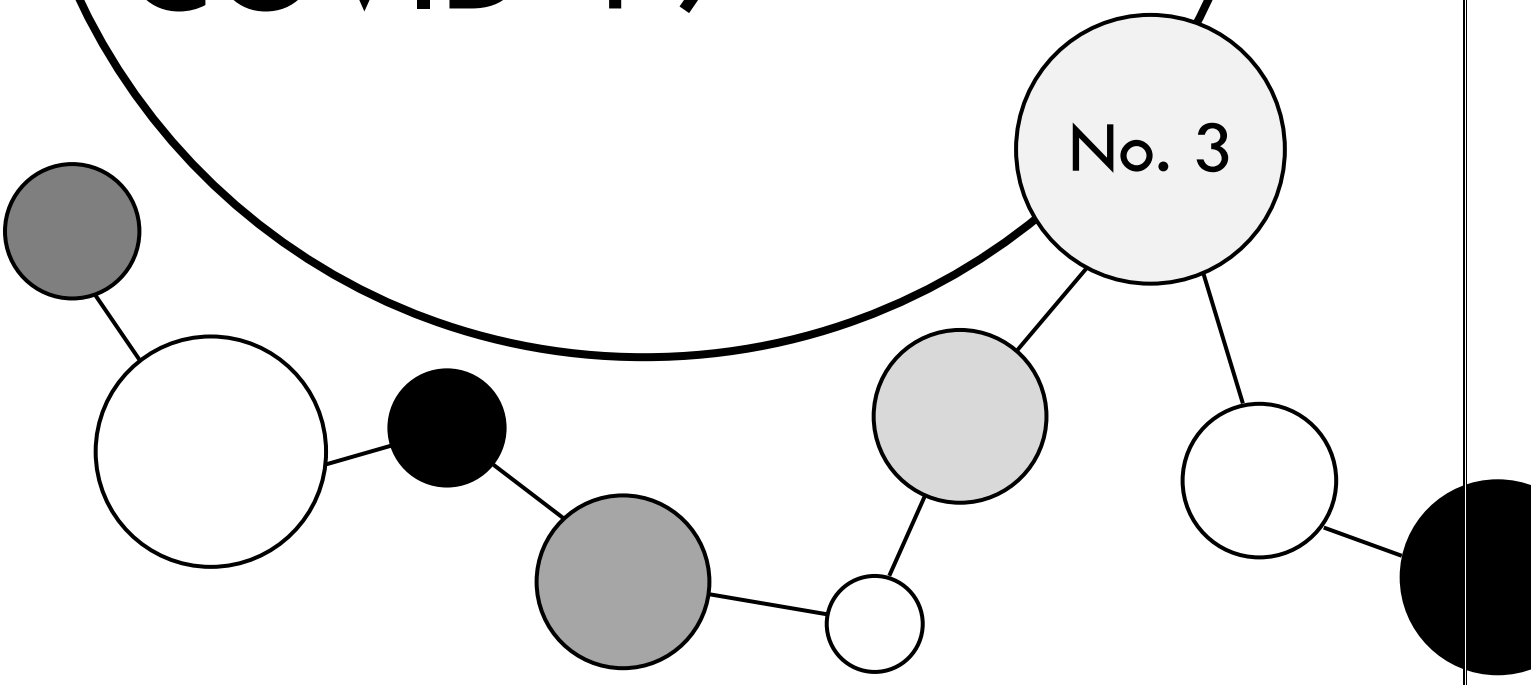
Suicide Prevention and 988: Before, During and After COVID-19



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Suicide Prevention and 988: Beyond Beds Before, During and After COVID 19

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Abstract:

Evaluations of crisis line networks in the U.S. have established the effectiveness of crisis line services as suicide prevention tools while also identifying the need for continued development of a robust and integrated crisis response system to meet the needs of individuals in suicidal and mental health crisis. These evaluation findings bolstered the rationale for the establishment of 988 as the new three-digit dialing code for the National Suicide Prevention Lifeline (Lifeline) beginning in July 2022. The upcoming transition to 988 will require expanded crisis center capacity and enhanced collaboration and communication across the crisis response system. The Lifeline responded to the COVID-19 pandemic by supporting crisis counselors' transition to remote work and remote supervision, and by providing online resources and information about stress management, COVID-19, and the expectable stages of psychological response to a disaster. An increase in calls to the Disaster Distress Helpline (a Lifeline subsidiary) was observed during the height of the pandemic, but an increase in Lifeline calls was not. Finally, testimony from Lifeline callers offers insight into their perceptions of their crisis call's effectiveness in preventing their suicide.

