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Challenges to Just and Effective 988 Implementation: Workforce

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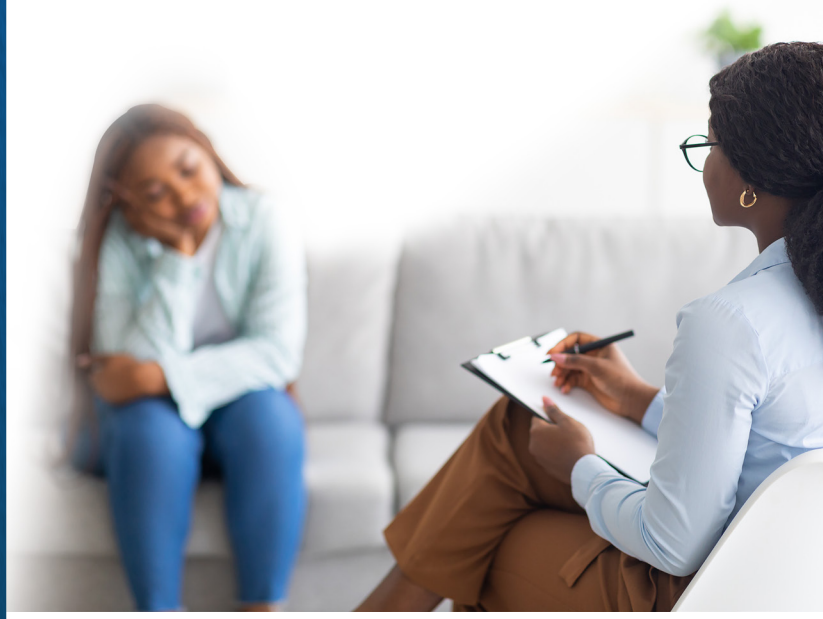
The National Suicide Hotline Designation Act, which was signed into law after receiving bipartisan support in 2020 and launched in 2022, authorized 988 as the new three-digit number for people experiencing suicidal, mental, and behavioral health crises.



The 988 Suicide & Crisis Lifeline (988 or The Lifeline) is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by Vibrant Emotional Health (Vibrant).[1] As 988 is rolled out, there is growing concern from policymakers, advocates, and community members around its implementation and impact on those seeking mental and behavioral health services, especially for marginalized young people.

This is the third in a series of fact sheets exploring the challenges and missed opportunities to effectively implement 988 and transform our existing mental and behavioral health crisis response system. This fact sheet focuses on the impact of mental and behavioral health workforce shortages on just and effective 988 implementation.

One Year at a Glance

- Since launching in July 2022, 988 has received almost 5 million contacts, of which nearly 1 million are from the Veterans Crisis Line, a part of 988. The rest consist of 2.6 million calls, over 740,000 chats, and over 600,000 texts.[2]
- Since its implementation, 988 has seen decreased response times[3] and improved response rates.[4]
- More than 200 local and state-run call centers with crisis counselors support people in need, share resources, and make community connections.[5]
- Twenty-six states have enacted legislation to implement 988.[6] Of these states, only five have enacted legislation to sustain 988 through telecommunication fees. Thirteen states have set up funds to support 988 implementation.[7]

Mental & Behavioral Workforce Challenges in the Midst of 988 Implementation

Law enforcement and the criminal legal system have long been the primary responders and providers of mental health services for Black youth. This is due in part to the significant shortage of quality behavioral health providers,[8] and the substandard infrastructure of the mental and behavioral health system. As of April 2023, every state was operating at least one 988 crisis center, and 20 states reported independent crisis centers outside the 988 network. This gap in the coordination of services can impact access and the quality of care that people receive when seeking services through 988.

Even before the pandemic, the mental and behavioral health system experienced staff shortages. Since the pandemic, the demand for mental and behavioral health support in communities has increased, while the workforce continues to decrease.[9] As 988 was rolled out, crisis centers rationed services and restricted access to frequent callers, as allowed by the Lifeline's policy, due to a lack of capacity and coordination between crisis response and longer-term services that prevent the needless institutionalization or incarceration of people with disabilities.

