Report to Congress on 988 Resources

Substance Abuse and Mental Health Services Administration (SAMHSA)

December 2021

SAMHSA
Substance Abuse and Mental Health Services Administration

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Contents

Executive Summary

In October 2020, Congress passed the National Suicide Hotline Designation Act of 2020 (Hotline Designation Act), which tasked the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Veterans Affairs (VA) with overseeing the transition to a "universal, easy-to-remember, 3-digit phone number and connect people in crisis with life-saving resources." The establishment of 988 represents a once-in-a-lifetime opportunity to strengthen and expand the National Suicide Prevention Lifeline (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.

The Hotline Designation Act also required SAMHSA and the VA to "jointly submit a report that details the resources necessary to make the use of 988 operational and effective across the United States." In addition to the sections contributed by the VA, the SAMHSA response includes three sections, which are highlighted below.

Section 1: Overview of the Current State and Need for Behavioral Health System Transformation

There has never been a more important moment for deepening the nation's commitment to a fully functioning behavioral health crisis care system. Individuals with mental and substance use disorders have long experienced difficulty accessing care, often fall through the cracks of a fragmented system, and are arrested and incarcerated at disproportionately high rates. Over the past two decades, America's behavioral health crisis has intensified. From 1999 through 2019, the suicide rate in the United States increased by 33 percent.[1] The COVID-19 pandemic has, in many ways, magnified the deficiencies across our current behavioral health crisis care system. Among adolescents ages 12 to 17, average weekly emergency department visits for suspected suicide attempts were 22.3 percent higher during summer 2020 and 39.1 percent higher during winter 2021 (February-March 2021) than during the corresponding periods in 2019, with a more pronounced increase among females.[2] In the year ending April 2021, over 100,000 individuals died from drug overdoses, representing a nearly 30 percent increase from the prior year. These statistics highlight an ongoing and urgent public health crisis that must be addressed.

Section 2: Background and Current State of the Lifeline

For the past two decades, the Lifeline has been an indispensable resource for individuals in a suicidal or mental health crisis. Established by Congress in 2005, the Lifeline is a national network of over 180 independently operated crisis call centers, three Spanish language centers, and the Veterans Crisis Line (VCL). The network is linked by a toll-free telephone number, 1-800-273-TALK, which is available 24 hours a day, 7 days a week.

The Lifeline network has grown significantly since its inception. In 2005, it handled approximately 50,000 calls. By comparison, in 2020, there were 1.8 million initiated calls (excluding VCL "press 1" calls), 1.5 million initiated chats, and 34,000 initiated texts. Included in the total call number are 49,000 calls that were routed to the Spanish subnetwork. The Lifeline also has recently started using 711 as a Telecommunications Relay Service for individuals with hearing or speech disabilities and is exploring videophone capabilities. The Lifeline capacity, however, has not grown quickly enough to keep pace with existing demand. As of December 2020, the Lifeline was able to address only about 85 percent of calls, 56 percent of texts, and 30 percent of chats. This means there are thousands of users—many of whom may be in suicidal crisis—who seek assistance and are unable to get the lifesaving help they deserve. As 988 goes live in July 2022, an expected increase in contact (call, chat, and text) volume will further challenge the Lifeline, which is already under-resourced and understaffed.

Section 3: Vision and Recommendations for Implementing 988

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.

Addressing these challenges and preparing the Lifeline for 988 operational readiness will require a bold vision for a system that provides direct, life-saving services to all in need **and** that links to community-based providers uniquely positioned to deliver a full range of crisis care services. Bringing this vision to life across the nation will require the right leadership, staff, and resources.

SAMHSA sees 988 as the linchpin and catalyst for a transformed behavioral health crisis care 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 3-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.

SAMHSA has identified two overarching goals that must inform 988's launch and future operations in order to align with the vision:

- 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.

These two overarching goals are intertwined. The Lifeline itself provides life-saving services, and access to it is an essential piece of a larger system that, when strengthened, will effectively link those in need with local and robust behavioral health crisis care services.

To execute on the first goal—strengthening and expanding the Lifeline capabilities—SAMHSA has identified four primary recommendations: (1) enhance the Lifeline network operations; (2) expand local center response capacity; (3) launch a large-scale public awareness and communications campaign; and (4) establish a 988 and Behavioral Health Crisis Coordination Office. SAMHSA believes that these recommendations would comprise at least $680 million in costs within the first full year of 988 operation. 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.

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. A fully realized behavioral health crisis care system will save lives; decrease unnecessary arrests and hospitalizations; and promote responsive, person-centered care.

Section 1: Overview of Current State and Need for Behavioral Health Crisis Care System Transformation

For the purpose of this report, a **behavioral health system** refers broadly to a system of care that promotes mental health, resilience, and well-being across the lifespan; includes the treatment of mental and substance use disorders; and supports those who experience and/or are in recovery from these conditions, along with their families and communities. A behavioral health crisis care system represents a key set of services within this overall system that addresses the acute behavioral health needs of individuals in crisis, aims to prevent suicide and other adverse crisis-related outcomes, and links to subacute and outpatient services to ensure ongoing engagement toward recovery. Too often, individuals with mental health and substance use treatment needs cannot access the care they need, or they get lost in transition across a highly fragmented and under-resourced system.

1a. Data Highlighting Current System Needs

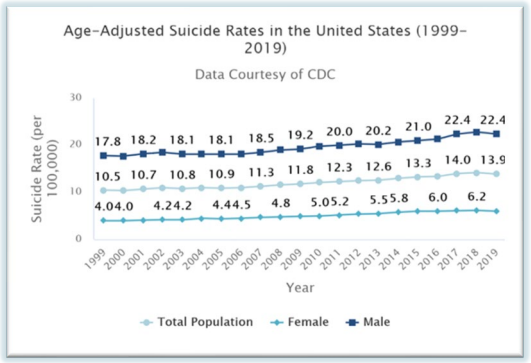
There is ample evidence that individuals with mental and substance use disorders often experience gaps in treatment. For example, according to the 2020 National Survey on Drug Use and Health (NSDUH), 50 percent of individuals with serious mental illness experienced an unmet service need. For individuals with mental illness and co-occurring substance use treatment needs, only 5.7 percent received both mental health services and substance use treatment at a specialty facility.[3] These gaps have important implications for the crisis system for a number of reasons. First, untreated mental health and substance use conditions will ultimately increase suicide risk. Second, there will continue to be a need for crisis service availability for situations that do not include suicidality. The Lifeline currently responds to non-suicidal crisis calls and is promoted for those in "emotional distress" as well as those contemplating suicide. As the National Suicide Hotline Designation Act of 2020 (Hotline Designation Act) explicitly broadens the scope of 988 to include mental health crises, there will be expected increases in the volume of calls and the variety of clinical situations in which call center workers must be trained. Third, the lack of coordinated care for individuals with co-occurring mental and substance use disorders will challenge crisis system capabilities and increase risk for other adverse outcomes, including overdose and arrest. In the year ending April 2021, over 100,000 individuals died from drug overdoses, representing a nearly 30 percent increase from the prior year. Service delivery systems are often segregated by condition, and program regulations, policies, and funding streams often limit integrated approaches. The bidirectionality of mental health and substance use disorders, along with incomplete treatment options, is likely to result in more crisis situations for individuals with complex needs. The behavioral health crisis care system is not presently trained and equipped to fully address these needs.

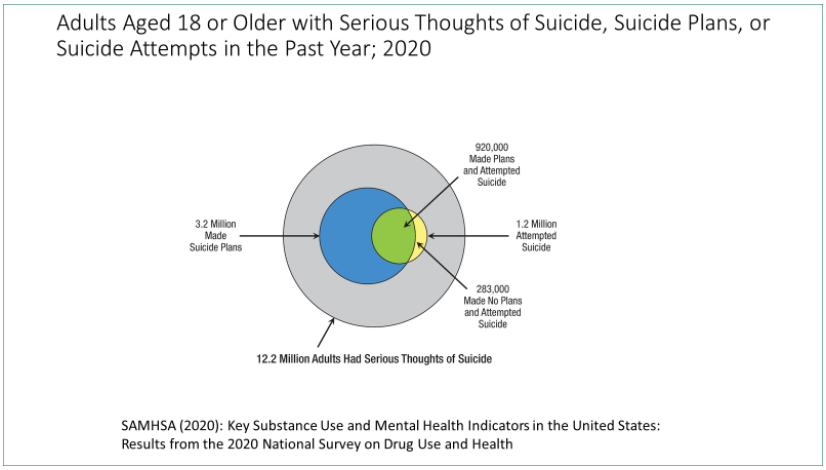
Gaps in the behavioral health system of care, including crisis care, result in overreliance on law enforcement and the criminal justice system for the management of individuals with behavioral health conditions.[4] Over 2 million people with serious mental illness are booked into jail each year, and the prevalence of mental health and substance use disorders in jails/prisons is three to four times that of the general population.[5,6,7,8] One quarter of police-involved shooting deaths involve individuals with signs of mental illness, and many of these shootings occur in the person's own home.[9] A functioning behavioral health crisis care response system that includes a call line and mobile response teams that can respond on site as an alternative to law enforcement could reduce adverse outcomes that are too often seen with law enforcement responses to people experiencing a behavioral health crisis.

