The Journey Toward 988

A Historical Perspective on Crisis Hotlines in the United States

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KEYWORDS

• Suicide prevention • Crisis • Hotline • Lifeline • 988 • Crisis chat • Crisis text

KEY POINTS

- In the twentieth century, community crisis and suicide prevention efforts were not integrated into community mental health care systems. Rather, behavioral health crises were primarily managed either through public safety response systems or anonymous crisis hotlines.
- At the beginning of the twenty-first century, the Substance Abuse and Mental Health Services Administration (SAMHSA) grant-funded the networking, certification, and evaluation of crisis hotlines. This effort led to the establishment of the National Suicide Prevention Lifeline and the first definitive evidence of the efficacy of crisis hotlines in reducing emotional distress and suicidality in service users. The evaluations also showed the need for more uniform, evidence-based standards, trainings, and practices across the network of centers throughout the 50 states.
- Increasing public awareness and the use of the toll-free Lifeline service—as well as evidence of the service's effectiveness—led to the overall growth and expansion of Lifeline-related services nationwide. The Department of Veterans Affairs (VA) established and integrated the Veterans Crisis Line into the Lifeline network number, and national helpline services were extended via the Lifeline Crisis Chat and Text services, as well as the SAMHSA-funded Disaster Distress Helpline.
- The continuing increase in suicide rates inspired Congress to propose in 2018 the consideration of a national 3-digit number to enable greater access to the Lifeline's 10-digit-dial service. After careful study of reports from SAMHSA and the VA, as well as inputs from a wide variety of stakeholders nationally, the US Federal Communications Commission assigned a new 3-digit number to the Lifeline in 2020, "988.".
- The establishment of 988 holds the promise of transforming behavioral health and crisis care in America's twenty-first century, by providing a complete public health response (instead of solely a public safety response) to behavioral health crises, as well as integrating the primary value of access to care "anywhere, for anyone at any time" into traditional behavioral health care systems.

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When the US Federal Communications Commission (FCC) recommended the designation of 988 as the national 3-digit dialing code for suicide and behavioral health crisis in 2019, they cited an expectation that it would "help increase the effectiveness of suicide prevention efforts, ease access to crisis services, reduce the stigma surrounding suicide and mental health conditions, and ultimately save lives."[1] In a report to Congress prior to 988's national launch on July 16, 2022, the US Substance Abuse and Mental Health Services Administration (SAMHSA) noted that 988 would spur behavioral health systems transformation like 911 has catalyzed change in US emergency medical services.[2] That report described how 988 was also intended to reduce unnecessary encounters of persons in behavioral health crisis with both the police and hospital emergency departments.

The 988 number has become the more public face of the National Suicide Prevention Lifeline (Lifeline), a network of locally and independently operated crisis hotline centers (eg, "crisis centers"), a project that has been funded by the SAMHSA since 2001. This network's role as the nation's front door and safety net for suicide prevention, crisis, and mental health services is the result of a historical trajectory for crisis hotlines in the United States. In the 60 years of their existence, crisis hotlines frequently emerged as a "grassroots" community resource designed to be *an alternative* to accessing traditional mental health services. For us to understand how 988 may transform behavioral health systems in America, it is important to understand how crisis hotlines have also evolved over these many decades, and how they may ultimately affect how people seek and receive effective behavioral health care in the United States.

BRIEF HISTORY OF CRISIS AND SUICIDE PREVENTION HOTLINES IN THE UNITED STATES

Throughout the twentieth century, in the United States, custodial approaches—law enforcement and institutionalization—were the primary means for communities responding to individuals experiencing mental health and suicidal crises.[3,4] As public safety responses reinforced the long-standing stigma and discrimination associated with mental health crises, crisis hotlines began to spring up in the mid-twentieth century as an alternative means for people in crisis to seek help. A crisis service that was free, anonymous, and 24/7/365—and accessible in the privacy of one's home—ran counter to the hours-limited, inconvenient, expensive, and nonanonymous offerings available (or not) in community mental health clinics. Importantly, the anonymity of early hotlines allowed people in crisis to access help with less fear of police intervention.

The Los Angeles Suicide Prevention Center

In 1958, a National Institute of Mental Health grant allowed psychologists Ed Shneidman and Norman Farberow along with psychiatrist Robert Litman to establish the Los Angeles Suicide Prevention Center (LASPC), the first of its kind in the United States. The LASPC was originally focused on the evaluation and treatment of survivors of suicide attempts in hospitals when word-of-mouth about the center prompted persons in suicidal crisis to call the service at all hours.[5] In 1962, the LASPC piloted a 24/7/365 hotline service with clinicians responding, soon staffing the 24/7 line with volunteers as a more practical alternative. LASPC volunteers established rapport, assessed for safety, and collaborated with callers on a "treatment plan." LASPC was the first crisis center to collect data about anonymous callers' problems, demographics, and history of past suicidality and treatment.[5] Through the LASPC, research and clinical practices related to suicidality became integrated with hotline services.

By 1971, over 200 crisis centers were operating, with 1 expert proclaiming that each of the centers owed a debt to LASPC for developing their "basic concepts of suicide prevention."[6] LASPC's co-director, Ed Shneidman, founded the American Association of Suicidology (AAS) in 1968, which became a global hub for suicide prevention research and began accrediting crisis centers in best practices in 1976.[7] In addition, the use of nonprofessionals and volunteers at the LASPC and many other crisis centers gained considerable notice. Suicide prevention expert Louis Dublin described the use of nonprofessionals as "the single most important discovery in the 50-year history of the suicide prevention movement."[8]

Crisis Hotlines and Behavioral Health Systems in the Late Twentieth Century

While the use of volunteers on hotlines was good news for 24/7 clinical workforce challenges, it created a persistent perception that suicide prevention was the province of paraprofessionally staffed hotlines, while community clinical services were designed for ongoing "non-crisis" treatment. Consequently, when hotlines could not de-escalate suicidal crises over the phone, the default venue for clinically managing psychiatric crises became hospital emergency departments into the 1990s.[9] To this extent, calls to 911 for psychiatric emergency transport to hospitals typically prompted a police response, further reinforcing the public safety approaches long familiar to persons in behavioral health crisis in America.

