithmic.
2. Assumes Lifeline volume and local/regional center volume grow at 7% annually. Assumes 61% of non-Lifeline local/regional center volume is in scope for 988 and ~80% of this volume transfers to 988 by year five. Assumes 6% of 911 volume is in scope for 988 and 20% of this volume transfers to 988 by year five. Assumes 10% of the currently non-serviced serviceable population is newly served by year five. Assumes ramp-up to 911 diversion is exponential while ramp-up to local/regional center diversion and new volume growth is logarithmic.
3. Assumes Lifeline volume and local/regional center volume grow at 14% annually. Assumes 61% of non-Lifeline local/regional center volume is in scope for 988 and ~90% of this volume transfers to 988 by year five. Assumes 6% of 911 volume is in scope for 988 and 30% of this volume transfers to 988 by year five. Assumes 15% of the currently non-serviced serviceable population is newly served by year five. Assumes ramp-up to 911 diversion is exponential while ramp-up to local/regional center diversion and new volume growth is logarithmic.
4. Assumes channel preference begins with current breakdown (based on total routed/offered volume) and by year five reaches observed NYC Well breakdown (based on NYC Well August Report) given NYC Well has been universally marketed across channels since its inception.
10

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