Highlights:

- Suicidal crisis callers report significant reductions in intent to die, hopelessness, and psychological pain over the course of their crisis call
- Crisis counselors are able to secure the caller's collaboration on an intervention on over 75% of imminent risk calls
- Emergency services are involved on 43% of imminent risk calls, and on 58% of third-party calls about a person at imminent risk
- When emergency services are involved, crisis centers often do not know the outcome of the intervention (i.e., whether the service was dispatched, whether the person-at-risk was located, or whether the person-at-risk was transported to a hospital)
- Users of crisis chat services are younger and more likely to report suicidal ideation than crisis callers

Recommendations for the Transition to 988:

1. Higher levels of funding will be needed to support the expansion of capacity at Lifeline call centers
2. In addition to crisis call centers, expanded access to mobile crisis teams and crisis stabilization facilities will be needed to support the diversion of callers from 911
3. Enhanced communication between crisis call centers and other crisis and emergency services will be needed to support continuity of care
4. Ongoing research should be supported to evaluate components of crisis services in order for systems to continue to be informed by evidence.

The National Suicide Hotline Designation Act of 2020 designates 988 as the national number for suicide prevention and mental health crisis response.[1] This has propelled crisis centers, specifically those within the National Suicide Prevention Lifeline (Lifeline) network, into the epicenter of plans for an improved mental health and suicide crisis response system in the U.S. When 988 becomes functional on July 16, 2022, the Lifeline will have an ever-increasing role in providing and coordinating crisis interventions in the U.S.

Suicide Prevention and 988 presents evidence on crisis lines as effective suicide prevention tools and discusses the challenges posed by COVID-19 and the upcoming implementation of 988. This includes:

- empirical evidence on the effectiveness of crisis lines in the U.S. that have helped establish them as a critical resource for individuals at risk for suicide
- an overview of current operations at the Lifeline, the Veterans Crisis Line (VCL), and the Disaster Distress Helpline (DDH), including responses to COVID-19
- the vision of 988 and the goal of a comprehensive behavioral health crisis response system
- challenges faced by crisis centers to meet the extra demands generated by 988
- examples of insights from Lifeline callers into the effectiveness of their crisis calls

Evaluations of U.S. Crisis Line Networks

National crisis lines were first highlighted in the 2012 *National Strategy for Suicide Prevention* and have continued their prominent position in the 2021 *Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention.*[2,3] Yet, in 2001 when the first *National Strategy* was published, suicide crisis lines were noticeably absent. At that time, the evidence base for crisis lines' effectiveness was considered insufficient to include them in the National Strategy. The major milestone in the advance of crisis lines in the U.S. was the funding of a national network of local, certified call centers by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2001. This network which since 2005 has been called the National Suicide Prevention Lifeline (Lifeline), serves as a central switchboard, connecting callers to a crisis center geographically nearest the caller from among a national network of more than 180 crisis centers in 50 states and the District of Columbia. The Lifeline added crisis chat services in 2013, and crisis text services in 2021. The Lifeline provides 24/7/365 free and confidential support directly to individuals in distress and to those calling, chatting, or texting out of concern for the well-being and safety of someone else. The Lifeline receives consultation and guidance from suicide prevention experts, consumer advocates and other stakeholders though the Lifeline's Steering, Lived Experience, and Standards, Training and Practices committees.[1] The evaluation of the national network has been ongoing since the network's inception in 2001. Results from the evaluations have been used by SAMHSA and the Lifeline to shape best practice standards across the network.

The National Suicide Prevention Lifeline can be reached by dialing 1-800-273-TALK (8255)

On July 16, 2022, 988 will be activated nationally as the three-digit dialing code for the Lifeline, with the goal of making the Lifeline more accessible.

The earliest evaluations of SAMHSA's crisis line initiatives examined proximal outcomes of crisis centers' effectiveness. One means to evaluate proximal outcomes involved silent monitoring of calls.[4,5] Another

[1] More information on current Lifeline operations is provided in a separate section below.

means was through follow up assessments with callers to this network.[6,7] For example, in one study, researchers monitored 2,611 calls to 14 crisis lines in the Hopeline Network (the precursor to the Lifeline), observing counselor behaviors, caller characteristics, and changes during the calls.[8,9] The authors found that better call outcomes were associated with intervention styles that involved a supportive approach, good contact, and collaborative problem-solving – counselor behaviors that have been adopted as Lifeline standards. Other research studies assessed the outcomes of calls by employing callers' own ratings of their mental state and suicidality, in response to a standardized set of inquiries by the crisis counselors at the beginning and end of the call, to assess the immediate proximal effect of the crisis intervention.[10,11] A follow-up assessment, two to four weeks later, was then conducted to assess the duration of the effect and the impact of the telephone intervention on future suicidal risk and behavior. The study of adult suicidal (n=1085) and non-suicidal crisis (n=1617) callers, sampled from eight crisis hotlines in the Hopeline network, demonstrated that seriously suicidal individuals were calling telephone crisis services (e.g., 8% in midst of an attempt, 58% had made a prior attempt); and that significant reductions in callers' self-reported crisis and suicide states occurred from the beginning to the end of the calls. Specifically, there were significant decreases in callers' reports of intent to die, hopelessness, and psychological pain over the course of the call.