Suicide prevention will remain a core function of the crisis care system response, given that over the past two decades, suicide rates have increased significantly. A recent Centers for Disease Control and Prevention (CDC) analysis highlighted that, from 1999 through 2019, the suicide rate in the United States increased 33 percent.[10]

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).[11,12]

In addition, according to recent SAMHSA data, millions more individuals consider or attempt suicide each year. In 2020 (the most recent year for which data are available), 12.2 million adults seriously thought about suicide. Of these individuals, 3.2 million made a plan for suicide, and 1.2 million made a nonfatal suicide attempt.[13]





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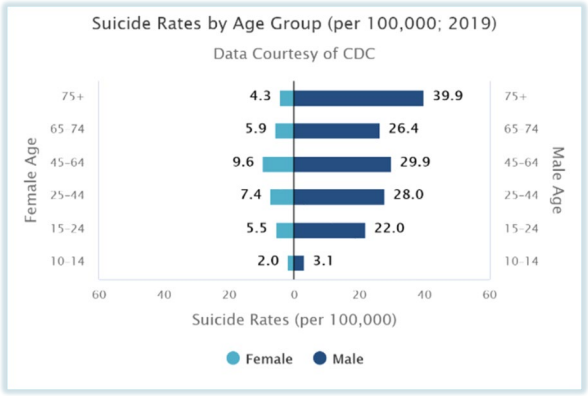
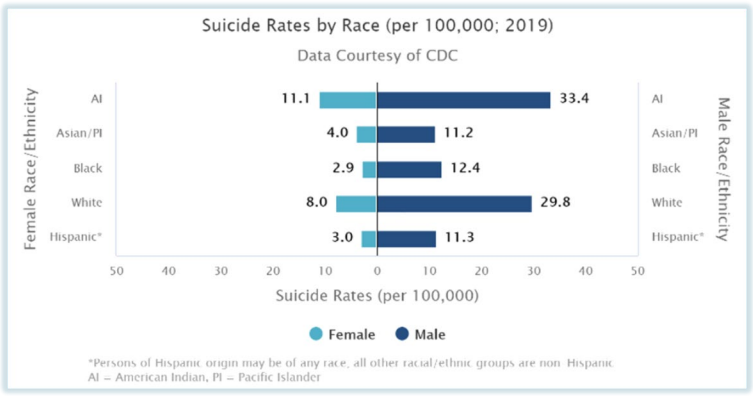
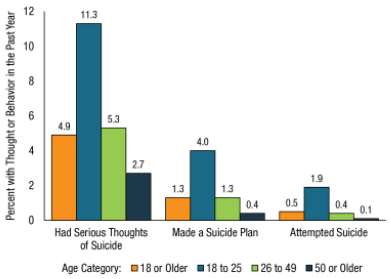




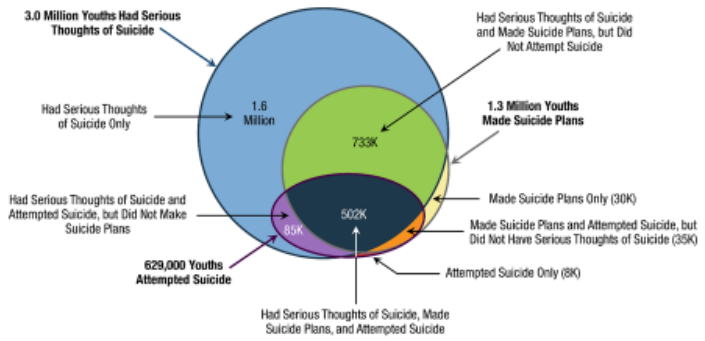
While suicide rates are higher among older adults, the prevalence of suicidal thoughts and past-year suicide attempts is highest among young adults ages 18 to 25.[15] Further, suicide is the second leading cause of death for ages 10 to 34.[16] According to recent SAMHSA data, 3 million youth ages 12 to 17 experienced serious thoughts of suicide in the past year, and 1.3 million youth made suicide plans. Suicide risk among Black youth is increasing, with Black children ages 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.[17] Among adolescents ages 12 to 17, the mean weekly number of emergency department (ED) visits for suspected suicide attempts was 22.3 percent higher during summer 2020 and 39.1 percent higher during winter 2021 than during the corresponding periods in 2019, with a more pronounced increase among females.[18]

Had Serious Thoughts of Suicide, Made a Suicide Plan, or Attempted Suicide in the Past Year: Among Adults Aged 18 or Older; 2020



SAMHSA (2020): Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health

Youths Aged 12 to 17 with Serious Thoughts of Suicide, Suicide Plans, or Suicide Attempts in the Past Year; 2020



3.0 Million Youths Aged 12 to 17 Had Serious Thoughts of Suicide, Made Suicide Plans, or Attempted Suicide in the Past Year

SAMHSA (2020): Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health

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 in the most urban counties (large central metropolitan areas), where suicide rates were the lowest.[19]

Other high-risk groups for suicide include lesbian, gay, bisexual, transgender, queer and questioning, other sexual and gender identity (LGBTQ+) youth, and veterans. Lesbian, gay, and bisexual (LGB) youth have higher suicide risk than heterosexual youth—with the most recent CDC Youth Risk Behavior Survey estimating that 23 percent of LGB youth made suicide attempts within the past year, compared to 5 percent of heterosexual youth.[20] 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.[21] The data are overwhelmingly clear that suicide remains persistently high in the United States, and that resources are needed to address the growing public health crisis.

1b. National Guidelines for Behavioral Health Crisis Care

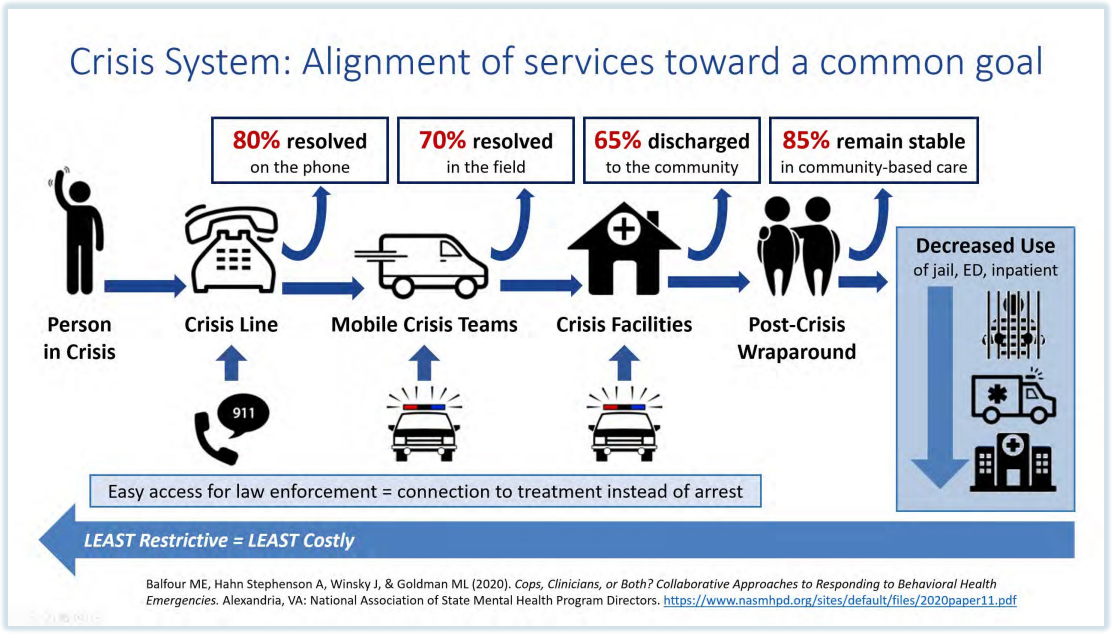
SAMHSA published the *National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit* to signal the need for more comprehensive and integrated practices with respect to system design. Given the high degree of behavioral health crisis service variability across states and localities, along with ongoing resource challenges faced by many communities, the National Guidelines are intended to serve as both a vision and technical implementation support. To save lives and offer those experiencing a crisis the care they deserve, the United States needs a comprehensive and fully funded behavioral health crisis care system. Establishment of 988 represents a once-in-a-lifetime opportunity to drive toward this far-reaching vision.

As SAMHSA's *National Guidelines for Behavioral Health Crisis Care* highlights, the nation must provide behavioral health crisis care services that are available to anyone, anywhere, anytime. SAMHSA's 2020 *National Guidelines* toolkit identifies three core elements that underpin a robust crisis care system:

- **Regional Crisis Call Centers:** Regional 24/7 clinically staffed crisis call centers that provide crisis intervention capabilities (telephonic, text, and chat). Such a service should meet National Suicide Prevention Lifeline (Lifeline) standards for risk assessment and engagement of individuals at imminent risk of suicide, provide training and protocols in working with high-risk populations, and offer quality coordination of crisis care in real time. SAMHSA defines a regional crisis center as a 988/Lifeline call center that covers either a multi-county geographic area or a population base of 3 million people, is coordinated with overall state and territory 988 response, and has expanded functionality (e.g., chat/text, follow-up, mobile dispatch, bed registries). Centers must be designed and resourced to respond to case mix and variation in volume.
- **Mobile Crisis Teams:** Mobile crisis teams available 24/7 to reach any person in the service area in their home, workplace, or other community-based setting in a timely manner.
- **Crisis Receiving and Stabilization Facilities:** Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.[22]

As the linchpin of this system, crisis call centers serve as a lifesaving, coordinating hub. For many callers, these centers can play an instrumental role in de-escalating crises. In other situations, crisis call centers also function like "air traffic control," helping deploy mobile crisis teams to an individual in crisis or facilitating access to crisis receiving and stabilization facilities.

The diagram below illustrates this vision, depicting how each step in the crisis continuum works to reduce crises and their adverse outcomes. Previous analyses suggest that, in a mature crisis ecosystem, up to 80 percent of calls to a crisis call center can be resolved effectively without the need for further deployment of resources.[23] Replication of these findings through peer-reviewed research will be critical, though this is an important signal of the potential of more person-centered crisis response. For those who require further support in person, mobile crisis teams can resolve roughly 70 percent of their immediate concerns in the field. And for the remaining individuals who require admission to behavioral health crisis care facilities, 65 percent are discharged back to the local community without requiring hospitalization.