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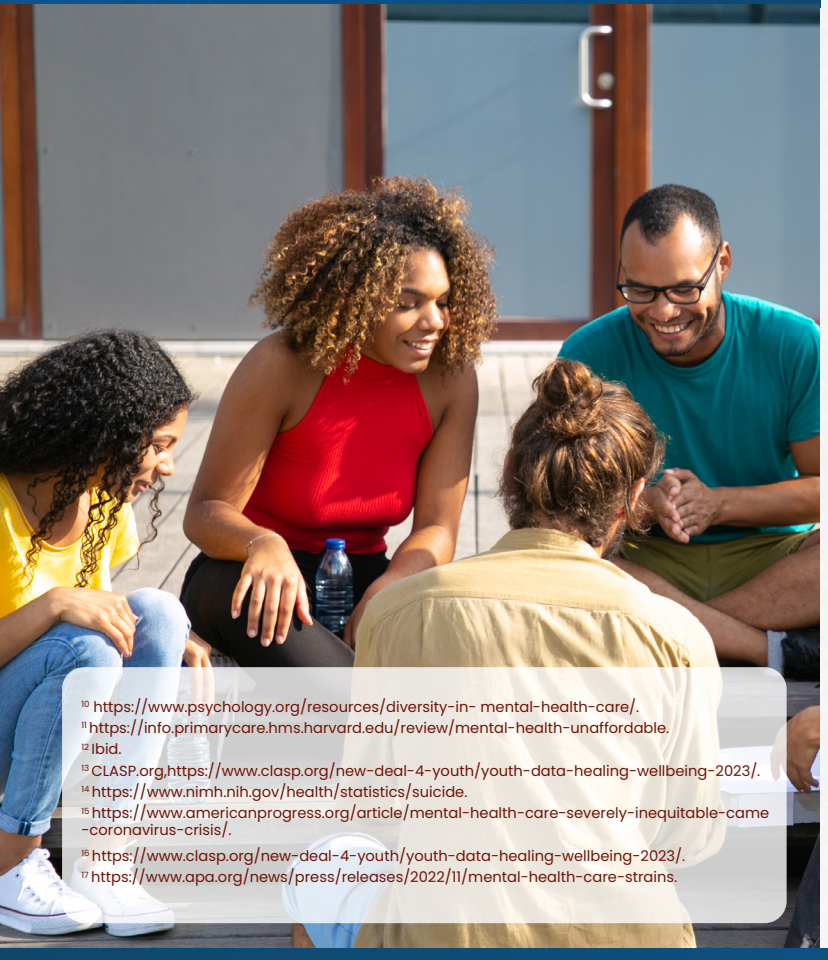
[1] https://www.samhsa.gov/newsroom/press-announcements/202106161430.
[2] https://www.samhsa.gov/sites/default/files/988-one-year-anniversary-fact-sheet.pdf.
[3] The average speed to respond to people decreased from 2 minutes, 39 seconds to 41 seconds nationally. Ibid.
[4] 1,135% more texts were answered, 141% more chats were answered, 46% more calls were answered. Ibid.
[5] Ibid.
[6] https://nashp.org/state-tracker/state-legislation-to-fund-and-implement-988-for-the-national-suicide-prevention-lifeline/.
[7] Ibid.
[8] https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage.
[9] https://www.apa.org/news/press/releases/2022/11/ mental-health-care-strains.