In addition to the demonstration of crisis lines' effectiveness, early evaluations also identified a need for improvement in risk assessments, practices with imminent risk callers, and continuity of care for suicidal callers – areas foundational to a behavioral health crisis system. The evaluation findings in each of these areas are discussed below. Evaluations of the Lifeline Crisis Chat (LCC) intervention and those specifically focusing on the Veteran's Crisis Line will be discussed separately.

Risk Assessments

While providing support for the clinical effectiveness of the crisis lines, the results of the early evaluations also raised concerns about the adequacy of suicide risk assessments conducted by some crisis line staff.[12,13] For example, researchers found that counselors did not consistently evaluate suicide risk and when evaluations were conducted they were usually incomplete.[14] Furthermore, another study found that of the callers who were rated as non-suicidal crisis callers by crisis staff, 12% reported at the study's follow-up assessment that they had been feeling suicidal either during or since their calls to the center.[15] Half of these callers reported being suicidal at the time of their crisis call, but this was not known or recognized by the counselor during their call.

In response, SAMHSA and the Lifeline focused attention on the standardization of crisis counselors' practices and training across the network.[16] SAMHSA and the Lifeline began disseminating LivingWorks' Applied Suicide Intervention Skills Training (ASIST) across its network of centers.[17] The evaluation of the impact of the implementation of ASIST across the Lifeline network utilized data from 1,507 monitored calls from 1,410 suicidal individuals to 17 Lifeline centers.[18] Callers were significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful by the end of calls handled by ASIST-trained counselors. Improvements in callers' outcomes were associated with ASIST-related counselor interventions, including exploring reasons for living and exploring informal support contacts. Despite these positive findings, most of the counselor interventions that were assessed did not differ between ASIST-trained counselors and non-ASIST-trained counselors. These findings may be explained by the considerable overlap in the content of the Lifeline centers' routine

> LivingWorks' Applied Suicide Intervention Skills Training is an internationally disseminated gatekeeper training program designed as "suicide first aid."

trainings and the ASIST training, particularly with regard to risk assessments, as evidenced by the finding that both ASIST-trained and non-ASIST-trained counselors asked about or explored suicidal thoughts on over 90% of calls where callers acknowledged being suicidal. A more recent study involving the monitoring of 241 calls to ten California suicide prevention crisis lines also showed that most counselors asked about current suicidal ideation, but occurrence varied significantly across sites.[19] Of note, they found that counselors at Lifeline centers were more likely to inquire about current suicidal ideation, recent ideation, and past attempts. Moreover, callers to centers that were part of the Lifeline network were more likely to experience reduced distress than callers to centers that were not part of the Lifeline.

Interventions with Imminent Risk Callers

The need for a clear and explicit policy for high-risk callers to the Lifeline was highlighted by the early evaluations of network crisis lines published in 2007.[20,21,22] On monitored calls where a suicide attempt was in progress, one study found that emergency services were known to be dispatched in 18% of cases, and the caller changed his/her mind about the attempt in 24%, leaving 58% of calls without an observed mitigation of the caller's risk.[23] Another study found that emergency responses for callers deemed to be at imminent suicide risk varied considerably across eight crisis centers.[24] Overall, emergency rescue was initiated in 38% of cases in which callers had taken some action to kill themselves immediately before calling the centers.

In response to these shortcomings, the Lifeline published a Policy for Helping Callers at Imminent Risk of Suicide that provides guidance on making a judgment regarding imminent risk and outlines recommended practices for reducing imminent risk through crisis line interventions.[25] The Lifeline's Imminent Risk policy encourages counselors to actively seek collaboration with callers at imminent risk and to enable these callers "to work toward securing their own safety" ("active engagement");[26] the policy furthermore encourages counselors to use the least invasive interventions capable of preserving the caller's safety. Involuntary interventions ("active rescues") are to be used as a last resort because they may be unnecessarily stigmatizing and traumatizing and may deter future outreach for help.[27] Nevertheless, the Lifeline policy highlights the importance of initiating an active (i.e., involuntary) rescue when all other possible actions to prevent a caller from dying by suicide have been exhausted.