By 1990s, several metropolitan areas around the country were beginning to utilize crisis services as a primary means for connecting people to care in their behavioral health system. SAMHSA's new Center for Mental Health Services conducted a survey of 69 well-developed crisis care systems, with crisis hotlines delineated as an essential element of more advanced crisis systems, along with mobile crisis outreach teams and community crisis receiving facilities.[10] While most crisis centers surveyed indicated telephone counseling and information and referral as a function, nearly all underscored their primary concern was to screen and assess callers for face-to-face services. At this time, there was no clear evidence that crisis hotlines themselves were effective in reducing suicidality or emotional distress with the people they served.[11]

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION GRANT TO NETWORK AND CERTIFY CRISIS HOTLINES

In 2001, congressional funding was provided to SAMHSA to establish a national network of crisis hotlines, linked to a single toll-free number, to effectively reach and serve all persons at risk of suicide across the United States.[12] The grant administrator's "networking and certifying" objectives included

- Building a network infrastructure of independently operated and funded local crisis call centers in every state. Calls to a national toll-free line would be connected to providers nearest to the caller, based on the area code they were calling from.
- A national accrediting body such as AAS would certify this coast-to-coast network of local crisis hotlines, to further establish base line expectations of member center services.
- National best practices for crisis centers would be identified through ongoing evaluations conducted by an independent team of researchers funded through the grant.

In 2004, SAMHSA awarded the hotline grant to the New York City (NYC)–based organization Vibrant Emotional Health (or Vibrant, formerly known as the Mental Health

Association of NYC). Vibrant and its long-time partners, the National Association of State Mental Health Program Directors (NASMHPD), successfully launched the new 1-800-273-TALK (8255) service with 109 network members in January 2005. That same year, Vibrant established 3 national advisory committees that would build field consensus on best approaches for reaching and serving people in suicidal crisis: the Steering Committee; the Consumer-Survivor (persons with lived experience of suicide loss and suicide attempts) Committee; and the Standards, Trainings and Practices Committee (STPC) (researchers, program evaluators, crisis center directors, and so forth).

LIFELINE EVALUATION FINDINGS

Perhaps the most influential requirement at the conception of the SAMHSA hotline grant was dedicating network center participation to ongoing evaluation efforts to continuously improve crisis services. In the first 20 years of the grant, 68 network centers participated in 15 studies published in peer-reviewed journals. The published works and **Fig. 1** illustrate the iterative process through which Lifeline center practices are implemented, evaluated, and refined to continuously improve service quality. The findings from these evaluations of crisis hotlines have proven to be groundbreaking for the field of suicide prevention and crisis hotlines, both nationally and internationally.[13]

SAMHSA-funded investigations of network member hotlines consisted of mostly discerning caller outcomes associated with counselor behaviors. **Table 1** comprises a sample of early Lifeline evaluations where inbound caller outcomes were reported by the users themselves. Most evaluations were overseen by Dr Madelyn Gould and her team from the Research Foundation for Mental Health at Columbia's Psychiatric Institute.

As noted in **Table 1**, all evaluations observed positive outcomes for callers, with most demonstrating significant reductions in both suicidal and crisis states for service users.[14–17] Brian Mishara and his evaluation team from Quebec[16] underscored 2 areas of counselor practices that were associated with these positive outcomes. First, counselors need to establish good contact/rapport with callers. Second, they found that "active listening" alone was insufficient for effectively reducing suicidal distress; some degree of guiding the conversation and collaborating with the caller to address his/her concerns was essential ("collaborative problem solving").

Fig. 1. Lifeline iterative process for developing evidence-based national network standards, practices, and policies.

Table 1
Substance Abuse and Mental Health Services Administration–funded evaluations of networked crisis centers, outcomes, and impact

PI & Date of Evaluation Publication	Purpose of Evaluation	Key Outcomes & Recommendations	Program Impact
Gould & Kalafat, 2007 Kalafat & Gould, 2007	Post-call crisis and suicidal outcomes (end of call and follow-up, at approx. 3 wk), 1085 suicidal callers. Post-call crisis outcomes (end of call and follow-up), 1617 crisis callers.	• Is reaching seriously suicidal people (callers with suicide plans, attempts, and so forth). • Reductions in crisis and suicidal states by end of call and at follow-up. • 11.7% of callers not assessed for suicide • Need to follow-up with callers still at risk (43% post-call).	• Justified continued increases in federal funding of Lifeline services. • Led to SAMHSA-funded follow-up grants to Lifeline centers. • Influenced need for developing national suicide risk assessment standards.
Mishara et al, 2007	Silent monitoring of 2611 callers to 14 network crisis centers to determine what counselor processes affect caller outcomes.	• Centers vary greatly in helper behaviors. • Some lives may have been saved. • Need to train and reinforce empathy, respect, and collaborative problem-solving for good outcomes. • Many counselors did not assess risk and/or did not fully assess risk.	• Influenced need to standardize risk assessment framework for all centers in network. • Led to Lifeline sponsoring ASIST trainings for network and later developing a uniform training for all network counselors in 2022.
Gould et al, 2013	To assess impact of Lifeline-sponsored ASIST on counselor behaviors at 17 centers. Silently monitored 1507 exchanges between suicidal callers and ASIST-trained counselors.	• Callers working with ASIST-trained counselors felt less depressed and suicidal and more hopeful by the end of the call • Distinct behaviors from ASIST having an impact: exploring caller reasons for living and their informal supports.	• Led to continued Lifeline support of ASIST trainings at network centers. • Later incorporated effective counselor behaviors into Lifeline online best practice trainings for all network counselors in 2022.

Partial summary of key evaluation findings published 2007 to 2021.
Abbreviation: ASIST, applied suicide intervention skills training.

These findings were unprecedented in clearly demonstrating the impact that crisis lines had on reducing caller distress and suicidality. Since 1990s, crisis lines had been trending toward focusing more on their screening, assessment, and referral function, with the belief that care and treatment for people in crisis was best performed in face-to-face clinical settings. In contrast, the findings of the Gould, Kalafat, and Mishara teams indicated that the assessment and referral functions of these hotlines needed considerable attention, while the potential for crisis lines as a "mental health service" was much greater than had been previously known.