A robust behavioral crisis care continuum—equipped with appropriate wrap-around supports—allows the majority of individuals to successfully address crisis needs in community-based settings that are less restrictive than other settings. This coordinated and comprehensive behavioral health crisis care system can reduce the need to deploy law enforcement and emergency medical services, thereby decreasing avoidable emergency department (ED) transfers and arrests.

In accordance with the SAMHSA guidelines, the establishment of 988 requires a concerted focus on two overarching goals:

1. Investing heavily in Lifeline crisis call centers that can de-escalate crises and provide real-time coordination with appropriate community-based mental health services; and
2. Transforming the behavioral health crisis care system in the country so that it is available to anyone, anywhere, anytime.

These goals align closely with the intent of the Hotline Designation Act, which encourages investment in both routing calls to local crisis centers and providing broader behavioral health services. The Act specifically authorizes states to impose cell phone fees that address:

1. "Ensuring the efficient and effective routing of calls made to the 9–8–8 national suicide prevention and mental health crisis hotline to an appropriate crisis center; and
2. Personnel and the provision of acute mental health, crisis outreach and stabilization services by directly responding to the 9–8–8 national suicide prevention and mental health crisis hotline."[24]

1c. Establishment of Follow-up Contacts

Individuals remain at elevated risk of suicide in the period following crisis encounters. This includes time after crisis calls, emergency department discharges and inpatient psychiatric hospitalizations. Gould and colleagues (2007) found that 43 percent of callers experiencing a suicidal crisis who completed evaluation follow-up assessments experienced some recurrence of suicidality (ideation, plan, or attempt) in the weeks after their crisis call, and only 22.5 percent of those callers had been seen by the mental health care system to which they had been referred.[25] In response to these findings, SAMHSA funded an initiative in 2008 to offer and provide follow-up to all Lifeline callers who reported suicidal ideation during or within 48 hours before making a call to Lifeline. An evaluation of this initiative, which included interviews with 550 callers followed by 41 crisis counselors from 6 crisis centers, revealed that 79.6 percent of callers interviewed 6–12 weeks after their crisis call reported that the follow-up

calls stopped them from killing themselves.[26] Callers said follow-up gave them hope, made them feel cared about, and helped them connect to further mental health resources.

Recent national approaches have included safety planning interventions followed by a follow-up phone contact, a model that has been shown to be effective in patients discharging from emergency department settings in particular. Outcomes include improved treatment engagement, decreased risk of hospitalization, and reduced suicidal behaviors.[27,28,29,30] Given the potentially life-saving impact of follow-up interventions, along with explicit requirements for follow-up care in the Hotline Designation Act, the Lifeline centers must be sufficiently resourced to maximize responsiveness of the Lifeline system.

Section 2: Background and Current State of the Lifeline

2a. History of the Lifeline

Beginning in fiscal year (FY) 2001, Congress appropriated funding for the networking and certification of suicide prevention hotlines. SAMHSA awarded a competitive, discretionary grant to a single lead grantee for the establishment of a network of crisis centers that could answer calls from their local communities. A single national number was established that provided routing to local crisis centers, thus allowing for nationwide public education and promotion of the number. This early network provided a common infrastructure. In 2005, the National Suicide Prevention Lifeline (Lifeline) was launched with the number 1-800-273-8255 (TALK). In 2006, a Spanish language subnetwork was created in the Lifeline and currently is the "press 2" option in the recorded Interactive Voice Response (IVR) greeting. The subnetwork assures someone is always available to respond to calls in Spanish any time of the day or night.

In 2007, SAMHSA and the Department of Veterans Affairs (VA) partnered to establish 1-800-273-8255 (TALK) as the access point for the Veterans Crisis Line (VCL) to connect veterans in crisis to VA care across the nation. This service went live in July 2007. Now, callers to 1-800-273-8255 (TALK) hear an interactive voice recording message ("if you are a veteran, press 1"), and by pressing 1, veterans are connected to the VCL. In 2015, the Disaster Distress Helpline was also incorporated into the Lifeline cooperative agreement, using the same telephony system but a different number and separate funding stream.

Given an increasing demand for online crisis services, SAMHSA began providing the Lifeline with supplemental funds in 2011 to build the capacity of network centers to provide chat crisis intervention services. The Lifeline added a chat service, available at www.suicidepreventionlifeline.org, for 12 hours per day on February 14, 2013. The chat service now operates 24/7, 365 days a year. Since May 2016, the Lifeline chat link comes up when a person types "suicide" or related terms into the Google search engine. This link has resulted in a steady increase in chats since that time. Investments made by SAMHSA, following increased FY 2020 Congressional appropriations, resulted in an increase to 17 core chat centers in the Lifeline network. There are now 38 active Lifeline chat centers. In August 2020, a texting service was added to the Lifeline for the first time, thereby offering those in crisis another way to access support.

2b. Structure of the Lifeline

The Lifeline is currently a network of over 180 local crisis centers, and 9 of those centers also function as national backup centers. The network is overseen by the Lifeline administrator through a cooperative agreement with SAMHSA. This network is linked by the single toll-free telephone number 1-800-273-8255 (TALK) and is available to people in suicidal crisis or emotional distress 24 hours per day, 7 days per week. The service routes calls from anywhere in the United States to the closest certified local crisis center in all 50 states. "Closest" is currently defined by the area code of the caller's phone number. Should the closest center be overwhelmed by call volume (e.g., call not answered locally within 3 minutes), if a local center experiences a disruption in service, or if there is no available local center in the network, the system automatically routes callers to a backup center. Counselors assess callers for suicidal risk, provide crisis counseling and crisis intervention, link callers to emergency services when needed, and provide behavioral health referrals. SAMHSA's second report to Congress, the *Report to Congress on Training and Access for High-Risk Populations*, more thoroughly addresses SAMHSA's 988 training recommendations. The local crisis centers in the Lifeline network are not currently funded by SAMHSA to answer the Lifeline calls unless they are providing a specialized service.

Please see below for a summary of the Lifeline structure and operations:

	Lifeline Structure and Operations
Contact Response	Local crisis center staff
Number of Crisis Centers	Over 180 local independently owned and operated crisis centers (9 of which also function as backup centers) and 1 national administrator
Call Routing	Lifeline calls come through 1-800-273-8255 (TALK); approximately 1/4 of calls are routed to VCL
Chat and Text Capabilities	38 crisis centers (19 core centers and 19 support centers) respond to chat and text; these are a subset of the more than 180 centers
Additional Responsibilities	Local crisis centers are responsible for responding not only to Lifeline calls, but also for response to contacts on local resource, support, and/or suicide prevention lines supported by their primary funders.
Funding Source	SAMHSA federal funds support the network and telephony infrastructure of the Lifeline through a cooperative agreement with a Lifeline administrator; the provision of clinical standards, training, and technical assistance; 9 backup centers to answer calls that cannot be answered within 3 minutes locally; and 19 core chat/text centers. The remainder of local crisis center funding is a patchwork of local and state funding, private funding, and a small stipend of $2,500 to $5,000 in federal funding from the Lifeline.
Prior Federal Funding	• FY 2021, Enacted: $24 million • FY 2018, Enacted: $7 million
Staffing	Employees or volunteers of local crisis centers
Connectivity to Health Care	Connectivity to local behavioral health and health services is largely dependent on local relationships. Referral is possible, but assurance of treatment engagement and follow-up is more challenging.

2c. Lifeline Volume, Demand, and Challenges

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

Over the last three 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 2018-2020.

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

[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

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. 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. As such, 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 December 2020, the Lifeline maintained a 56 percent text answer rate. Included in the total call number are 49,000 calls that were routed to the Spanish subnetwork. The Lifeline also has recently started using 711 as a Telecommunications Relay Service for individuals with hearing or speech disabilities and is exploring videophone capabilities. In CY 2020, the Lifeline performance metrics reflected a 46-second average speed to answer a call. Call data reveal that approximately 23 percent of callers to the Lifeline reported suicidal thoughts within 24 hours of the call, and in CY 2020, a minimum of 60,890 calls, or 4 percent of all answered Lifeline calls, were placed by callers assessed per Lifeline protocols to be at imminent risk for suicide.[31] At least 13,649 calls, or 1 percent of all answered Lifeline calls in CY 2020, were from callers in the midst of a suicide attempt at the time of their calls. Approximately 28,179, or 2 percent, of all answered CY 2020 Lifeline calls resulted in deployment of emergency rescue services.

Many local crisis centers are unable to respond to Lifeline calls within 3 minutes, with in-state answer rates (percentage of calls originating in state vs. answered in state) during the period January to March of 2021 ranging from 21 percent to 99 percent (https://suicidepreventionlifeline.org/wp-content/uploads/2021/05/ll-instate-report-2021-01-01.pdf). The Lifeline Network Administrator contracts directly with the 9 Lifeline national backup centers, as many of the local crisis centers are neither funded nor staffed to respond to local and state Lifeline demand. These national backup centers provide an essential safety net for individuals reaching out during a crisis by ensuring 100 percent nationwide coverage and ability to receive calls that are unable to be served by a local center. Additionally, the Administrator provides clinical standards, training, technical assistance, quality improvement feedback, and recommendations, as well as the networking and telephony infrastructure of the Lifeline.

Despite the backup infrastructure, the Lifeline's greatest challenge is its capacity to respond to increasing demands, with the greatest response gap occurring for those reaching out via crisis chat. While some individuals reaching out to the Lifeline may choose to disengage for reasons other than wait time (reaching out to a wrong number, changing their mind about seeking help, etc.), it is possible that many disengage due to wait times, and the best solution to the problem of wait times is improving the capacity of both the local Lifeline crisis centers and the national backup centers.

