According to the latest (2018) data from the Centers for Disease Control and Prevention (CDC), suicide is the tenth leading cause of death in the United States and the second leading cause of death for youth and young adults ages 10-34 (CDC, 2020). In 2018 alone, 48,344 people in the U.S. died by suicide (CDC, 2020). A recent CDC report found that from 1999 through 2018 the suicide rate increased 35%, with a significant increasing trend after 2006; the rate increased on average approximately 1% per year from 1999 to 2006 and by 2% per year from 2006 through 2018 (Hedegaard, Curtin, & Warner, 2020). While these statistics point to a serious public health problem, we do know that suicide is preventable.

Suicide and suicide attempts have a devastating impact on individuals, families, and communities across the country. Upwards of 90% of individuals who ultimately die by suicide were living with a diagnosable mental health condition at the time of their death, although these conditions often go undiagnosed or untreated. Illnesses like depression, anxiety, and substance problems, especially when unaddressed, increase risk for suicide.

Connecting individuals with mental health services and resources is a vital component in suicide prevention. By offering immediate help to everyone that may need it, crisis lines provide invaluable support at critical times. The National Suicide Prevention Lifeline and statewide hotlines help to ensure that gaps in local services are served and that crisis calls can truly be answered 24/7/365. Timely access to mental health services and crisis supports can save lives.

**Overview of the National Suicide Prevention Lifeline:** The National Suicide Prevention Lifeline (NSPL) is a national network of state and local crisis centers linked through a 24/7 toll-free number (1-800-273-TALK or 8255) that connects callers throughout the U.S. to immediate crisis care. Trained counselors assess callers for suicidal risk, provide emotional support and crisis counseling, and offer referrals to behavioral health and emergency services when necessary (Gould, Munfakh, Kleinman, & Lake, 2012). The Lifeline is accessible in over 150 languages and includes chat and TTY services for the deaf and hard of hearing. The Lifeline also includes Veteran specific services through call routing to the Department of Veterans Affairs’ Veterans Crisis Line as well as non-English speaker specialized services (“About the Lifeline,” n.d.). The Lifeline is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by Vibrant Emotional Health (National Suicide Prevention Lifeline (NSPL), 2019).

The Lifeline network consists of over 170 independently operated local- and state-funded crisis call centers in 48 states, with Minnesota and Wyoming being the only two states with no Lifeline-affiliated crisis center (NSPL, 2019). Callers dial the Lifeline number and are routed to their nearest crisis center based on area code. Ideally, callers are connected with a local counselor in their own state. However, if the local center is unable to answer, the Lifeline reroutes calls to backup centers in their network, both in- and out-of-state (“Our Network,” n.d.).
Affiliation with the Lifeline network requires accreditation from a certifying organization such as the American Association of Suicidology, the Council on Accreditation, and the Joint Commission. The crisis call center must also have liability insurance, the capacity to consistently cover a geographic region, designated and trained staff, administrative guidelines, and adherence to Lifeline quality assurance – including evaluations, referrals, and other best practices (NSPL, 2017).

Since 2005, 12 million calls have been answered by the Lifeline and its network of crisis centers, with a record 2.2+ million calls in 2018 alone. Additionally, the Veterans Crisis Line has served 3.5 million callers since its inception in 2007, including 600,000 Veterans and active service members in 2018 (NSPL, 2019).

The Lifeline’s united network provides uniformity for at-risk individuals across the country with a single, well-known phone number and name. This unity enables the Lifeline to assure that centers are accredited, provide training for counselors, and disseminate best practices. Most crisis centers are nonprofit organizations, and many utilize trained volunteers as well as mental health professionals (“Our Network,” n.d.).

**Lifeline Effectiveness:** There is clear evidence that the Lifeline can be effective in reducing suicide. Utilization of the Lifeline has been found to successfully de-escalate callers classified as high risk and to reduce the burden on emergency rooms, police, emergency responders, and other mental health emergency services.

A 2013 study of imminent risk callers found that crisis counselors actively engaged the callers in collaborating to keep themselves safe on 76.4% of calls; on 19.1 percent of calls the counselors collaborated to send emergency services, and on 55 percent other collaborative interventions were used such as reducing access to lethal means, involving a third party, collaborating on a safety plan, and agreeing to receive rapid follow-up from the crisis center (Gould et al., 2016).

Additionally, a 2018 survey of Lifeline centers found that almost 98 percent of the crisis calls are de-escalated such that costly, highly restrictive responses from law enforcement and emergency medical services are not necessary (NSPL, 2018b).

In an evaluation of a national initiative funded by SAMHSA to provide follow-up care to high-risk callers, a majority of the follow-up call recipients interviewed reported that the intervention stopped them from killing themselves (79.6%) and kept them safe (90.6%) (Gould et al., 2017).

**Lifeline Challenges:** Although the Lifeline has proven itself to be an essential and necessary component of the suicide prevention and mental health care system, the network of crisis centers consistently faces two main interconnected barriers to its effectiveness and success: (1) insufficient funding, and (2) the capacity to respond to a steadily increasing call volume.