Although these initial evaluation findings answered many long-standing questions about hotline efficacy and related practices, each discerned several marked shortcomings in counselor practices that required systematic attention. In all, findings from these studies identified 3 major areas as targets for practice improvement: the need for uniform standards and practices for *suicide risk assessment* among callers; a clear policy for necessary actions to take to maintain the safety of callers assessed to be at *imminent risk (IR)* of suicide; and a need for *follow-up* with callers at risk, to both de-escalate risk and promote linkages to community care.[13]

NATIONAL STANDARDS AND PRACTICES

Toward developing consensus approaches to actualize the 3 main recommendations emerging from the initial SAMHSA-funded hotline evaluations, the Lifeline formed in 2005 a national advisory group now referred to as the STPC. The STPC included project evaluators and other leading suicide prevention researchers, practitioners, and crisis center directors from around the country. Following are among the most prominent standards, guidelines, and practices that ultimately emerged from the ongoing evaluation findings and committee recommendations.

National Suicide Risk Assessment Standards for Crisis Hotlines

To better assure that all callers to the National Suicide Prevention Lifeline would be appropriately assessed for suicidality, Vibrant required all network member centers to adopt their STPC-approved standards for assessing risk beginning in 2007, with a recently updated edition in 2022. Rather than venturing to develop or identify a specific risk assessment instrument where reliability and validity would be questionable, the Lifeline's STPC instead chose to create a standard framework for suicide risk assessment.[18]

This framework was shaped around 4 core principles of risk assessment, distinguished by the committee's factor analysis from various crisis center risk assessment scales and decades of research in suicide assessment. Three of Lifeline's 4 principles are consistent with STPC Chair Thomas Joiner's Interpersonal Theory of Suicide[19] which proposes that the combination of suicidal desire with intent and acquired capability is associated with the risk of suicide. Buffers–the fourth core principle– relate to established protective factors that can moderate or mitigate against suicidal desire or intent. What factors indicate each of these principal areas of suicide assessment and how they interact to affect potential safety concerns are described in **Table 2**.

The Lifeline's STPC underscored in 2007 that suicide risk assessment was not intended to predict suicidal behavior. Rather, it is intended to help counselors collaborate with callers in care planning, to explore "the most effective way to reduce callers' isolation, anxiety, and despair, and to begin the exploration of alternative ways of addressing their problems."[18] This intention was further emphasized by Vibrant in their updated "Safety Assessment" standards in 2019.[20]

Table 2
988 suicide and crisis lifeline suicide risk assessment framework

Risk Principle	Indicators of Risk Principle[a]	Risk Principle Interactions Affecting Risk Ranges
Desire for suicide	Suicidal thoughts, often driven by feelings of hopelessness; feeling trapped and a burden to others, feeling intolerably alone, self-hatred, and intense psychological pain.	Low to moderate risk range • Suicidal desire or capability alone are present • Buffers against suicide are: ○ Present to potentially reduce risk ○ Absent to potentially enhance risk
Intent to die by suicide	Suicide attempt in progress, or suicide plan, including preparatory behaviors with an expressed intent to die.	Moderate to high risk range • Suicidal desire and intent are present • Suicidal desire and capability are present • Buffers against suicide are ○ Present to potentially reduce risk ○ Absent to potentially enhance risk
Capability for suicide	One's degree of fearlessness in taking suicidal actions, such as past suicide attempts and/or self-harming behaviors (eg, "practicing" to overcome fears of dying). Also includes available means and one's inability to control suicidal impulses (eg, emotional dysregulation, current intoxication, substance use, acute mental illness symptoms, and so forth). May also include history of violence and/or exposure to another's suicide.	High-risk range • Suicidal desire, intent, and capability are all present. • Buffers are not likely to mitigate risk
Buffers preventing suicide	Risk mitigating factors, such as having reasons for living, expressed ambivalence about dying, access to immediate social supports, future plans, engagement with the counselor, and personally held values against suicide.	

[a] Bolded indicators represent items with highest weight of research regarding contribution to risk, see *Vibrant Suicide Safety Policy 2022* and *Joiner et al, SLTB, 2007*.

Lifeline's efforts to improve risk assessment and collaboration with callers were encouraged by subsequent evaluations, including research reported by Rand on California-based crisis centers. The Rand findings demonstrated that callers to Lifeline member centers were much more likely to be assessed for suicide risk

and feel less distressed by the end of the call than callers contacting non–Lifeline crisis centers.[21]

National Policy for Helping Callers at Imminent Risk of Suicide

Following the identification of a suicide assessment framework, the Lifeline STPC set out to identify best practices for counselors working with callers to be assessed at imminent risk of suicide (eg, "IR").[13]

Lifeline's policy noted that counselor actions to help callers at IR of suicide must consider least invasive approaches to preserve a caller's safety.[22] Less invasive approaches essentially ordain the need for committed *collaboration*, beginning with the counselor's collaboration with the caller to take actions to reduce their own risk ("active engagement"). These active collaborations extend to (a) supervisory consultation as needed and (b) center relationships with community crisis and emergency services that could respond to their callers to keep them safe. As a last resort, if the individual was *in the act of killing themselves* and/or is *unwilling or unable* to take actions to prevent their imminent suicide, the counselor would be compelled to activate emergency services ("active rescue," a 911 contact) on behalf of the caller's safety.

Table 3 provides examples of behaviors outlined by Lifeline's Policy to Help Callers at Imminent Risk of Suicide, which was recently updated by Vibrant in 2022 to underscore needs for active engagement and least invasive interventions.[23] It is important to note in the new policy edition that Vibrant has replaced the term "active rescue" to its more accurate label, "involuntary emergency service" activation, to distinguish it from consensual emergency services and all other collaborative means used by counselors to keep callers safe.

An evaluation of the policy's impact on Lifeline counselor behavior with callers at IR was undertaken.[24] Evaluators had previously estimated from samples that around 1 in 4 Lifeline callers presented suicide-related issues, with persons at highest (or "imminent") risk being a smaller subset of callers.[2] In reviewing 491 imminent risk calls, crisis counselors actively engaged the callers in collaborating to keep themselves safe on 76.4% of calls, providing an array of successful interventions ranging from safety planning, offering follow-up, engaging third-party support, or making mobile crisis referrals. Emergency rescue services, without the callers' collaboration, were needed on 24.6% of calls. These "active rescues" were largely limited to calls where callers expressed many or strong reasons for dying and had little sense of purpose in their lives. Having an attempt in progress, being intoxicated at the time of the call, and a low level of engagement with the crisis counselor also increased the odds of active rescue. Overall, findings indicated that the IR policy had a marked impact on improving counselor active engagement interventions with IR callers. For all calls to the Lifeline (including non-suicidal crises and information and referral needs), Vibrant reported that approximately 2% required a need for emergency services.[2]

Promotion of Follow-Up Contacts to Further Reduce Suicide Risk

As evaluators showed that some number of suicidal callers remained at risk after the initial call, Lifeline provided resources and guidelines to promote crisis center follow-up for callers at risk. Follow-up approaches ranging from hospitals sending post-discharge caring letters and postcards to persons who had been admitted for suicidality,[25,26] as well as follow-up calls and visits post-discharge[27,28] consistently demonstrated reductions in suicide attempts and deaths.