An evaluation of the assessment and management of imminent risk callers to the Lifeline employed data from 491 call reports completed by 132 counselors at eight crisis centers.[28] Findings demonstrated that crisis counselors obtained the collaboration of the vast majority (over 75%) of callers they identified as being at imminent risk, consistent with the Lifeline Imminent Risk policy. On 19% of imminent risk calls, the counselors sent emergency services (police, sheriff, EMS) with the collaboration of the callers, while on a quarter of the imminent risk calls, the counselors sent emergency services without the caller's collaboration. Overall, emergency services were involved on 43% of imminent risk calls. Other types of collaborative interventions implemented on imminent risk calls included getting rid of means (i.e, means that an individual might use to harm themselves), involving a third party, collaborating on a safety plan, and the caller's agreeing to receive follow-up from the crisis center. At least one collaborative, non-emergency intervention was implemented on 68% of all imminent risk calls, and on 37% of imminent risk calls where emergency services were involved.

The Lifeline is widely promoted as a resource not only for individuals in crisis but also for people who are concerned for the safety of someone in their social network. Given the reluctance of many suicidal individuals to seek help for themselves, working with individuals calling on behalf of someone else ("third-party callers") is as much a Lifeline priority as working with individuals calling on their own behalf

("direct callers"). It is believed that those who do not call on their own behalf may be at higher risk of suicide than those who do.[29] A recent study provided information on "third-party calls."[30] Reports on 172 third-party calls concerning individuals deemed to be at imminent suicide risk were completed by 30 crisis counselors at six Lifeline crisis centers. The study found that third-party callers were most likely to be calling about a family member or friend and were significantly more likely than the people about whom they were calling to be female and middle-aged or older. Counselors were able to collect information about suicide risk from the third parties, and counselors and third parties were nearly always able to identify at least one intervention to aid the person-at-risk.

Interventions identified were varied. Emergency services were contacted on 58% of the third-party imminent risk calls, which represents a somewhat higher rate of emergency services involvement than previously reported on imminent risk calls placed by the person-at-risk.[31] The odds of emergency services involvement were higher if the third party was a high school student or young adult in contrast to middle-aged or older, if the third party was a friend or acquaintance of the person-at-risk in contrast to a family member, and if the third party's information was based on sources other than face-to-face contact with the person-at-risk. Odds of emergency services involvement were also higher if the person-at-risk was in the midst of an attempt or planned to act on suicidal thoughts within a few hours, or if these risk factors could not be ruled out. Counselor characteristics did not predict emergency services involvement. Non-emergency interventions, such as having the third party maintain a watch over the person-at-risk, or involving a mobile crisis team for evaluation or follow-up, were implemented on 69% of all calls, and on 47% of calls where an emergency intervention was also implemented. The study demonstrated that individuals calling the Lifeline when they are worried about someone are provided a range of interventions that can supplement, and at times replace, calling 911. Information about the outcome of emergency services dispatch was unavailable to the crisis counselors over half the time, indicating a need for improvements in information sharing across services.

Continuity of Care for Suicidal Callers

The early evaluation published in 2007 by Gould and colleagues highlighted the need for crisis centers to heighten outreach strategies to minimize suicide risk and enhance follow through with referrals.[32] Follow-up assessments conducted two to four weeks after the crisis call found that a substantial proportion (42%) of callers continued to express suicidal ideation, 7.4% had made a suicide plan and nearly 3 percent had made a suicide attempt. Furthermore, only 23% of suicidal callers had been seen by the behavioral health care system to which they had been referred.

In response, SAMHSA funded an initiative in 2008 to have crisis center staff offer and provide follow-up calls to all Lifeline callers who reported suicidal ideation during or within 48 hours before making a call to the Lifeline. An evaluation of this follow-up initiative included 550 callers followed by 41 counselors at six crisis centers. Findings indicated that follow-up had a positive impact. In interviews with these follow-up clients, 80% indicated that the follow-up intervention stopped them from killing themselves and 91% reported that it kept them safe.[33] Clients were more likely to report perceived benefits of follow-up if they had higher baseline risk scores or if they had a previous suicide attempt.[34] Another evaluation demonstrated that a Lifeline crisis call can also play an important role in connecting at-risk callers to ongoing mental health care.[35] This study of 376 suicidal callers and 278 non-suicidal crisis callers showed that 52% of callers who received mental healthcare referrals ended up accessing care after their call. Thus, the Lifeline is enhancing the continuity of care for suicidal individuals, which is a priority of the U.S. National Strategy for Suicide Prevention.[36]