Another important consideration is that more individuals reaching out via chat tend to be in suicidal crisis at the time of their Lifeline contact, relative to those reaching out via phone. Specifically, among those reaching out via chat and responding to a pre-chat survey, 66 percent reported "current" suicidal ideation.[32] By contrast, a Lifeline evaluation study suggested that approximately 23 percent of callers to the Lifeline were suicidal at the time of the call.[33] While those waiting to use the crisis chat and text services receive instructions to call the Lifeline number if they require help immediately, there is not available data on

[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

how many do so. While continuing to improve service delivery across modalities remains a continued priority, improving the Lifeline's capacity to respond via chat and text, in particular, is a priority of utmost importance for SAMHSA.

While the Lifeline has grown significantly since its inception, current Lifeline capacity is sufficient to address only about 85 percent of calls, 56 percent of texts, and 30 percent of chats. This means there are currently thousands of users—many of whom may be currently suicidal—who seek help and are unable to connect with a trained counselor. Many factors impact these challenges, including insufficient funding for local crisis call centers, an inadequately resourced workforce that relies partially on volunteers, and the lack of robust behavioral health crisis care services in many call center regions.

Without proper resourcing, the supply-demand gap is likely to be exacerbated by the creation and promotion of 988. Extensive volume estimates have been conducted for Vibrant Emotional Health to forecast expected volume growth as 988 goes live. 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 modelling for future full years following 988 implementation are noted in Appendix A. Based on low, moderate, and high-volume growth scenarios, the projected contact volume following 1 full year of implementation (July 2023) is 6 to 12 million in total volume of calls, chats, and texts. By year 5 (July 2027) this total volume of calls, chats, and texts is expected to grow to 13–41 million. The professional judgement cost projections that follow are based upon the moderate growth scenario and exclude VCL contacts. While this projected growth presents challenges to a system already challenged by current demand, the launch of 988 provides a unique opportunity to make significant and enduring investments in the Lifeline network.

Section 3: Vision and Recommendations for Implementing 988

3a. 988 Legislation and Opportunity

In 2018, Congress passed, and the President signed into law, the National Suicide Hotline Improvement Act, in which SAMHSA and the VA were called upon to report to the Federal Communications Commission (FCC) regarding the effectiveness of the existing National Suicide Prevention Lifeline (Lifeline) and the potential value of a 3-digit number being designated as the new national suicide prevention number.[34] Based on the SAMHSA and VA reports submitted in 2019, as well as its own review and process of public comment and review, the FCC recommended to Congress that the number 988 be designated as the new national suicide prevention number. The FCC then solicited public comment on a proposed rule designating 988 as the new suicide prevention and crisis intervention number. On July 16, 2020, the FCC issued a final order designating 988 as the new Lifeline and Veterans Crisis Line (VCL) number.[35] This order gave telecom providers until July 16, 2022, to make every landline, every cell phone, and every voice-over internet device in the United States capable of using the number 988 to reach the Lifeline's existing telephony structure. On October 17, 2020, the National Suicide Hotline Designation Act of 2020 (Hotline Designation Act) was signed into law, incorporating 988 into statute as the new Lifeline and VCL phone number.[36] The Hotline Designation Act also requires SAMHSA and the VA to jointly report to Congress on the resources necessary to "make the use of 9–8–8, operational and effective across the United States."

In this report on the Act, section 3(c) addresses the following mandatory components: (1) the findings and conclusions of the Secretary(s) with respect to the resources necessary for the 988 Initiative as noted in paragraph 4 of section 251(e) of the Communications Act of 1934 (47 U.S.C. 251(e)) and the added subsection (a) of the Act; and (2) the recommendations for operational and effective implementation of the 988 Initiative across the nation and throughout all Lifeline and VCL call centers.

3b. Vision and Principles for 988

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.

SAMHSA sees 988 as the linchpin and catalyst for a transformed behavioral health crisis care system in much the same way that, over time, 911 spurred the growth of emergency medical services in the United States. Over time, the behavioral health crisis care system that SAMHSA envisions will aim to:

- Provide enhanced access for people in behavioral health crisis through the use of an easily remembered 3-digit number;
- Reduce reliance on the police by linking Lifeline centers with mobile crisis teams (when the person in crisis requires services beyond what the call center itself provides);
- Reduce 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 over-crowding/boarding by providing needed evaluation and crisis intervention in the community whenever possible; and
- Better meet the behavioral health care 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.

In addition to the overarching goals of strengthening and expanding the Lifeline and transforming the nation's behavioral health crisis care system, SAMHSA has identified eight principles that should guide the long-term development of 988:

1. **Strengthen and expand existing infrastructure**
    - *Foundation:* The Lifeline will serve as the backbone of 988. As highlighted above, the Lifeline network has evolved and grown significantly since its inception in 2005. For nearly two decades, Lifeline centers have provided critical suicide prevention and crisis intervention services. SAMHSA-funded evaluations have demonstrated that, through the efforts of these centers, the Lifeline network has helped reduce hopelessness and suicidality during calls and decreased the frequency of emergency interventions required for callers at imminent risk.[37,38] As such, the FCC's 988 mandate (https://www.fcc.gov/suicide-prevention-hotline) requires all telecom providers to direct 988 contacts to the

Lifeline routing infrastructure.

- *Core federal partners:* 988's launch will be spearheaded by SAMHSA, the VA, and the FCC. Together, these federal agencies are helping to drive overall 988 planning, implementation, and execution. SAMHSA is also working with public and private sector partners to ensure adequate capacity to answer Lifeline/988 calls, chats, and texts; provide operational roadmaps for states/crisis centers; develop effective collaborations with 911; build a coordinated data infrastructure to foster ongoing evaluation and quality improvement; and launch a large-scale 988 public awareness campaign. VA is simultaneously working to ensure operational readiness for 988. The FCC is overseeing the enabling of all cell phones, landlines, and voice-over internet devices that will need to connect to 988. The FCC has also requested public comment on texting to 988 and has made recommendations regarding further consideration of geolocation within the 988/Lifeline system. As 988 planning intensifies, SAMHSA, VA, and the FCC will continue to work closely with numerous other federal partners.
- *Network administrator:* SAMHSA's Lifeline grantee—Vibrant Emotional Health (Vibrant)—will continue administering the Lifeline network and working with crisis call and contact centers across the country to prepare for 988 implementation. In June 2021, Vibrant was awarded the grant to manage the Lifeline network through 2026.

2. **Deliver a seamless and high-quality experience for all call center users**

   - *Timely access:* Long wait times and low answer rates are unacceptable and may easily lead to tragic outcomes. As the Lifeline network strengthens, it must strive to answer all contacts, and seek to build upon the service level expectations for 911 and for the VCL (https://cdn.ymaws.com/www.nena.org/resource/resmgr/standards/nena-sta-020.1-2020_911_call.pdf; for the VCL, the expectation is a 95 percent answer rate within 20 seconds for inbound telephone service).
   - *Staffing:* Crisis call centers must be adequately resourced in their service delivery model to support paid staff and provide access to clinical training and supervision. As SAMHSA's corresponding *Report to Congress on Training and Access for High-Risk Populations* articulates, crisis call center staff must be culturally competent and equipped to address the needs of populations at high risk of suicide.
   - *Quality care:* All persons contacting 988 receive care that is consistent with Lifeline's best practices. Standardized performance metrics demonstrating quality care will be established by the Lifeline administrator, and all centers will actively participate in monitoring, collecting, and reporting this data toward network-wide quality assurance.
   - *Integrated approach:* The system must adopt a "no wrong door" approach so that individuals with specialized and/or complex needs can have their needs met via a single point of entry through direct service delivery and/or facilitated referrals. This includes ultimately developing a system of response that can support and connect individuals with substance use and co-occurring conditions and for crisis centers to be connected to other safety net settings of care.

3. **Ensure services are available to all in need**

   - *Awareness:* 988 must achieve broad public awareness (similar to 911), with a clear understanding of the services provided through the Lifeline. Educating the public about the health benefits of 988 and when to call 988 as opposed to 911 will be of great importance.
   - *Channels:* 988 must offer a seamless experience across calls, chats, and text. Young people, in particular, may prefer access through chat or text, and the Lifeline needs to be able to respond to their communications using whatever channel of communication they feel most comfortable using.
   - *Equitable:* 988 must offer trusted support that is tailored to meet the needs of specific populations (e.g., services to meet cultural and linguistic needs, and services to meet the needs of individuals with disabilities). This will include the ability to provide timely access to specialized services required by populations at higher risk, an understanding of principles of antiracism and historical trauma, as well as consideration of the disproportionate impact of reliance on law enforcement for crisis response. Enhancements in data collection must be developed to facilitate disaggregation to identify impact disparities. This includes analysis of rates of law enforcement involvement and hospital transfers among different racial and ethnic populations. Such data will be used to support SAMHSA's ongoing system evaluation and quality improvement efforts.