In 2008, SAMHSA began to provide Lifeline centers with funding specifically aimed at establishing follow-up services for high-risk Lifeline callers (later to include

Table 3
988 Lifeline policy for helping callers at imminent risk of suicide

Policy Intervention Area	Counselor or Center Behaviors	Related Interventions and Protocols
Active engagement	Intensive collaboration with caller to explore least invasive interventions to maintain safety and reduce risk. Empower caller choices that prevent their suicide, leveraging their resources and strengths.	Listening to caller's reasons for dying and engage reasons for living; safety planning, including removing access to lethal means, engaging immediate supports, coping strategies, attain agreement to receive urgent assistance (mobile crisis, voluntary transport to emergency room, and so forth)
Involuntary emergency intervention (*prev. "active rescue"*)	If active engagement efforts fail and person is unwilling and/or unable to choose actions that could reduce their imminent risk (including attempts in progress), counselor must initiate contact with emergency services to prevent the caller's suicide.	Utilize caller's available identifying information (caller ID, url address if chat, and so forth), share essential info with emergency officials to locate them and assure their safety. Track emergency service disposition and transport of individual, sharing information to authorities in support of individual's care and safety, where needed.
Community engagement and collaboration with crisis & emergency services	Network centers must investigate and promote alternatives to 911 interventions in their community. Develop relationships, cross-trainings, policies, and communications protocols with community first responder entities toward assuring optimal chain of care.	Center develops formal agreements, protocols, and trainings with first responder entities. Includes memorandums of understanding (MOUs)/protocols designed with mobile crisis teams, 911 public-safety answering points (PSAPs), local law enforcement, emergency medical service (EMS), emergency departments (EDs) and other receiving facilities, and so forth.

Extracted from 988 Suicide and Crisis Lifeline Safety Policy, Vibrant, 12/27/2022

local emergency department discharges).[13] To date, 44 follow-up grants to 41 crisis centers have been issued. For crisis centers, follow-up is usually by telephone and typically occurs between 24 and 48 hours after the initial contact. Phone calls are brief, and while they can be tailored to the individual's need, they are structured and focus on continued assessment of risk and safety, review and revision of

the established safety plan, status of any upcoming appointments, and problem-solving obstacles to linkage. Follow-up typically continues until a caller is connected to care, is determined to be stable, and no longer in need of support or refuses services.

As with other Lifeline initiatives, follow-up practice within the network has been thoroughly evaluated by researchers. Initial findings indicate significant benefits, with 79.6% of callers indicating that the crisis center follow-up intervention stopped them from killing themselves, whereas 91% reported that it kept them safe.[29] Individuals who presented with higher levels of risk at the time of their initial call to the Lifeline perceived the follow-up intervention to be more valuable than those at lower suicide risk. Counselor activities, such as discussing distractors identified in the caller's safety plan, social contacts to call for help, and continued exploration of a caller's reasons for dying, were also found to be particularly helpful.

Lifeline follow-up evaluations established another major milestone for crisis hotlines. While AAS accreditation standards had long underscored the important function of following up with suicidal callers, most hotlines have been funded to focus on managing inbound calls. Gould's 2007 findings demonstrated the need for post-call follow-up to reduce suicidality and promote care linkages, and her subsequent evaluations of SAMHSA-follow-up- grant funded centers showed that such dedicated practices are essential to potentially saving lives.[13]

LIFELINE NETWORK EXPANSION BEFORE 988

Spurred by evaluations showing the Lifeline's effectiveness, federal and national stakeholders continued to build on the service. In 2006, Lifeline launched a specialized service option for Spanish language callers to the service in 2006, followed by the Veteran Administration's Veterans Crisis Line (VCL) in 2007 for current and past members of military service ("press 1"). Approximately 1 of every 4 callers to the Lifeline pressed 1 for assistance in the VCL's first decade.[13] Similar to the evaluation findings for the Lifeline, analyses of VCL's efficacy in serving callers found significant reductions in caller distress and suicidality during the call.[30]

Crisis Chat and Text Services

As online help-seeking became ubiquitous in the twenty-first century, some crisis centers began to venture into providing digital assistance to supplement their telephonic offerings. The VCL established the first federally funded crisis chat service in 2009, and the Lifeline followed suit in 2013. Individuals seeking crisis chat assistance could access help through the respective Web sites for each service. While the VCL added a text service in 2012, the Crisis Text Line (CTL) launched their broadly promoted national service in 2013 independent of the Lifeline. The CTL eventually joined the Lifeline when 988 integrated broad-scale text capabilities in 2022.

As with hotlines, evaluations of digital helplines showed considerable promise. Dr Gould's team evaluated both the Lifeline chat and CTL services in separate studies and found that a significant majority of users felt helped by either service, with nearly half reporting feeling less suicidal by the end of a crisis chat[31] or text.[32] Interestingly, the digital helplines showed strikingly different user profiles than phone lines, with the most common user for chat and text presenting as young (under 25), female (65% and 79%, respectively), and—in relation to crisis chat services—significantly more likely to be suicidal than callers. For example, CTL users presented with the same frequencies of suicidality as the Lifeline (23%),[32] while Lifeline crisis chat users presented suicidal thoughts or behaviors a remarkable 84% of the time.[31]

988 AND ITS IMPACT ON FUTURE BEHAVIORAL HEALTH SYSTEMS

Federal Action to Implement 988

Recognizing suicide as a major public health priority, Senator Orrin Hatch and Representative Chris Stewart of Utah introduced the National Suicide Hotline Improvement Act of 2018 with near unanimous bipartisan Congressional support. The Act required the FCC to coordinate with SAMHSA and the Department of Veterans Affairs (VA) to study the effectiveness, impact, and feasibility of establishing a 3-digit number for the National Suicide Prevention Lifeline, toward promoting immediate access to suicide prevention and crisis care resources.[33] In 2019, the FCC received reports from SAMHSA and the VA that affirmed the effectiveness of their crisis services and supported the value of assigning an easier to remember and dial 3-digit number to this national hotline network. Citing the known effectiveness of the Lifeline, the FCC subsequently assigned 988 to the Lifeline in July 2020 and Congress authorized the program in The National Suicide Hotline Designation Act in October of the same year.[34,35] The FCC required that the 988 Suicide and Crisis Lifeline be accessible on all telephone platforms across the United States and its territories by July 16, 2022, via phone and text.[34] As indicated in its new name, the Suicide and Crisis Lifeline would also be designed and promoted to address all behavioral health crises (substance use and mental health), in addition to persons in suicidal crisis.