New Media: Lifeline Crisis Chat

To increase access to crisis services, Lifeline's service format has evolved to include not only telephone but also synchronous (i.e., in real time) chat crisis interventions. The Lifeline Crisis Chat (LCC) network, which serves all ages, has grown extensively since its formal establishment in 2013, answering 231,335 chats in 2020.[37] The availability of crisis interventions via chat is particularly critical for young people who are more likely to choose online rather than telephone crisis services,[38,39] and who are also more likely to discuss "weighty problems," such as mental health problems and suicide on an online crisis service than by telephone.[40,41]

A study assessing the effectiveness of the LCC employed 13,130 linked pre- and post-chat surveys completed by recipients of Lifeline's online crisis chat services in 2017-2018.[42] Findings indicated that chatters were significantly and substantially less distressed at the end of the chat intervention than they were at the beginning. This is of particular import because the vast majority of individuals seeking help from the LCC were highly distressed when they contacted the service. Moreover, almost 84% of LCC chatters endorsed either current or recent suicidal ideation on the pre-chat survey, which is markedly higher than the estimated 23% of Lifeline callers who were identified by silent monitors as being suicidal on the day of or the day before their calls.[43] Findings were consistent with other research that also reported that crisis chatters reveal higher rates of suicidal ideation than crisis callers.[44,45,46] By the end of the chat, two-thirds of suicidal chatters reported that the chat had been helpful and nearly half reported they were less suicidal, which offered some empirical evidence for the effectiveness of Lifeline's online crisis chat services.

A second study analyzed pre-chat survey data and data abstracted from the transcripts of 1,034 Lifeline crisis chats in 2015 and found that chatters are younger on average than crisis callers and as noted previously are more likely than callers to disclose suicidal ideation at the time of the crisis intervention.[47] Lifeline chat counselors engage in rapport-building on nearly every chat with a suicidal visitor, and engage in problem-solving on over two thirds of such chats, demonstrating what seems to be a more balanced approach than has been observed in other evaluations of online counseling interventions.[48] However, counselors were not observed to assess suicide risk on all chats, and appeared to base their risk assessment activity to a significant degree on the visitor's Pre-Chat Survey response. Information on current suicidal ideation was unavailable (i.e., current suicidal ideation was not discussed sufficiently to enable the coder to confirm it as present or absent) in the transcripts of a third of chats where the chatter had endorsed current suicidal thoughts on the pre-chat survey, over half of chats where the chatter had endorsed recent suicidal thoughts, and nearly three-quarters of chats where the chatter had denied suicidal thoughts on the pre-chat survey.

Veterans Crisis Line

The Veterans Health Administration (VHA) has set suicide prevention as a top priority given veterans' increased risk of suicide compared to the general U.S. population.[49] To address this heightened suicide risk, in 2007, the Veterans Suicide Prevention Hotline (now called the Veteran's Crisis Line (VCL)) was founded. Veterans, active-duty service members, and their families are connected to this line by calling the Lifeline number and pressing "1" when prompted. An online chat service was added in 2009, followed by a text-message service in 2011. Originally comprised of one call center, the VCL opened a second and third call center in 2016 and 2018. Since its creation, the VCL has received more than 5.4 million calls, 630,000 chats, and 204,000 texts.[50] Additional information about VCL is provided under Current Operations, below.

There have been few studies examining the effectiveness of the VCL. Employing VCL responders' evaluation of 646 calls from October 1 through 7, 2010 made by veterans who had endorsed current or recent suicidal ideation or a lifetime history of suicide attempt, the findings indicated that 84% of calls ended with a resolution, a referral to a local provider, or both.[51] High-risk callers, as determined by responders' observations of intent to die and absence of future plans, had greater odds of ending the call with a referral (77%) compared to lower-risk callers (49%). A recent study interviewed 155 VCL users who were referred to a Veterans Affairs Medical Center Suicide Prevention Team.[52] VCL users' responses to questions adapted from previous research indicated that 87 percent of interviewees expressed satisfaction with the intervention, nearly 82% reported that the VCL was helpful, and 72.9% said that the VCL helped keep them safe.[53] Nearly 83% of those with suicidal thoughts reported that the crisis contact helped stop them from killing themselves.

Overall, the empirical demonstration of the effectiveness of crisis lines in the U.S. for the past two decades helped to bolster arguments and lay a foundation for the new three-digit dialing code (988) for the national suicide prevention and mental health crisis hotline system.

Current Operations and Response to COVID-19

The volume of calls, chats and texts received by centers in the National Suicide Prevention Lifeline Network in 2020 is presented in Table 1.