4. **Create private-public partnerships that yield meaningful support**
    - *Multi-sector leadership:* 988 needs to be a strong partnership between the public sector, private sector, and key non-profit entities. Key partners will include the network of Lifeline centers, state and local governments, national mental health and suicide prevention provider and consumer groups, and multiple sectors with an interest in seeing a transformed behavioral health crisis care system.
    - *Sustainability:* Engagement with partners requires long-term commitment to address systemic and institutional barriers to effective service implementation, including funding limitations, fragmentation, and parity concerns.
5. **Integrate behavioral health services into one transformed behavioral health crisis care system**
    - *Local crisis services:* 988 must be integrated into a coordinated crisis system that seeks to assure ready access to mobile crisis, crisis receiving, intervention, and stabilization services.
    - *Continuum of behavioral health services:* 988 must be linked to the broader continuum of mental health and substance use treatment services and social supports, including Certified Community Behavioral Health Clinics, community mental health centers, substance use treatment facilities, and Federally Qualified Health Centers.
    - *Follow-ups:* Contact centers must be adequately funded and staffed to be able to conduct follow-up contacts so that people do not fall through the cracks of fragmented systems.
    - *Regional hubs:* Over time, SAMHSA will encourage the development of regional crisis center hubs, with some potential elements of these hubs described in *SAMHSA's National Guidelines*. Many Lifeline centers currently function in this role. SAMHSA will work to further define core features of regional hubs, as well as enhance and expand their capabilities over time.
6. **Be consistent across standards and services provided**
    - *Consistent platform:* Call and contact centers have access to and can successfully adopt a consistent platform to ensure robust and consistent data collection, as well as efficient and streamlined routing.
    - *Operational alignment:* Clear performance management standards, training expectations, and metrics shall be in place across the network. This will include regular review and public dissemination of select key performance indicators. More detail on expected training elements are noted in SAMHSA's *Report to Congress on Training and Access for High-Risk Populations.*
7. **Fund adequately at scale and with operational efficiency**
    - *Administrator:* The Lifeline administrator must have sufficient resources and tools necessary for managing a highly efficient and effective national network that can offer backup services to ensure that people in crisis can receive immediate care.
    - *Call centers:* Crisis call centers must have resources to address all contacts.
    - *Crisis capacity:* Core crisis services—including call centers, mobile crisis, and receiving/intervention/stabilization facilities—must be funded to meet community and state demand.
8. **Commit to continuous improvement, driven by innovation, measurement-based care and evidence**
    - *Quality improvement* efforts must be ongoing and data driven, with incorporation of enabled and supported technology to facilitate data collection activities.
    - *Rigorous evaluation* must be conducted to optimize outcomes, including safety, efficacy, and timeliness of service.
    - *Ongoing coordination* is needed to incorporate evolving evidence and best practice, to identify gaps, and to ensure multi-partner participation in system design. This includes the essential role of individuals with lived experience and communities that are disproportionately affected by suicide and trauma in helping to identify gaps, innovations, and recommendations for quality improvement.

3c. Near-Term Recommendations

988 affords a once-in-a-lifetime opportunity to strengthen and expand the Lifeline. To achieve this vision, SAMHSA has outlined four critical objectives:

- ***Near-term objective 1: Improve contact answer rate and response quality by strengthening the Lifeline network operations.*** Most critically, the Lifeline must be equipped to answer a higher percentage of contacts, especially chats and texts. The system must also be resourced to adapt to evolving digital modes of communication, particularly for youth and young adults in high-risk groups. The current Lifeline network cannot keep pace with current contacts, and this challenge will be exacerbated significantly with the rollout of 988. Over the next 2 fiscal years, it is critical to invest in strengthening Lifeline network operations. While further system transformation will require additional capacities (e.g., substance use integration, coordination across the crisis continuum), the immediate priority is ensuring the Lifeline has sufficient resources to address the scope of contacts addressed directly in the Hotline Designation Act, including individuals in suicidal or mental health crisis. In the near term, efforts should be made to map available local resources so that facilitated transfers and referrals can be made to support individuals with additional needs. Recommendations for subsequent enhancements necessary to achieve the vision of system transformation are noted in later sections.
- ***Near-term objective 2: Improve local crisis call center capacity to improve in-state answer rates.*** Investments in local centers are critical to improve overall response rates and shift toward greater crisis response and integrated service delivery at the state, regional, and local levels. In order to provide sufficient integration with local crisis systems, support to local centers must be accelerated to increase their capacity to respond to all modalities of contact.
- ***Near-term objective 3: Educate the American public about 988 through the launch of a large-scale public awareness and communications campaign.*** In advance of 988's launch in July 2022, planning must begin for a large-scale communications campaign to educate the public about how and when to use 988. Initial planning, research, and partner engagement will take place in FY 2022. Potential communications should be targeted both to the general population and to specific populations at high risk of suicide, and should build confidence that calling 988 will lead to an effective response that is different from what would be provided if calling 911.
- ***Near-term objective 4: Strengthen 988 coordination and planning by establishing a 988 and Behavioral Health Crisis Coordination Office.*** Strengthening our federal infrastructure to enable planning, coordination, and communication for all crisis care services across public and private partners is critically important. Creating a 988 and Behavioral Health Crisis Coordination Office within SAMHSA—modeled on the existing national 911 entity at the Office of Emergency Medical Services managed by the Departments of Transportation and Commerce—would assist SAMHSA in achieving these goals. This Office could focus on the immediate operational needs of preparing the Lifeline network for the launch of 988. A key deliverable for the Office in the near term will be to improve 988 coordination with the 911 system at the local, state, and federal levels. This will include the development of communication and triage protocols. This collaboration is essential to maximize the opportunity to save lives. Lessons learned from decades of 911 implementation will also be instrumental in messaging to communities about the public health benefit of the 988 crisis system.

3d. Near-Term Cost Estimates

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.

In order 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 further 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 requested in the President's Budget; 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 $177M 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;
    - 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 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), 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. The resource needs are subject to change based on contact volume and ongoing operational readiness assessments of the Lifeline network. 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 underlying potential future needs of the Lifeline are detailed in Appendix B. As additional data becomes available on state and local readiness, SAMHSA recognizes that ongoing analysis will be required to inform final resourcing needs in future years. Key areas 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 per year total of Federal and non-Federal funding):**

   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, i.e., rent)
   - 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, 3-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. Similar past campaigns have costed between $125 million and $225 million.
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.

3e. 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 throughout 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 allows states to impose and collect cell phone fees to support 988 operations. As of August, 2021, 4 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 state-wide, 24/7 Crisis Access Line; mobile crisis teams with statewide coverage; and crisis stabilization units for adults and children. GA 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), which 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. KY 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, MO 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.

3f. Longer-Term Considerations

While strengthening the Lifeline is a critical first step in realizing the promise of 988, in the long term, SAMHSA aspires to transform America's behavioral health crisis care system to one that saves lives by serving anyone, at any time, from anywhere across the nation. This challenging and bold vision will require close coordination among federal, state, and local partners.

As part of our longer-term vision, SAMHSA has identified three additional objectives, detailed below.

Long-term objective 1: Expand access to high-quality behavioral health crisis services by building a more robust and responsive crisis continuum.

As states, territories, and local partners continue to improve local crisis ecosystems, it is critical to focus on enhancing core crisis services, service integration for substance use, and rapid access to crisis care.

Core services: As detailed above, SAMHSA's 2020 *National Guidelines* toolkit highlights three core elements of a robust crisis system: regional crisis call centers, mobile crisis teams, and crisis receiving and stabilizing facilities. These elements—which form the foundation of the Crisis Model—need continued and ongoing investment across all states, territories, and localities.

- **Regional crisis call centers:** The centerpiece of this Crisis Now model—and the primary focus of SAMHSA's near-term recommendations above—is a regional crisis call center designated to serve as a coordinating hub. As this report describes, the "air traffic control" model provides an innovative approach for the coordination, monitoring, and delivery of crisis services in which Lifeline crisis centers would serve as a hub for effective deployment of mobile crisis services. A sufficiently resourced crisis center hub could stay in connection until the person in crisis is safely linked to ongoing care, such as a Certified Community Behavioral Health Clinic. Appendix D includes examples of three states (Georgia, Colorado, and Connecticut) that have employed a hub model to coordinate crisis services.
- **Mobile crisis teams:** Another critical component is mobile crisis teams, which should be available 24/7 to reach any person in a given service area in their home, workplace, or other community-based setting. According to one estimate, for every 100,000 members of a representative population, 200 members will experience a crisis that requires something more than a typical outpatient or telephone intervention.[39] Various clinician and peer-led mobile team models have been implemented in jurisdictions around the nation; many of these programs have data supporting their success in diverting individuals away from jails and hospitals and maintaining clients in the least restrictive community environments. For example, reduction of law enforcement utilization has been achieved in Austin, Texas, through the deployment of a two-person mobile crisis outreach team. Of those calls resulting in mobile crisis outreach deployment in FY 2020, 83.4 percent were able to be conducted without law enforcement, which highlights the importance of mobile crisis outreach capabilities coordinated with crisis hotlines (https://talk.crisisnow.com/austins-911-call-center-integrates-mental-health-call-crisis-diversion/). Mobile crisis services around the country have also engaged in innovative partnerships with medical first responders to improve outcomes for individuals in crisis. An example of a type of mobile crisis response team partnership that has achieved considerable prominence in the past year is the Crisis Assistance Helping Out On The Streets (CAHOOTS) model.[40] First launched in Eugene, Oregon, 30 years ago at White Bird Clinic, this model dispatches a two-person team consisting of a nurse, medic, or EMT and a mental health crisis worker to manage mental health crises at the scene, including non-emergent medical issues, thereby avoiding costly ambulance transport and emergency room treatment. White Bird reports that in 2019, out of a total of 24,000 CAHOOTS calls, law enforcement backup was requested only 150 times. There are additionally a number of promising youth-focused mobile intervention models that require more attention and study, recognizing that successful adult models do not necessarily translate for children and families.
- **Crisis receiving and stabilizing facilities:** The third element—crisis receiving and stabilizing facilities—provides short-term observation and crisis stabilization services to all referrals. To align with best practice recommendations, these facilities must operate 24/7; accept walk-ins and first responder drop-offs; limit admission refusals; and provide linkage and handoff to other elements of the care system when needed, including withdrawal management, hospitalization, or outpatient care. They must also be able to diagnose and initiate stabilizing treatment. Data suggest that a high proportion of people evaluated for hospitalization can be safely managed in crisis settings. Agar-Jacomb and Read found that individuals who had received crisis services preferred going to a safe place, speaking with peers and trained professionals who could understand what they were experiencing, and interacting with people who offered respect and

dignity to them as individuals—an experience they felt they did not have at the hospital. In such an alternative setting, psychiatric crises can be de-escalated.[41]

Service integration for substance use: To fully realize the potential of a coordinated crisis system, interventions must be capable of responding to the needs of individuals with substance use challenges. The Lifeline currently does respond to contacts regarding substance use, though enhancements are needed in the overall crisis system to strengthen service delivery. These enhancements include staff trained in targeted screening and assessment, level of care assessment, medical monitoring and triage, and brief counseling interventions, as well as facilities with the capacity to provide withdrawal management and stabilization. Too often, service capacity is poorly integrated, leading to an artificial divide between mental health and substance use needs. The Certified Community Behavioral Health Clinic (CCBHC) model is a useful approach that can link individuals in crisis with a network of services either performed on-site or through designated collaborating organizations. This is also a crucial area where coordination and protocol development with 911 is critical, as there are substance-related situations—including intoxication, withdrawal, and/or overdose—that will require 988 to closely collaborate with the 911 system.