National and State Ramp-Up for 988 Launch

To mobilize and scale behavioral health and crisis systems capacity to successfully launch 988 in July 2022, the executive and legislative branches of federal government, SAMHSA, Vibrant, the Lifeline network centers, and all states (with the help of NASMHPD) would need to work together in ways that were unprecedented. In January 2021, Vibrant provided $10 million in private funds for "988 state planning grants," which were subsequently awarded to the 46 states, Washington D.C., and 3 territories that applied for them.[36] In December 2021, SAMHSA provided $282 million to Vibrant and the states to shore up the 988 crisis network infrastructure. Grants were provided to the states to supplement local funds to enhance local 988 crisis center response, while Vibrant received federal support to expand national back-up center capacity for phones, text, and chat services. Vibrant was also required to apply funds toward enhancing the Lifeline sub-network for Spanish language-speakers and explore pilots for other specialized services [lesbian, gay, bisexual, transgender, queer or questioning, or another diverse gender identity (LGBTQ+) youth, American Indian/Alaskan Natives (AI/AN), and so forth].[37]

Areas of Public Concern and Challenges Related to 988 Implementations

Now that 988 crisis centers were becoming more integrated with the country's behavioral health crisis systems, the very suspicions that spurred their creation in 1960s began to rear their head for some mental health advocates. Would 988 remain anonymous, free, equitable, and be less prone to invasive and coercive practices than the systems they were now integrating with? Some communities expressed worries about 988's potential interface with 911, fearing even more police interventions into mental health crises. These fears, advocates noted, could undermine public trust in 988 and prevent some from calling this more accessible number.[38]

Lifeline's Director noted that callers would continue to be serviced if they wished to remain anonymous, and that policies, practices, and trainings were in place to keep people safe without emergency services intervention in the great majority of contacts. However, there would remain the "last resort" circumstances where emergency service

responses would be the only means for keeping 988 callers and related community members safe from imminent harm.[38]

Many of the privacy concerns raised by 988 critics have related to geolocation, that is, a mechanism for potentially giving 988 the same capability as 911 to precisely locate individuals at IR to connect them with emergency services, with or without their consent. As required by Congress, the FCC provided a detailed report on 988 geolocation to explore its cost and feasibility for this service.[39] The report identified "georouting" as a distinct issue for 988, separate from geolocation's fine-tuned tracking capability designed for 911 dispatch. The report noted that Lifeline's centralized routing system has historically routed calls to the nearest local center based on the area code registered to the caller's phone, an unreliable predictor of a caller's location given that most callers are using mobile devices. If the caller *is not* connected to the nearest center, the responder is less able to connect them to local services that could keep them safe and supported after the call, including alternatives to 911 such as mobile crisis or crisis receiving facilities. Consequently, the FCC and SAMHSA are pursuing means of enabling georouting—sending calls to the cell tower nearest the caller—so that callers can receive the benefits of connecting with the centers nearest to them without having their precise location information available to 988 counselors.[39]

The potential interface between 988 and 911 has highlighted both challenges and opportunities for responding to behavioral health crises and emergencies. On one hand, the lack of geolocation capabilities for 988 call, text, or chat users seriously inhibits rapid emergency response for callers at highest risk who are unwilling or unable to inform the counselor where they are.[39] This is particularly noteworthy insofar as 8% of suicide-related calls to the service involve suicides in progress.[15] Consequently, Vibrant and the National Emergency Number Association co-developed an interoperability standard for Lifeline call, text, and chat users to guide 911 operators and 988 counselors on collaborative strategies to respond to users at highest risk whose location was unknown.[40]

Conversely, a significant proportion of 911 callers present with non-emergent behavioral health crises (estimated to be approximately 6%—over 14 million—of 911 callers annually[2]), callers whom could be better served by 988. Several counties around the country have seized upon this opportunity by implementing effective models of diverting non-emergent mental health calls from local public-safety answering points to local 988 centers.[41]

There were also 988 pre-launch concerns related to counselor workforce shortages. Both counselor recruitment and retention issues were reported by 988 crisis centers, with 911 experts raising worries about similar responder burnout problems anticipated for 988 staff. Several centers sought to attract more staff by increasing salaries with increased funding, while SAMHSA established a web site to promote public awareness of 988 counselor job openings at centers.[42]

988 Post-launch and Future Considerations

By July 2022, a crisis hotline number—once seen as an alternative to a traditional mental health service—became a front door to the nation's behavioral health system for all people in crisis. A month after 988's launch, SAMHSA reported that federal and state investments in 988 had significantly improved the overall response rate for the service, citing 152,000 more contacts than the same month a year before, and an overall reduced wait time for all modes of contact from 2.5 minutes to 42 seconds.[43] At that time, SAMHSA began providing network-wide 988 response data to the public on their 988 web site,[44] while Vibrant continued to provide state-level 988 performance metrics on their site.[45]

An independent analysis of Vibrant data by the Kaiser Family Foundation showed that in its first year of service, 988 achieved a 93% overall answer rate by May 2023, a notable improvement over the 70% answer rate reported the same month the year before. As illustrated in **Fig. 2**, this achievement was driven largely by the major federal investments in the nationally centralized chat and text subnetwork response, which was necessary due to sparse local within-state digital crisis care capacity. In its first year, 988 centers (including the VCL) responded to almost 5 million contacts, up 33% from May 2023 compared to May 2022.[46]

With the initial launch successfully completed, SAMHSA received $502 million in fiscal year (FY) 2023 and another $836 million in 2024 to support a variety of national, state, and local 988 crisis care services.[47] For the 988 network, the funding allowed for the realization of long-desired specialized services for underserved and high-risk populations.