Table 1. Volume of Calls, Chats, and Texts Received[i] in 2020

	Centers	Calls received	Chats received	Texts received
National Suicide Prevention Lifeline	>180[ii]	>1.8M[iii]	~1.2M	>34K[iv]
Veterans Crisis Line (VCL)	3[v]	>679K	>80K	>35K
Disaster Distress Helpline (DDH)	3[vi]	>60K	n/a	>11K

[i] Not all contacts that are received are successfully answered
[ii] Over 30 of these centers handle chats and texts in addition to calls
[iii] This figure excludes calls to the VCL, which is reached by dialing the Lifeline number and then pressing '1'
[iv] This total comes from a 4.5-month pilot program, prior to the official rollout of Lifeline Text
[v] VCL calls are routed to three dedicated VCL centers
[vi] DDH calls are received on dedicated lines at three Lifeline centers, with two centers also handling texts

Callers are routed to the center closest to the area code they are dialing from, with the goal being for calls to be handled locally by counselors who are familiar with local resources and culture. States vary in their ability to answer calls in-state, with the top third answering 82% or more and the bottom third answering 66% or less. Nine centers serve as national backup centers, handling calls that roll over when local centers have reached capacity. Individual Lifeline centers may maintain separate "warm lines" with their own telephone numbers, some of which are answered by individuals with lived experienced of suicidal or mental health crises (also called peer-support lines); however, the Lifeline does not administer a warm line or peer-support line at the national level. As Lifeline members, centers receive access to information, training, technology, networking, and a small annual stipend. Center operations are state- and locally funded. Centers range from stand-alone call centers to larger behavioral health organizations incorporating a call center along with one or more other services such as onsite outpatient treatment, crisis stabilization units, or mobile crisis teams. Lifeline centers may be non-profit, for profit,

or governmental (e.g., county-run), and they may be staffed by licensed mental health clinicians, by other paid employees, by volunteers, or by a combination of these. To standardize the crisis response provided across these diverse institutions, the Lifeline provides guidance regarding best practices in suicide prevention and crisis intervention through newsletters, webinars, and on its members-only Network Resource Center website (https://networkresourcecenter.org/). Crisis centers seeking to join the Lifeline network must be certified, accredited, or licensed by an external body, must have written policies or guidelines addressing counselor training, referrals, and suicide risk assessment, and must be willing to participate in Lifeline evaluation activities. Application is possible through the Lifeline website (https://suicidepreventionlifeline.org/our-network/). As described above, the Lifeline bases its policies and practices on ongoing evaluation research and on consultation with academic subject area experts and individuals with lived experience of suicide (see https://suicidepreventionlifeline.org/lived-experience-committee/ and https://www.activatinghope.com/).

As noted above, although the Veterans Crisis Line (https://www.veteranscrisisline.net/) shares the Lifeline's national toll-free telephone number, callers who press '1' to reach the VCL are routed to one of three call centers specifically dedicated to veterans' care. Unlike many Lifeline call centers, VCL call centers do not utilize volunteers. VCL responders are clinicians trained in both crisis intervention and military culture, and may be Veterans themselves. They have the capacity to make referrals within the United States Department of Veterans' Affairs (VA) mental healthcare system,[54] and to link callers to a Suicide Prevention Coordinator at their local VA medical center, if needed and desired. The VCL thus provides a model of integrating crisis lines within larger health-care settings. The volume of calls, chats and texts received by VCL centers in 2020 is presented in Table 1.

The Disaster Distress Helpline (DDH, https://www.samhsa.gov/find-help/disaster-distress-helpline and https://strengthafterdisaster.org/) is a SAMHSA-funded national hotline dedicated to responding to distress caused by natural or human-caused disasters. DDH, a subsidiary of the Lifeline with a separate telephone number, was launched in 2012 and is accessible via telephone, text, or video phone for speakers of American Sign Language. DDH calls are routed to dedicated lines at three Lifeline call centers, with two centers also handling texts. DDH is now launching its first three Online Peer Support Communities, to be moderated by trained peer supporters with oversight by a Lifeline crisis center, accessible via Facebook Groups. These communities will be specifically targeted to healthcare workers impacted by COVID-19, parents and caregivers of children and youth impacted by COVID-19, and survivors of and responders to mass shootings in the U.S.

In response to the COVID-19 pandemic, SAMHSA increased its promotion of DDH, which saw a dramatic increase in calls, peaking in April 2020 at approximately 500% of pre-pandemic call volume, and stabilizing by August 2020 at approximately 250% of pre-pandemic call volume, a "new normal" which can still be considered part of the COVID-19 surge. The volume of DDH calls and texts received in 2020 is presented in Table 1. It should be noted that DDH call volume was relatively low prior to this surge, with centers receiving only 12,171 DDH calls and 1,543 DDH texts in 2019, roughly 1/5th and 1/7th the call and text volume in 2020, respectively. Unlike DDH, the Lifeline itself did not see an increase in calls during the height of COVID-19. This difference is likely to reflect both targeted efforts to promote DDH during this period, as well as the prevalence of DDH callers experiencing distress, but not suicidality, in response to the pandemic. Less than 1% of DDH callers and texters were identified by counselors as suicidal during their contacts with DDH.[55] Globally, no increase in suicide deaths has been observed since the onset of the pandemic;[56] however, an online survey of a nationally representative sample of US adults in late April 2020 found rates of moderate and serious mental distress elevated to three times their 2018 levels, portending possible increases in mental illness and suicide risk in future.[57] A survey of