Rapid access to post-crisis care: Across the continuum, rapid access to ongoing post-crisis support is essential. This provides reach beyond the immediate follow-up calls to promote connection to outpatient or other services that can continue to assess and treat individual needs. Without this component, individuals are more likely to cycle through repeated crises. Many organizations and localities have moved to models that prioritize initial "same-day" appointments. Access to community mental health centers, substance use treatment facilities, CCBHCs, and Federally Qualified Health Centers is likely to be of particular importance.

Long-term objective 2: Scale and optimize BH crisis services through key drivers, including financing, workforce, equity, data, and technology.

Financing: Far-reaching crisis system transformation requires sustainable financing mechanisms. One high-level estimate conducted by RI International suggests that, at scale, mobile crisis teams would cost over $650 million, while crisis receiving units would cost roughly $5.6 billion (Appendix E). SAMHSA recognizes that such cost estimates must continue to be syndicated and refined over time. There are multiple financing considerations, including coverage by public and private payers and parity with other emergency medical benefits.

As SAMHSA's 2020 *National Guidelines* suggest, "It would be unthinkable for any community, except frontier or very small ones, to go without their own fire department. Because this is known to be an essential public expenditure, fire stations and fire trucks are simply made available. Sometimes users may pay a fee for service calls, but the station and the equipment are available to anyone in need regardless of ability to pay. In most communities, mental health crisis services take a different approach or are not offered at all due to the lack of coverage or reimbursement for this level of care."

Workforce: Workforce needs—including recruiting, retention, and ongoing support—represent another critical challenge today for crisis systems across the country. As local crisis systems continue to grow, current workforce gaps may be further exacerbated. Building the BH crisis workforce is an important component of increasing access to crisis services. Potential approaches to address workforce issues include:

- Including crisis workers in loan repayment programs;
- Addressing loan repayment site eligibility restrictions;
- Pipeline infrastructure support to develop additional peer support and paraprofessional training opportunities in crisis work, with additional content focus in youth crisis services;
- Collaboration with existing training programs to develop specialized curricula in crisis work;
- Interventions addressing compassion satisfaction, fatigue, and burnout in the crisis workforce;
- Expansion of rural and tribal grants to expand behavioral health partnerships; and
- Support for ongoing assessment and evaluation of workforce needs in the behavioral health crisis care continuum, including analysis of crisis service staffing models, recruitment and retention strategies, and sustainability approaches.

Equity: Access to BH crisis services can vary significantly for different populations. As crisis services develop further, it will be critical to ensure they are universally accessible and specifically support high-risk populations (e.g., LGBTQ+ youth and adults, people who live in rural areas, people with disabilities, American Indian/Alaska Native (AI/AN) communities). SAMHSA's corresponding *Report to Congress on Training and Access for High-Risk Populations* provides initial recommendations that would help advance more equitable access to crisis services, while accounting for diverse racial, ethnic, and cultural needs. The system must also be responsive to communities disproportionately burdened by ineffective crisis response, and evaluation of performance must include disaggregated data to address impact disparities.

Data and technology: Data and technology enhancements could enable stronger continuity of care and more expansive information sharing, where appropriate. Examples of enhanced data and technology might include:

- Full text and chat capacity across a unified call center platform;
- Direct calling for sign language and languages other than Spanish (eliminating need for third-party interpreters);
- Coordination with the FCC following its recommendations on further study of geolocation capacity for callers in crisis;
- Integrated mobile dispatch from the 988 call centers;
- Data sharing protocols with 911, first responders, and crisis receiving facilities;
- Registries to identify bed availability for receiving and stabilization facilities;
- Coordination with CDC and other federal entities to promote real-time sharing of suicide trends; and
- Consistent data definitions and collection methods (integrity and universality) to evaluate system performance and improvement needs.

Long-term objective 3: Provide ongoing direction for BH crisis services through increased collaboration and partnership

Ongoing federal partnership with states and localities will be instrumental to transforming crisis services. While a 988 and Behavioral Health Crisis Office would initially focus predominantly on the near-term objectives identified above, in the longer term, the Office will also help provide ongoing direction and leadership regarding crisis services. This could include:

- **Convening federal, state, local, and private partners to develop and update a crisis implementation roadmap.** The roadmap could identify clear goals and milestones for scaling crisis services and incorporate input from a wide array of public and private stakeholders.
- **Providing ongoing technical assistance to state and local partners.** The Office could continue to shape and disseminate evidence-based and evidence-informed best practices regarding core crisis services, service integration for substance use, peer recovery supports, and rapid access to crisis care.
- **Developing a continuous evaluation and quality improvement plan for performance of the crisis system that is driven by innovation and evidence.**
- **Launching and managing federal workgroups charged with making recommendations regarding BH crisis financing, workforce, equity, data, and technology.** Working across core federal partners, the Office would establish workgroups to identify innovative solutions and submit preliminary recommendations to SAMHSA within 6-12 months of their formation. These activities could link to many existing efforts underway, including the White House Interagency Policy Committee subgroup on crisis services and HHS's Behavioral Health Coordinating Council on Suicide Prevention.

Conclusion

SAMHSA appreciates the opportunity to present this report to Congress outlining the development and challenges of the Lifeline network, and to provide SAMHSA's professional judgment estimates to support a successful 988 launch in July of 2022. The establishment of 988 represents a once-in-a-lifetime opportunity to strengthen and expand the National Suicide Prevention Lifeline and transform America's behavioral health crisis care system to one that saves lives by serving anyone, at anytime, anywhere across the nation.

The near-term priority is to ensure that the Lifeline Network Administrator and the local call centers have the resources needed to support staffing, data, and training to improve current response rates and meet the increased demands expected with 988 rollout. Given the lives at stake and the high level of federal accountability, SAMHSA also recognizes the importance of federal leadership in promotion and oversight of the 988 system. A more robust federal structure would help ensure that system performance is evaluated, that efforts are coordinated throughout the government and with external partners, that there is an emphasis on data and equity, and that quality improvement and best practices are disseminated and adopted broadly. This national leadership is critical in a system that has been limited by gaps, inequities, fragmentation, and wide variation in practice.

Sadly, suicides and suicide attempts remain a common cause of mortality and morbidity in this country, and there is evidence that individuals experiencing a behavioral health crisis are not able to obtain the care they need. SAMHSA embraces this inflection point in the provision of behavioral health crisis care services and is encouraged that there is great will and passion on the part of so many critical partners to support those who are experiencing a behavioral health crisis. The successful implementation of 988 will serve as a cornerstone on which the nation's behavioral health crisis care transformation will be built.

Appendix A: 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),[42] which reflects the following estimates of the prevalence of mental and/or substance use disorders and exposure to potentially traumatic events:[43]

- 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).

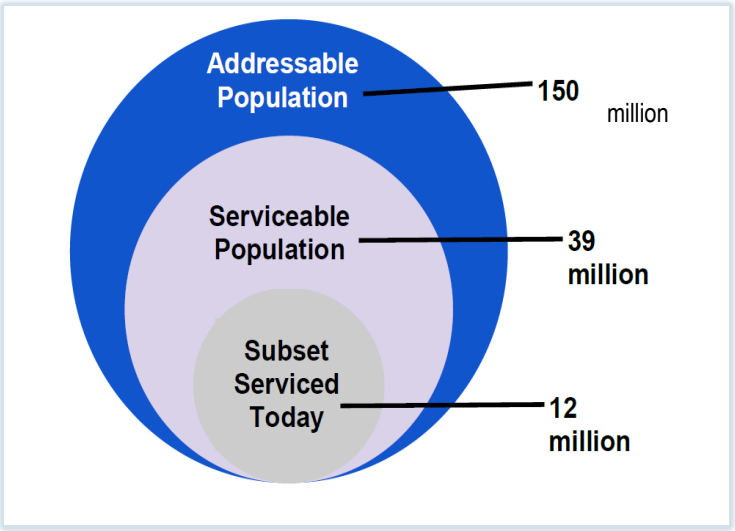
The potential serviceable population for 988 is a subset of the potential addressable population that may be vulnerable to a mental health or suicide-related crisis at a given time and is estimated at 39 million (about 14 percent of the U.S. population age 12 and older).

- 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).[44]
- 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).[45]

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 may also not be receiving support.

Being able to serve this many people will require 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. It should be noted that contact volume is different than numbers of unique persons served.

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

Growth in Baseline Volume. Growth in baseline volume 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 many instances, call volume did not return to its previous baseline.