- *LGBTQ+ youth (“press 3” option).* In the fall of 2022, Vibrant established a pilot initiative with the Trevor Project to extend help to the high-suicide-risk LGBTQ+ youth population. The phone, text, and chat service grew to 24/7 with a larger subnetwork of centers in 2023, with approximately 1 in every 10,988 (non-Spanish language) users accessing this “press 3” service.[44,48]
- *The capacity for the 988 Spanish-language (“press 2”) response was strengthened,* further adding chat and text help for Spanish-speakers in 2023.[49] At the end of 2023, around 1 of every 41 (non-LGBTQ+) 988 users sought assistance in a Spanish language.[44]
- *American Sign Language (ASL) service for deaf and hard of hearing populations.* In the fall of 2023—approximately a year after the groundbreaking 988 LGBTQ + service began—Vibrant rolled out its ASL videophone service (“ASL now” button on 988lifeline.org) for deaf and hard-of-hearing individuals. This service, provided by DeafLEAD, Inc for the SAMHSA-funded Disaster Distress Helpline since 2021, replaced the Lifeline’s antiquated and rarely used teletypewriter (TTY) service to extend 24/7 access to 988 through this underserved community’s preferred means of communication technology.[50]
- *Washington’s Native and Strong Lifeline.* Local legislation enabled 988 AI/AN callers in the state of Washington to attain culturally capable assistance by pressing 4 for the Native and Strong Lifeline in the fall of 2022. This program was the first state-supported helpline program designed to serve the needs of the ethnic group with the highest suicide risk in the country.[51] While this Washington-only program leveraged the national 988 number for access, it broke ground for considering similar state-wide or regional hotline services for AI/AN populations, in line with recommendations made by the US Department of Health and Human Services in 2009.[52]

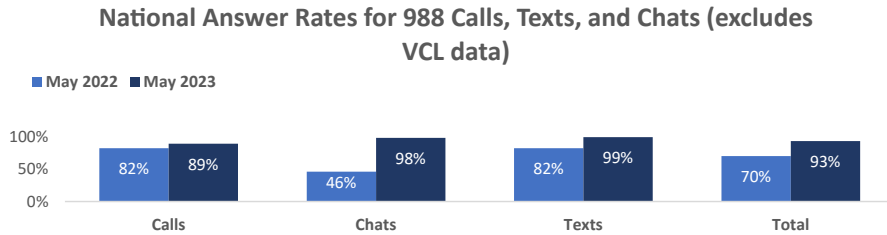

Fig. 2. The Kaiser Family Foundation (KFF) analysis of vibrant emotional health 988 lifeline data, July 14, 2023.

988 Transformation of Community Crisis Care Systems

The FY 2023 and 2024 funds previously noted were also intended to support SAMHSA's vision for extending crisis care well beyond the contact centers responding to calls.[44] SAMHSA expressed a commitment to transform systems to assure that there was "someone to talk to, someone to respond, and a place to go for anyone in crisis, anywhere at any time." As outlined in SAMHSA's National Guidelines for Behavioral Health Crisis Care and their 2021 report to Congress, national, state, and local public health authorities would need to build a full continuum of 24/7 crisis care services, including mobile crisis teams and community crisis receiving facilities. [2,53]

SAMHSA's 5-year vision for 988 began with fortifying funding for the foundation of the service, local member crisis centers. By 2025, SAMHSA aspires for these crisis centers to rapidly facilitate mobile crisis response for at least 80% of the population, with the additional goal of 80% of the country having access to community-based crisis receiving facilities by 2027.[54] In contrasting the role of 988 crisis centers with 911 call centers, SAMHSA noted that crisis hotlines were not in place solely to dispatch and/or connect behavioral health and crisis services with callers; rather, they were themselves an intervention that could resolve crises about 80% of the time.[2]

SUMMARY

For nearly 40 years, crisis and suicide hotlines of the twentieth century were largely viewed as services on the periphery of behavioral health care. Beginning in the twenty-first century, federal funding to network, certify, evaluate, and promote suicide hotlines facilitated greater awareness and credibility for these vital, lifesaving services. The evidence of the National Suicide Prevention Lifeline network's effectiveness was central to the federal government assuring its greater accessibility and visibility in assigning 988 as its new number. In moving from a more peripheral to central position in the nation's behavioral health care system, 988's crisis hotline services will face continuing challenges to meet the evolving needs of both the people seeking help and those seeking to help them. However, 988's transformative potential seems boundless.

As 911 has fueled countless emergency medicine and public safety jobs, intervention tools, and related resources, it is easy to imagine how 988 will do the same for crisis services in America. However, 911's limits in resolving public health and safety emergencies have generated public awareness of the need for earlier prevention approaches, ranging from nutrition education and smoke alarms to defensive driving and self-defense courses. Similarly, this century's 988 service could energize more upstream public mental health education and self-care efforts nationwide. Above all, a fully realized vision of 988 could significantly reduce the stigma, discrimination, and institutionalization of people in mental health crises that resulted from the public safety responses of America's twentieth century.

CLINICS CARE POINTS

- Suicide risk assessments should assess for an individual's desire for suicide (thoughts, etc.), intent for suicide (plans, preparatory behaviors, etc.), capability (past attempts, available means, etc) and buffers against suicide (reasons for living, etc.).
- For effective crisis counseling with individuals in suicidal crisis, establishing good contact (rapport, empathy, etc.) and collaborative problem solving (safety planning, etc.) are essential to good outcomes.

- For persons at imminent risk of suicide, counselors must make every effort to actively engage and collaborate with individuals towards empowering them to secure their own safety, pursuing the least invasive interventions to prevent their suicide.
- In the event an individual is unwilling or unable to collaborate with a counselor to prevent their suicide, and the counselor's assessment of risk indicates the person is likely to seriously harm or kill themselves if they do not act, the counselor must take every reasonable action to prevent their suicide, including contacting emergency response services.
- For persons who state some risk of suicide, counselors should engage them in safety planning and gain consent to pursue follow-up contacts, maintaining engagement with the individual until they are less in distress, less at risk, and/or linked to ongoing clinical care services.