US adults conducted by the Centers for Disease Control in June 2020 demonstrated elevated levels of suicidal ideation, particularly among young people, Black and Hispanic respondents, unpaid caregivers for adults, and essential workers.[58] Moreover, an examination of National Syndromic Surveillance Program (NSSP) data has identified an increase in emergency department visits for suspected suicide attempts among adolescents aged 12-17, especially girls, beginning in May 2020.[59] The more distal impact of COVID-19 on suicidal ideation and attempts, rates of completed suicide, and help-seeking by suicidal individuals is yet to be determined.

The Lifeline's response to COVID-19 to date has included offering the public information, coping tips, and digital resources accessible via the Lifeline website (https://suicidepreventionlifeline.org/current-events/supporting-your-emotional-well-being-during-the-covid-19-outbreak/). To facilitate engagement with Lifeline callers impacted by COVID-19, the director of the DDH offered Lifeline counselors guidance on the phases of reactions to disaster. Also for counselors, the Lifeline created a self-paced training entitled "Disaster Mental Health: COVID-19," housed on the Network Resource Center (NRC) and designed to familiarize Lifeline counselors with the types of mental health issues callers might be facing as a result of COVID. As many centers closed temporarily in early to mid-2020, the NRC offered guidance on the transition to remote work and remote supervision for crisis counselors.

988

In a 2019 Washington Post opinion piece titled "Let's dial 988 to stop suicides," Representatives Chris Stewart (R-Utah) and Seth Moulton (D-MA) described the National Suicide Hotline Improvement Act of 2018 as an effort to streamline access to the National Suicide Prevention Lifeline (Lifeline) for individuals in suicidal crisis by replacing its 10-digit telephone number (1-800-273-8255) with an easy-to-remember three-digit dialing code.[60] They referenced high rates of veteran suicide in particular as motivating their involvement in this legislation. In compliance with the directives of this Act, the FCC submitted to Congress a "Report on the National Suicide Hotline Improvement Act of 2018" based on reports from SAMHSA, the VA, and the NANC.[61] Findings from the Lifeline evaluations were included in this report, and supported the FCC's conclusion that the Lifeline was an effective crisis intervention tool and that its reach and functioning could be improved by the implementation of a three-digit dialing code. The report recommended the use of 988 as the new number for "a national suicide prevention and mental health crisis hotline system… a 911 for the brain."[62]

Following the FCC's recommendation that 988 be designated as the new Lifeline dialing code, Stewart and Moulton introduced to Congress the National Suicide Hotline Designation Act of 2020, in a further effort to improve Lifeline services by empowering states to collect fees to finance local crisis call centers in the Lifeline's national network. They envisioned this funding enabling Lifeline centers to improve response times and increase the percentage of Lifeline calls that are answered in-state rather than rolling over to a backup center. This legislation also created a legal basis to enable real-time communication between Lifeline crisis centers, 911/emergency dispatch, and hospitals. The legislation establishing 988 as the national number for suicidal and mental health crises thus takes concrete steps to streamline and support the connection of individuals in crisis to a Lifeline crisis counselor, while at the same time pointing in the direction of much more far-reaching reforms and toward the development of a comprehensive crisis response system.

When 988 is implemented, calls to 988 will be routed to Lifeline crisis centers, and callers will press '1' after dialing 988 to reach the VCL. DDH will continue to be reached via its current, ten-digit, toll-free number. With the increased visibility, promotion, and accessibility of 988, and given the intention

(discussed further below) of diverting substantial numbers of mental health-related calls away from 911, major increases in Lifeline call volume can be anticipated.