Below is the projected annual growth rate 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 language of the Hotline Designation Act and of the FCC's order includes the 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 upon the assumption that effective marketing will be the primary driver of these increases in new contact volume. These estimates assume 2-5 percent of the serviceable population not already connecting will reach out in year 1, increasing to 5-15 percent in year 5. This increase will be driven by 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 calls currently going to 911 being diverted 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 3-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 1-2 percent in year 1 to 10-30 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:

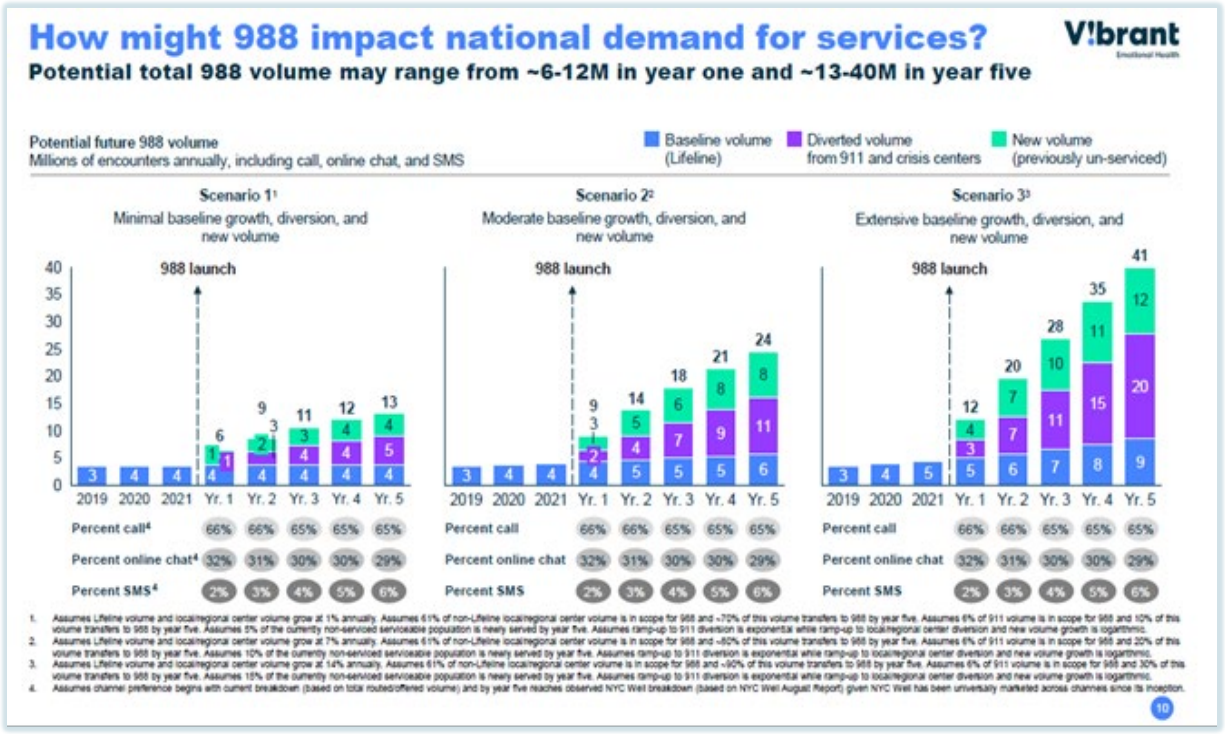
Additional 988 Contacts, Attributable to 911 Diversion Alone Year 5, Post-988 Launch		
Low Growth	**Moderate Growth**	**High Growth**
2 million	3 million	5 million

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 23-30 percent in year 1 to 69-90 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 13–41 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

Appendix B: 988 Cost Estimates

Overarching Guiding Principles

Accelerating the ability of local crisis centers to build capabilities to address all contacts, including calls, chats, and texts, is a critical consideration. Providing funding directly to local crisis call centers would shift some costs from the national chat/text centers (funded historically under the SAMHSA Suicide Prevention Lifeline program) to the local crisis call centers. While this model will take time, it is critical to driving integration of services within local behavioral health ecosystems. There will be a continuing need for backup centers to maintain capacity for the safety net function.

SAMHSA anticipates some shift in future years to more regionally based hub model approaches to call response. For the purpose of this analysis, SAMHSA defined a regional center as a 988/Lifeline call center that covers either a multi-county geographic area or a population base of 3 million people, is coordinated with overall state and territory 988 response, and has expanded functionality (e.g., chat/text, follow-up, mobile dispatch, bed registries).

Key Assumptions for FY 2022

- Expected volume across calls, chats, and texts (excluding the Veterans Crisis Line): 3.65 million (assuming a 25 percent call growth over FY 2021 volume)
- Answer rate: 80 percent of all calls, including TTY calls, should be answered by the Lifeline local centers
- Percentage of chat/text volume handled by national chat/text centers: 100 percent
- Percentage of call volume handled by national backup call network: 20 percent

Key Assumptions for Future Years

- Expected volume across calls, chats, and texts (excluding the Veterans Crisis Line): 7.6 million
- Answer rate: 90 percent of all contacts (including calls, TTY calls, chats, and texts) should be answered by the Lifeline regional centers
- Percentage of chat/text volume handled by national chat/text centers: 10 percent
- Percentage of call volume handled by national backup call network: 10 percent
- Not every local Lifeline center will necessarily need to be a regional center

The tables below include additional detail on SAMHSA's professional judgement estimates of 988 cost components in future years:

Future Year 988 Costs	Future Year Total Estimated Cost—By Category	Future Year Total Estimated Cost—By Component	Future Year Key Assumptions
1 Network operations	**$110 million** for enhancing 988 network operations. This funding would support infrastructure development and enhancements to the existing National Suicide Prevention Lifeline.	• Funding to backup centers, chat/text, and specialized services (e.g., Spanish subnetwork) • Network/telephony infrastructure • Standards, training, data tracking, evaluation, and quality improvement	• % of chat/text volume handled by national chat/text network: 10% • % of call volume handled by national backup call network: 10%
2. Local (regional) crisis call centers	**$560 million** for local crisis center capacity. This funding (federal and non-federal) would expand the capacity of regional crisis call centers to address 90% of all incoming contacts, including calls, chats, and texts.	• Future Year volume estimate: 7.6 million (excluding the Veterans Crisis Line) • Cost per contact: $82	• % of call/chat/text volume handled by local (regional) crisis call centers: 90%
3. Public awareness and communications	Costs associated with scaling a public awareness campaign to educate individuals and partners about 988's scope and services.	• TBD	• N/A
4. 988 and crisis team/office	**$10 million** for a 988 and Behavioral Health Crisis Coordination Office within SAMHSA. This funding would help sustain the federal office to drive 988 planning across government and with public and private partners.	• Technical assistance to states and crisis centers • Staff • Performance management, evaluation, and oversight • Program funds for partnerships, convenings, and cross-entity coordination	• N/A

Appendix C: Potential Cost Savings by Expense

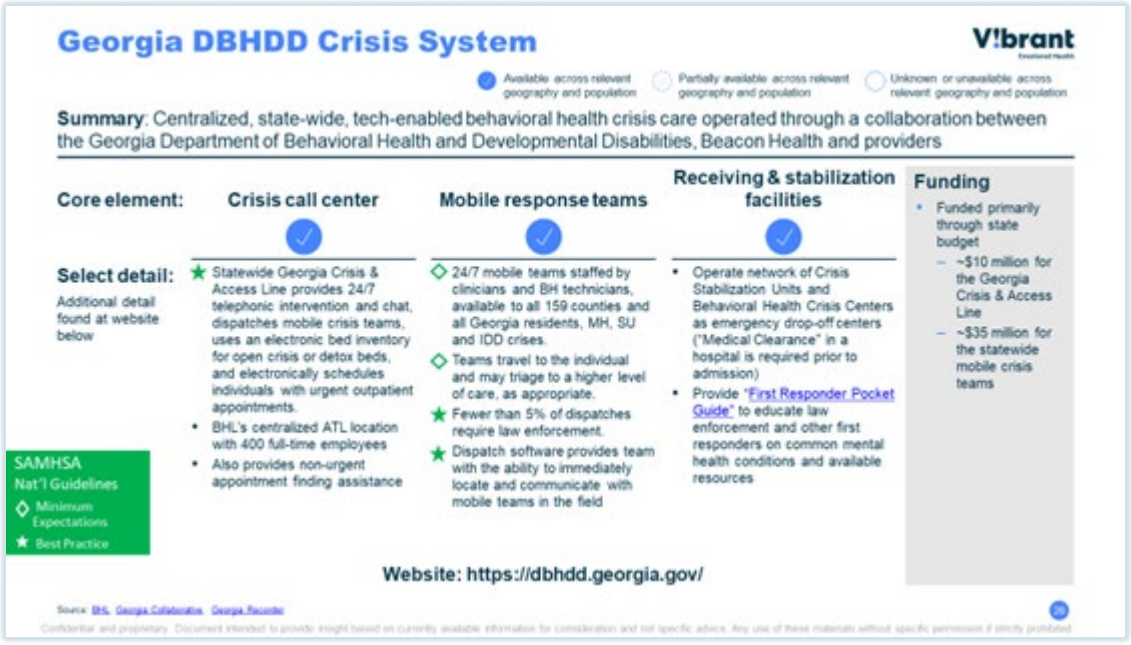
This section provides a sampling of potential cost savings associated with effective and appropriate utilization of 988.