DISCLOSURE

The content, views and opinions of the authors in this manuscript do not necessarily represent the views of Behavioral Health Link, Inc. nor the Substance Abuse and Mental Health Administration or any other branch of the U.S. Government.

REFERENCES

1. Federal Communications Commission, Report on the national suicide hotline improvement act of 2018, 2019, Wireline Competition Bureau; Washington, D.C., Available at: https://docs.fcc.gov/public/attachments/DOC-359095A1.pdf. Accessed February 2, 2024.
2. Substance Abuse and Mental Health Services Administration, 988 Appropriations Report to Congress. 117th Congress, Available at: https://www.samhsa.gov/sites/default/files/988-appropriations-report.pdf, 2021. Accessed February 2, 2024.
3. Sharfstein SS. What ever happened to community mental health? Psychiatr Serv 2000;51(5):616–20.
4. Lamb HR, Weinberger LE, DeCuir WJ Jr. The police and mental health. Psychiatr Serv 2002;53(10):1266–71.
5. Litman RE, Farberow NL, Shneidman ES, et al. Suicide prevention telephone service. JAMA 1965 April 5;192(1):107–11.
6. Brockopp GW. Seven Predictions for SP in the 70's. Crisis Interv 1970;2(1):3.
7. History of the American Association of Suicidology, American Association of Suicidology, Available at: https://suicidology.org/history/. Accessed February 2, 2024.
8. McGee RK, Berg D, Brockopp GW, et al. The Delivery of Crisis Intervention Services. In: Resnik HLP, Hathorne BC, editors. Suicide prevention in the 70's. Rockville, MD: National Institute of Mental Health (U.S.). Center for Studies of Suicide Prevention; 1973. p. 81–90.
9. Technical Assistance Collaborative (TAC). A community-based comprehensive psychiatric crisis response service. Boston, MA: Technical Assistance Collaborative; 2005.
10. Stroul B. Psychiatric crisis response systems: a descriptive study. center for mental health services. SAMHSA 1993.
11. Lester D. The effectiveness of suicide prevention and crisis intervention services. In: Lester D, Rogers J, editors. Crisis intervention and counselling by telephone and the internet. Illinois: Charles C. Thomas; 2012. p. 411–21.
12. Everett A. Groundbreaking Developments in Suicide Prevention and Mental Health Crisis Service Provision, Available at: https://www.samhsa.gov/blog/ground

breaking-developments-suicide-prevention-mental-health-crisis-service-provision, 2021. Accessed February 2, 2024.
13. Substance Abuse and Mental Health Services Administration (SAMHSA). National suicide hotline improvement act: SAMHSA report to the federal communications commission. Rockville, MD: Center for Mental Health Services Suicide Prevention Branch; 2019.
14. Kalafat J, Gould MS, Munfakh JL, et al. An evaluation of crisis hotline outcomes. Part 1: Nonsuicidal crisis callers. Suicide Life-Threatening Behav 2007;37:322–37.
15. Gould MS, Kalafat J, Harrismunfakh JL, et al. An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. Suicide Life-Threatening Behav 2007;37:338–52.
16. Mishara BL, Chagnon F, Daigle M, et al. Comparing models of helper behavior to actual practice in tele- phone crisis intervention: A silent monitoring study of calls to the U.S. 1-800-SUICIDE net- work. Suicide Life-Threatening Behav 2007;37:291–307.
17. Gould MS, Cross W, Pisani AR, et al. Impact of applied suicide intervention skills training on the national suicide prevention lifeline. Suicide Life-Threatening Behav 2013;43:676–91.
18. Joiner T, Kalafat J, Draper J, et al. Establishing standards for the assessment of suicide risk among callers to the National Suicide Prevention Lifeline. Suicide Life-Threatening Behav 2007;37:353–65.
19. Joiner TE. Why people die by suicide. Cambridge, MA: Harvard University Press; 2005.
20. National Suicide Prevention Lifeline. Lifeline Safety Assessment Model. Available at: https://networkresourcecenter.org/display/practiceguide/Safety+Assessment. [Accessed 25 August 2023].
21. Ramchand R, Jaycox L, Ebener P, et al. Characteristics and proximal outcomes of calls made to suicide crisis hotlines in California. Crisis 2017;38(1):26–35.
22. Draper J, Murphy G, Vega E, et al. Helping callers to the national suicide prevention lifeline who are at imminent risk of suicide: The importance of active engagement, active rescue, and collaboration between crisis and emergency services. Suicide Life-Threatening Behav 2014;45:261–70.
23. Vibrant Emotional Health, 988 suicide and crisis lifeline safety policy.published online december 27, 2022, Available at: https://988lifeline.org/wp-content/uploads/2023/02/FINAL_988_Suicide_and_Crisis_Lifeline_Suicide_Safety_Policy_-3.pdf. Accessed February 2, 2024.
24. Gould MS, Lake AM, Munfakh JL, et al. Helping callers to the national suicide prevention lifeline who are at imminent risk of suicide: Evaluation of caller risk profiles and interventions implemented. Suicide Life-Threatening Behav 2016;46(2):172–90.
25. Motto JA, Bostrom AG. A randomized controlled trial of postcrisis suicide prevention. Psychiatr Serv 2001;52:828–33.
26. Carter GL, Clover K, Whyte IM, et al. Postcards from the EDge: 24-month outcomes of a randomised controlled trial for hospital-treated self-poisoning. Br J Psychiatry 2007;191:548–53.
27. Vaiva G, Ducrocq F, Meyer P, et al. Effect of telephone contact on further suicide attempts in patients discharged from an emergency department: Randomised controlled study. Br Med J 2006;332(7552):1241–5.
28. Fleischmann A, Bertolote JM, Wasserman D, et al. Effectiveness of brief intervention and contact for suicide attempters: A randomized controlled trial in five countries. Bull World Health Organ 2008;86:703–9.