Comprehensive Behavioral Health Crisis System (Crisis Now model)

The National Action Alliance for Suicide Prevention's *Crisis Now: Transforming services is within our reach*[63] and SAMHSA's *National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit*[64] present a vision of a robust and integrated behavioral health crisis response system able to achieve the following aims: to divert individuals in mental health crisis away from jails and emergency departments, to reduce unnecessary psychiatric hospitalizations, and to reduce law enforcement involvement in mental health crises. The urgency of the need for crisis response reform is reflected in recent reporting by *The Washington Post* that "about a quarter of all fatal police shootings in the last six years involved someone in the throes of a mental health crisis."[65] The Crisis Now model places crisis call centers at the hub of an integrated crisis care system, which also involves universal access to mobile crisis teams and crisis stabilization facilities. According to this model, crisis call centers would be responsible not only for fielding calls, de-escalating crises, and referring callers to additional services as needed, but also for tracking and coordinating individuals' use of these other services, in a role described as "care traffic control." This might involve the use of real-time dashboards showing the locations of mobile crisis teams, available respite beds, available outpatient appointments, and so forth, reflecting levels of available resources and of information sharing which many US communities can currently only dream of. Whereas some Lifeline call centers have integrated mobile crisis teams and crisis stabilization facilities, and others have relationships with other organizations offering these services, still others are located in communities where these services are lacking. One mechanism for ensuring these resources are available to Lifeline counselors for callers who need them is the establishment of Certified Community Behavioral Health Clinics (CCBHCs), which are mandated to include mobile crisis services and which utilize Medicaid funding to support such things as competitive wages for clinic staff and the purchase of technology to enable electronic information exchange.[66] As of this writing, 21 Lifeline centers have been certified as CCBHCs.

Conclusions and Next Steps Toward the Realization of 988

Evaluations of crisis hotlines in general and the National Suicide Prevention Lifeline specifically informed the push to designate a three-digit dialing code for mental health and suicidal crises in the US, and these evaluations will continue to inform the implementation of 988. Key points from these evaluations are:

- Individuals at risk of suicide do utilize suicide hotlines,
- Callers experience reductions in their crisis and suicidal states over the course of the crisis call,
- Crisis counselors can collaborate with callers to deescalate imminent suicide risk without the use of 911 or an emergency department,
- Callers may experience continued or recurring suicidal thoughts in the weeks following their crisis call, indicating a need for continuity of care,
- Follow-up calls are important suicide prevention tools,
- Crisis chat services are utilized by a young and high-risk population, and are important adjuncts to telephone hotlines, and
- Lifeline centers have been shown to be more effective than centers outside the network.

Key challenges to the implementation of 988 include:

- Dramatic increases in call volume can be anticipated, which will necessitate rapid increases in staffing and technological capacity at crisis centers;
- Crisis centers' ability to effectively resolve high risk mental health and suicidal crises without recourse to 911 will depend in part on improved access to mobile crisis teams and crisis stabilization facilities, services which are not now universally available;
- Coordination of care across the crisis response system will require enhanced communication between call centers, 911, EDs, and other crisis and emergency services;
- Given that 988 will be implemented on a state-by-state basis, some state-level infrastructure may be needed to ensure the availability and coordination of crisis response resources;[67]
- Higher levels of funding will be needed to enable the expansion of call center capacity, reduce staff turnover, and facilitate the overall transformation of the US crisis response system.

Appendix: Insights from Lifeline Callers

Lifeline callers interviewed as part of an ongoing evaluation of the Lifeline who reported that the Lifeline call stopped them from killing themselves made the following comments in response to an open-ended question about what it was about the call that stopped them from killing themselves. These examples illustrate instances of crises being deescalated by the Lifeline call itself, and of high-risk callers being connected to additional resources without necessarily involving 911.

- *"I was at crisis point, I was very much considering killing myself and talking with the person got me from crisis to being very sad about the situation which is an emotion I can handle."*
- *"At first, I started off talking with complete honesty about how I had the knife to myself. At some point, the focus became less about the knife and more about what was going on in my life. It was very validating for me to be able to talk about the whole picture and vent for a bit. That really stopped me because I felt heard and understood. It felt very real and very raw. I got to talk about my life and the weight was lifted off my chest. The temptations went away after that."*
- *"She had me go and try to find the item that I was trying to end my life with and made sure I was comfortable throwing them away and helped me realize that I had a part that wanted me to live and helped me focus on that part and make it stronger."*
- *"I think it's bringing down the frantic energy because you get in this very volatile, emotional state where it feels like everything is happening so fast. You feel like you need to think and do everything so fast to keep up because you're panicking. I think that call slowed me down and made me realize I didn't have to make decisions in that moment."*
- *"She just kept talking to me and distracting me from that [killing myself]. She distracted me long enough until my brother was able to get there. They made sure my brother got there before they ended the call."*
- *"Without the call I would have never gone to the [community mental health] center. She helped me realize my breaking point and realize that I needed more help than I was getting. She helped me realize that I needed help."*

- *“I guess the way the person was talking to me and how they didn't assume things about me. They let me call somebody to come and pick me up and take me to the hospital. They let me choose to go to the hospital, but they also made me promise to go.”*
- *“I think that if I hadn't called anybody that night, I would've acted on my plan. I think it really saved my life that night. I had somebody to call and talk to, but it didn't involve cops and stuff. It was private and confidential.”*

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