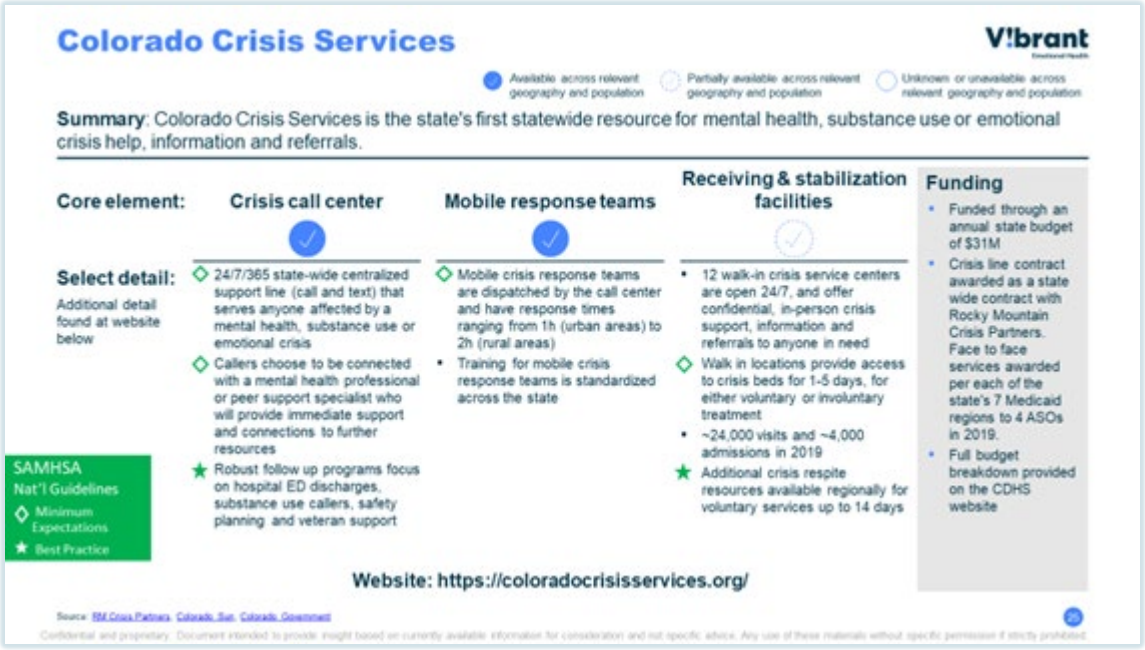
Expense	Description
911 calls	• If 988 could divert mental health-related 911 calls to 988, there could be lower 911 contact volume and therefore lower state and/or local costs associated with 911 operations. For example, in 2018, Washington state as a whole spent $317.8 million on 911 operations, or approximately $42 per capita, paid largely through counties (https://mil.wa.gov/asset/6012f4af4611d).
Law enforcement deployment	If mental health-related 911 calls divert to 988 and mobile crisis teams can respond effectively, there may be fewer potential deployments of law enforcement, which may contribute to state and/or local savings: • Law enforcement agencies report between 5 and 15 percent of their calls involve individuals with mental illness (https://www.powerdms.com/policy-learning-center/policing-the-mentally-ill). • A study by Scott (2000) showed that mobile crisis compared to usual law enforcement deployment resulted in a decreased cost per case of 23 percent.[46]
Deployment of emergency medical services (EMS)	• If 988 were to more effectively connect components of the crisis care continuum, there could be potential to reduce costs associated with the deployment of EMS. • Ambulance transport may not always be necessary for individuals experiencing a mental health-related crisis (e.g., a crisis may be resolved by a mobile crisis team and may not require transport to a hospital). • States pay up to $2,000 per ambulance transport; this does not include the cost of dispatch from 911 operators. • Diversion of mental health responses from EMS when an EMS response is not required has a direct impact on public health needs by preserving EMS resources for responding to medical situations they were designed and best trained for.
Criminal justice systems response	If 988 were to avoid unnecessary detention of individuals in crisis through better connectivity of the crisis care continuum, costs associated with detaining and treating individuals with mental illnesses in correctional facilities could be reduced: • Law enforcement personnel often have to travel greater distances and wait for longer periods of time to connect individuals to mental health support services compared to booking individuals at the nearest jail. This is particularly problematic in situations involving misdemeanor charges where non-violent individuals with mental health needs would be better served by treatment access. The costs associated with holding an inmate in jail are significant ($86 to $192 per day) (https://www.vera.org/downloads/publications/price-of-jails-summary.pdf), and millions of individuals with mental health conditions are booked into jails every year.
Costs associated with emergency department (ED) visits and hospitalization	By referring individuals to effective crisis care, avoiding ED use and hospitalization, and preventing readmission, 988 could potentially reduce costs associated with avoidable hospitalizations: • One study estimated that the national cost of suicides and suicide attempts in the United States in 2013 was $58.4 billion, based on reported numbers alone. Lost productivity (termed indirect costs) represents most (97.1%) of this cost. With adjustment for under-reporting, the total national cost of suicides and suicide attempts is estimated to be $93.5 billion or $298 per capita. A highly favorable benefit–cost ratio of 6 to 1 is suggested for investments in additional medical, counseling, and linkage services for such patients.[47] • Most individuals who receive mental health-related crisis care do not require ED/inpatient psychiatric (IP) care. Reducing the use of acute ED/IP beds by enabling referral to mental health crisis centers has been found to significantly reduce the overall costs of mental health crisis care. The Crisis Now model suggests a reduction of 45 cumulative years of psychiatric boarding, resulting in avoided medical costs estimated at $37 million (https://crisisnow.com/wp-content/uploads/2020/02/CrisisNow-BusinessCase.pdf). • Richardson and colleagues (2014) sought to examine the return on investment (ROI) of follow-up interventions (phone calls initiated by eight crisis centers) for patients discharged from hospitals and emergency rooms following admission for suicidal ideation or deliberate self-harm. ROIs were calculated as amount of return for every $1 invested. For patients discharged from a hospital, the ROI was $1.76 for commercial insurance and $2.43 for Medicaid. For those discharged from an ED, the ROI was $1.70 for commercial insurance and $2.05 for Medicaid. Of

Expense	Description
	those variables influencing readmission rates, post-discharge contacts had the greatest impact.[48] • Delivery of follow-up postcards for individuals identified with suicide risk who were discharged from the ED both improved outcomes and reduced cost.[49]
State costs associated with crisis care for the uninsured population	• By preventing unnecessary hospitalizations, 988 could reduce state and local costs of uncompensated care for uninsured individuals experiencing mental health crisis.

Appendix D: Examples of Crisis Center Hub Models

The crisis center hub models include those currently active in the states of Georgia (GCAL), Colorado (Rocky Mountain Crisis Partners), and Connecticut. Key features of these models are included below.





Connecticut Statewide Call Center Hub

Connecticut developed a statewide call center hub that works with both child and adult mobile crisis teams; the child and adolescent system represents an investment of $13.9 million dollars, which is supplemented by third-party reimbursements (5–15 percent of total funding). Funding allocation is specified as follows:

- **Connecticut Mobile Crisis Call Center: $1,035,962:** Includes $300,000 federal block grant (+20,000 calls annually and +15,000 episodes of care annually; average face-to-face time 29 minutes)
- **Connecticut Mobile Crisis Performance Improvement Center: $509,250** (monthly, quarterly, and annual quality improvement and quality assurance [QI/QA] reports, and 12 workforce development training modules offered multiple times annually for six contracted providers and their 14 sites)
- **Connecticut Contracted Providers (6):** State general funds = **$12,373,436**

The total funding for all three components of Connecticut's statewide call center hub is **$13,918,648** in state funds invested, in addition to the third-party reimbursement.

Most of the Connecticut youth mobile crisis outreach visits go to homes or schools, and they track responses in real time. This enables them to identify schools that are high utilizers of 911 or law enforcement response and to work with them to use mobile crisis outreach instead.

Appendix E: Crisis Now System Calculator

The calculator below employs modeling to estimate the expected utilization of crisis services based upon population size. The columns compare expected cost in communities both with and without a robust crisis system of care. The calculator depicts lower cost and less restrictive service utilization in robust systems.

Crisis Now Crisis System Calculator (Basic)		
	No Crisis Care	**Crisis Now**
# of Crisis Episodes Annually *(200/100,000 Monthly)*	7,877,749	7,877,749
# Initially Served by Acute Inpatient	5,356,869	1,102,885
# Referred to Acute Inpatient From Crisis Facility	-	438,397
Total # of Episodes in Acute Inpatient	5,356,869	1,541,282
# of Acute Inpatient Beds Needed	**114,149**	**32,843**
Total Cost of Acute Inpatient Beds	**$ 33,748,274,797**	**$ 9,710,073,476**
# Referred to Crisis Bed From Stabilization Chair	-	1,753,587
# of Short-Term Beds Needed	**-**	**13,345**
Total Cost of Short-Term Beds	**$ -**	**$ 3,945,570,362**
# Initially Served by Crisis Stabilization Facility	-	4,253,984
# Referred to Crisis Facility by Mobile Team	-	756,264
Total # of Episodes in Crisis Facility	-	5,010,248
# of Crisis Receiving Chairs Needed	**-**	**15,688**
Total Cost of Crisis Receiving Chairs	**$ -**	**$ 5,636,529,089**
# Served Per Mobile Team Daily	4	4
# of Mobile Teams Needed	**-**	**2,424**
Total # of Episodes with Mobile Team	-	2,520,880
Total Cost of Mobile Teams	**$ -**	**$ 654,459,110**
# of Unique Individuals Served	**5,356,869**	**7,877,749**
TOTAL Inpatient and Crisis Cost	**$ 33,748,274,797**	**$ 19,946,632,038**
ED Costs ($520 Per Acute Admit)	**$ 2,785,571,888**	**$ 801,466,382**
TOTAL Cost	**$ 36,533,846,685**	**$ 20,748,098,420**
TOTAL Change in Cost		**-43%**

State / County Contributions	
Crisis Line and Technology *(Core Crisis Service)*	$ 448,500,000
Mobile Crisis *(Core Crisis Service)*	$ 297,451,666
Crisis Receiving Centers *(Core Crisis Service)*	$ 2,561,802,471
Short-Term Beds *(Not core crisis service)*	$ 806,869,139
Total	**$ 4,114,623,276**

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