29. Gould MS, Lake AM, Galfalvy H, et al. Follow-up with callers to the national suicide prevention lifeline: Evaluation of callers' perceptions of care. Suicide Life-Threatening Behav 2018;48(1):75–86.
30. Britton PC, Karras E, Stecker T, et al. Veterans crisis line call outcomes: distress, suicidal ideation, and suicidal urgency. Am J Prev Med 2022;62(5):745–51.
31. Gould MS, Chowdhury S, Lake AM, et al. National Suicide Prevention Lifeline crisis chat interventions: Evaluation of chatters' perceptions of effectiveness. Suicide Life-Threatening Behav 2021;51:1126–37.
32. Gould MS, Pisani A, Gallo C, et al. Crisis Text Line interventions: Evaluation of texters' perceptions of effectiveness. Suicide Life-Threatening Behav 2022;52:583–95.
33. National suicide hotline improvement act of 2018, pub L No. 115-123, 132 Stat 64, 2018. Summary of H.R. 2345-115th Congress (2017-2018).
34. Federal Communications Commission, Order adopting rules to implement the national suicide hotline improvement act of 2018, fcc 20-100, 35 fcc rcd 6687, july 16, 2020, Available at: https://docs.fcc.gov/public/attachments/FCC-20-100A1_Rcd.pdf, 2020. Accessed February 2, 2024.
35. National Suicide Prevention Hotline Designation Act of 2020, Pub L No. 116-172, 134 Stat 815, 2020.
36. Vibrant Emotional Health, Vibrant emotional health to provide state grants in preparation for future 988 dialing code for the national suicide prevention lifeline; 49 states and u.s. territories to receive grant awards [press release], Available at: https://www.vibrant.org/wp-content/uploads/2021/01/Vibrant-988-Planning-Grant-Announcement.pdf, 2021. Accessed February 2, 2024.
37. Substance Abuse and Mental Health Services Administration, HHS Announces Critical Investments to Implement Upcoming 988 Dialing Code for National Suicide Prevention Lifeline [press release], Available at: https://www.samhsa.gov/newsroom/press-announcements/202112201100, 2021. Accessed February 2, 2024.
38. Pattani A. Social media posts warn people not to call 988. Here's what you need to know, 2022, KFF Health News, Available at: https://www.npr.org/sections/health-shots/2022/08/11/1116769071/social-media-posts-warn-people-not-to-call-988-heres-what-you-need-to-know. Accessed February 2, 2024.
39. Federal Communications Commission, Wireline Competition Bureau. 988 Geolocation Report — National Suicide Hotline Designation Act of 2020 (Document No. 371709A1). 117th Congress, Available at: https://docs.fcc.gov/public/attachments/DOC-371709A1.pdf. Accessed February 2, 2024.
40. National Emergency Number Association, NENA Suicide/Crisis Line Interoperability Standard (NENA-STA-001.2-2022, March 4, 2022), Available at: https://988lifeline.org/wp-content/uploads/2022/04/NENA-Suicide-Crisis-Line-Interoperability-Standard-Published-March-2022.pdf, 2022. Accessed February 2, 2024.
41. National Association of Counties, Shaping Crisis Response Spotlight Series (Pew Technical Report).NACo, Available at: https://www.naco.org/resources/shaping-crisis-response-spotlight-series, 2023. Accessed February 2, 2024.
42. Gorenstein D. and Levi R., Call centers struggling to hire for the new nationwide mental health crisis line. Slate, Available at: https://slate.com/technology/2022/06/988-mental-health-crisis-line-hiring.html, 2022. Accessed February 2, 2024.
43. Substance Abuse and Mental Health Services Administration, HHS Secretary: 988 Transition Moves Us Closer to Better Serving the Crisis Care Needs of People

Across America [press release], Available at: https://www.samhsa.gov/newsroom/press-announcements/20220909, 2022. Accessed February 2, 2024.
44. Substance Abuse and Mental Health Services Administration, 988 lifeline performance metrics. SAMHSA, Available at: https://www.samhsa.gov/find-help/988/performance-metrics. Accessed February 2, 2024.
45. Vibrant Emotional Health, 988 State Based Monthly Reports. 988 Suicide and Crisis Lifeline, Available at: https://988lifeline.org/our-network/. Accessed February 2, 2024.
46. Saunders H. Taking a look at 988 suicide and crisis lifeline implementation one year after launch, 2023, KFF, Available at: https://www.kff.org/mental-health/issue-brief/taking-a-look-at-988-suicide-crisis-lifeline-implementation-one-year-after-launch/. Accessed February 2, 2024.
47. Department of Health and Human Services, Budget in brief, fiscal year 2024, 2023, U.S. HHS, Available at: https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf. Accessed February 2, 2024.
48. Livingston K., 988 Suicide Lifeline Expanding LGBTQ services with 24/7 chat and text, 2023, ABC News, Available at: https://abcnews.go.com/Politics/988-suicide-lifeline-expanding-lgbtq-services-247-chat/story?id=97452550. Accessed February 2, 2024.
49. Department of Health and Human Services, 988 Suicide & Crisis Lifeline Adds Spanish Text and Chat Service Ahead of One-Year Anniversary [press release], Available at: https://www.hhs.gov/about/news/2023/07/13/988-suicide-crisis-lifeline-adds-spanish-text-chat-service-ahead-one-year-anniversary.html, 2023. Accessed February 2, 2024.
50. Substance Abuse and Mental Health Services Administration, 988 Suicide & Crisis Lifeline Adds American Sign Language Services for Deaf and Hard of Hearing Callers [press release], Available at: https://www.samhsa.gov/newsroom/press-announcements/20230908/988-suicide-crisis-lifeline-adds-american-sign-language-services-deaf-hard-of-hearing-callers, 2023. Accessed February 2, 2024.
51. Washington State Department of Health, Nation's First Native and Strong Lifeline Launches as Part of 988 [press release], Available at: https://doh.wa.gov/newsroom/nations-first-native-and-strong-lifeline-launches-part-988, 2022, November 17. Accessed February 2, 2024.
52. Office of the Assistant Secretary for Planning and Evaluation, An AI/AN suicide hotline: literature review and discussion with experts, 2009, November 14, U.S. Department of Health and Human Services, Available at: https://aspe.hhs.gov/reports/aian-suicide-prevention-hotline-literature-review-discussion-experts. Accessed February 2, 2024.
53. Substance Abuse and Mental Health Services Administration, National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit. Knowledge Informing Transformation, *SAMHSA*, 2020, Available at: https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf. Accessed February 2, 2024.
54. Substance Abuse and Mental Health Services Administration (SAMHSA), Palmieri J. Implementing the SAMHSA and NASMHPD 988 convening playbooks. Washington, D.C: TA Coalition Webinar; 2022.