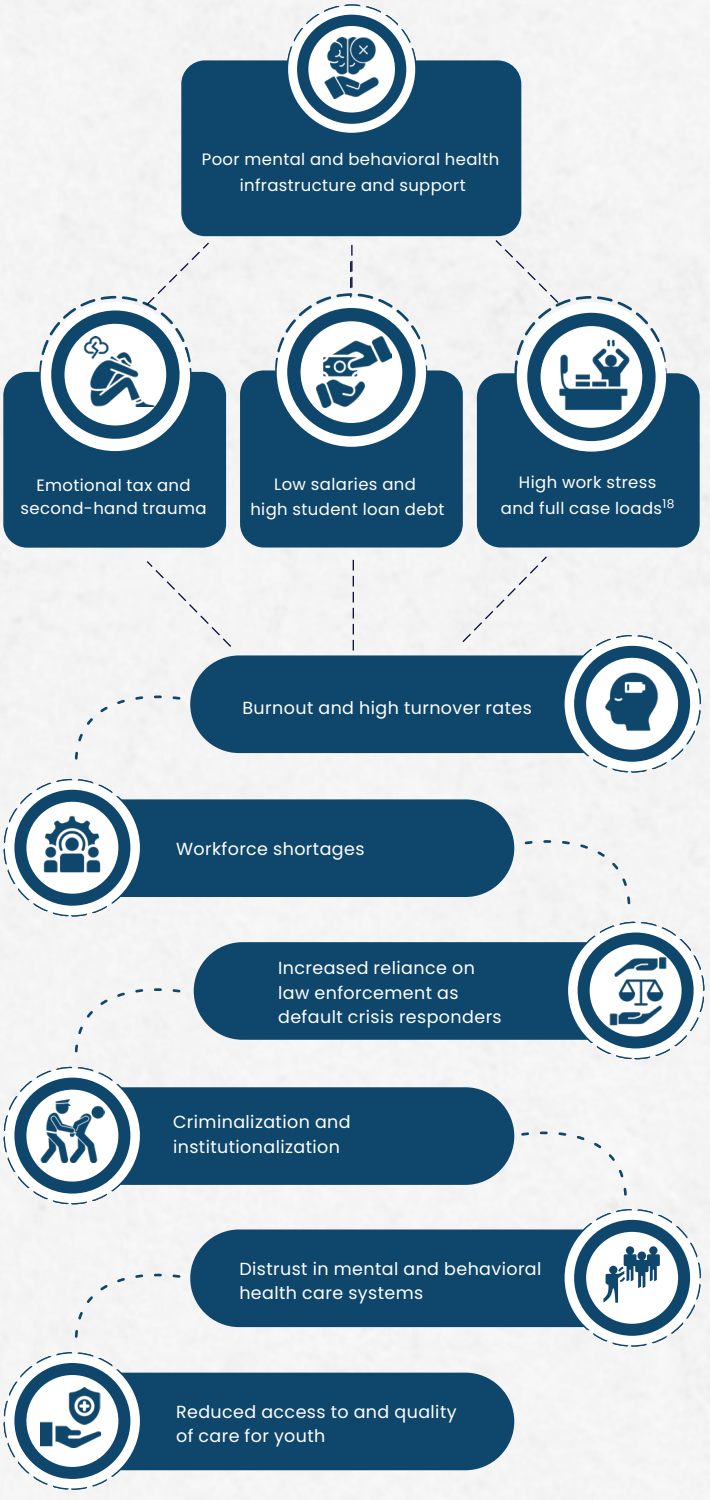
A **combination of factors** including the provider shortage, the lack of diversity in the mental health workforce,[10] high health care costs,[11] distrust of clinical providers, and a lack of insurance coverage for mental and behavioral health services has created barriers to accessing mental and behavioral health care:[12]