While the Lifeline is a national program, federal funding goes toward managing call routing, best practice standards, public messaging, capacity-building opportunities, and technical assistance for its nationwide network (NSPL, 2018b). As a result, local crisis centers answering the calls are reliant on funding from state and local contributors to operate and grow. Less than half of states have a suicide prevention specific line item in their state budgets in general, and only some of these have a provision that puts aside state funds for crisis centers. Many centers rely on private contributions and use of volunteers to keep their centers running.
Without the necessary resources, local centers are unable to answer calls, resulting in high out-of-state answer rates. Based on funding and staffing levels, local call centers set their own hours and determine their coverage area, and most Lifeline-affiliated call centers in the U.S. answer calls on other helplines in addition to the Lifeline (NSPL, 2018b). In addition, a convergence of modern-day events and other factors have caused a steady increase in the number of calls made to the Lifeline. Increased media attention, such as celebrity deaths and musical references to the Lifeline and social media posts, have also had a major effect on call volume in recent years (NSPL, 2018a).

When local call centers are unable to answer calls to the national hotline, callers get re-routed to other centers in their state, or out-of-state and into Lifeline’s National Backup Network. As a result, callers in crisis wait longer, they receive fewer linkages to effective local care, and they are more likely to abandon their calls. The use of in-state crisis centers as opposed to a centralized national help center is crucial; local counselors at in-state crisis centers are familiar with the community and better equipped to provide culturally competent support and referrals to local services.

Low in-state answer rates also put a strain on the backup network. A 2018 evaluation of four national backup centers that utilize Automatic Call Distribution (ACD) technologies found that the average longest wait time increased 29% in one year (NSPL, 2018a). In 2018, 21% of all calls were answered out-of-state (NSPL, 2019).

Currently, the only regular federal funding that goes to local Lifeline centers is a small annual stipend of $1,500, with an extra $1,000 if they collect data on Veteran calls, though centers can apply for additional grants (Vivekae, 2018). In 2014, 46% of the network’s crisis centers had flat funding and 31 percent had funding decreases; 73 percent of the centers with flat funding and 81 percent with funding cuts had call volume increases (NSPL, 2018a).

In summary, crisis call centers provide invaluable support at critical times and connect individuals to services that can save lives. Statewide crisis call centers can reduce gaps in local service delivery, and local Lifeline affiliated call centers ensure callers are linked with local services and resources. State, county, and local level support for and investment in the Lifeline network is critical for crisis centers across the U.S. at a time when many are underfunded and in jeopardy of having to reduce services, or in some cases, close entirely.

**Current Advocacy Efforts:** AFSP supports an increase in funding for the Lifeline network on both the federal and state or local levels. Adequate funding is needed to ensure that calls can truly be answered 24/7/365 by individuals who have been trained to handle suicide risk and other mental health crisis situations and who are supervised by a mental health clinician.

**Federal Efforts:** Congressional efforts to support the Lifeline and its network of backup call centers are through the appropriations process (federal funding) and through authorizing legislation (legislation to improve the Lifeline).

Federal appropriations for the Lifeline have gradually increased since its inception in 2005. The Lifeline is currently funded at $19 million for FY2020, nearly tripling its FY2018 funding level of $7.2 million. Federal funding pays for national Lifeline services, administration, and backup call
centers. Local call centers receive stipends of $1,500 to $2,500 from the federal government (Vivekae, 2018).

Current authorizing efforts in Congress include federal legislation to increase the Lifeline’s funding to $50 million to fortify quality assurance provisions, legislation to designate 988 as the Lifeline’s three digit number and empower state authority over fees to supplement crisis call center funding, and a public education campaign to raise public awareness of available crisis services. Visit afsp.org/actioncenter for details on current legislation.

Federal funding and authorizing legislation will go hand in hand to secure top-down support for the national Lifeline and the local call center network.

**State Efforts:** AFSP advocates for state legislation and initiatives that fund existing crisis centers, establish statewide hotlines overseen by or within a state department, and provide the resources for additional wraparound services such as mobile crisis programs and other follow-up and outreach. The AFSP Public Policy Office works with local AFSP chapters to connect with local Lifeline centers to partner on suicide prevention awareness, outreach, and training efforts; promote center volunteer needs; and determine center resource needs.

**For advocacy purposes, some questions advocates can ask their local center are:**

- What are your current funding sources/amounts? Is this adequate to meet the caller demand you are currently experiencing?
- What is the center doing well that you’d like to see continue?
- What challenges are currently facing the center that increased funding/resource support could address?
- What individuals/groups are you currently working with to increase support for the center? How can I get involved?

With a basic idea of what the center needs and who they are working with, advocates can educate state and local stakeholders and meet with their own public officials to advocate on behalf of the crisis center. In addition to the information gathered from their local center, advocates are also encouraged to utilize data from the Lifeline State Reports (suicidepreventionlifeline.org/lifeline-state-reports) and AFSP State Fact Sheets (afsp.org/statefacts).

During meetings, advocates can use the information gathered from each of these resources to: (1) demonstrate the scope of suicide risk and caller demand and show capabilities and challenges; (2) share their personal story of how suicide has impacted them and if applicable, their experience with the local call center or the Lifeline more broadly; and (3) share what they learned from the crisis center regarding their successes and challenges, providing a clear picture of what additional funding and support could help them achieve.

Finally, the passage of a more easily recognized three-digit number (988) and a related public awareness campaign will likely result in higher call volumes, and centers already at capacity will need even more help. More calls will require more trained personnel to answer the phones, mental health professionals to do the training and supervise shifts, and advanced infrastructure.
upgrades. If no action is taken and funding stays flat, centers will close or callers in distress will be placed on hold or routed outside their local area. If and when a three-digit number becomes reality, it will be imperative for advocates to work with stakeholders to discuss how this could exacerbate state and local access and crisis center resource needs, and what the possible solutions may be.

References:

About the Lifeline. (n.d.). Retrieved from https://suicidepreventionlifeline.org/about/