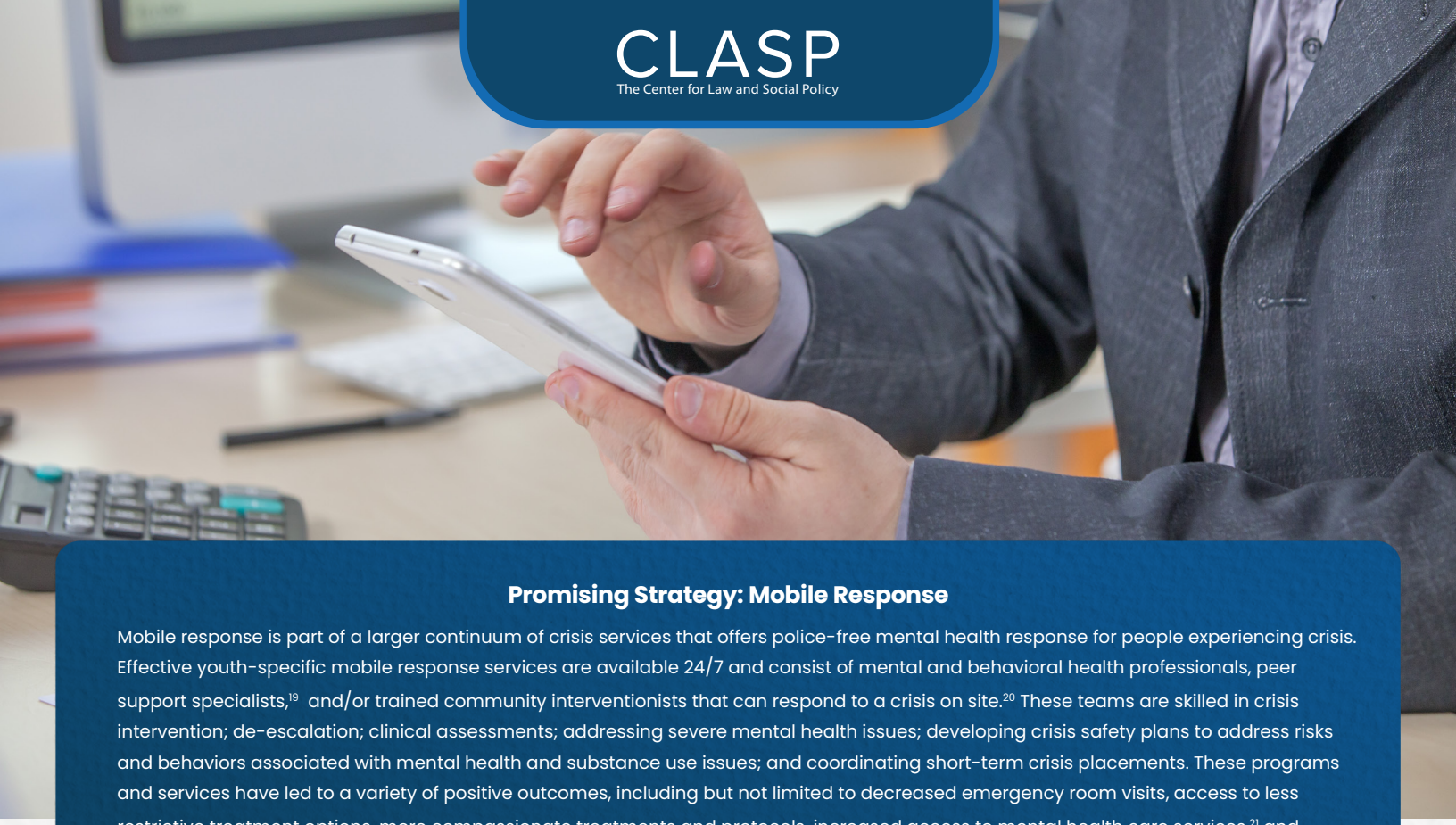
- In 2023, **74 percent of young people** reported extraordinarily high levels of depression and anxiety.[13]
- **Suicide was the second-leading cause of death** among individuals between the ages of 10-14 and 25-34 and the third-leading cause of death among individuals between the ages of 15-24 in 2020.[14]
- In 2016, **11.8 million Americans had a need for mental and behavioral health services that went unmet.** Of this population, about 38 percent could not afford the cost of treatment.[15]
- **Young adults have the highest uninsured rates of any age group in the United States.** Thirteen percent were uninsured in July 2022, and 16 percent were uninsured in July 2023.[16]
- **Nearly half (46 percent) of practitioners** reported being unable to meet the demand for treatment, and **nearly three-quarters (72 percent)** have longer waitlists than before the pandemic.[17]



[10] https://www.psychology.org/resources/diversity-in- mental-health-care/.
[11] https://info.primarycare.hms.harvard.edu/review/mental-health-unaffordable.
[12] Ibid.
[13] CLASP.org,https://www.clasp.org/new-deal-4-youth/youth-data-healing-wellbeing-2023/.
[14] https://www.nimh.nih.gov/health/statistics/suicide.
[15] https://www.americanprogress.org/article/mental-health-care-severely-inequitable-came-coronavirus-crisis/.
[16] https://www.clasp.org/new-deal-4-youth/youth-data-healing-wellbeing-2023/.
[17] https://www.apa.org/news/press/releases/2022/11/mental-health-care-strains.

Mental and Behavioral Health Workforce Challenges





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Promising Strategy: Mobile Response

Mobile response is part of a larger continuum of crisis services that offers police-free mental health response for people experiencing crisis. Effective youth-specific mobile response services are available 24/7 and consist of mental and behavioral health professionals, peer support specialists,[19] and/or trained community interventionists that can respond to a crisis on site.[20] These teams are skilled in crisis intervention; de-escalation; clinical assessments; addressing severe mental health issues; developing crisis safety plans to address risks and behaviors associated with mental health and substance use issues; and coordinating short-term crisis placements. These programs and services have led to a variety of positive outcomes, including but not limited to decreased emergency room visits, access to less restrictive treatment options, more compassionate treatments and protocols, increased access to mental health care services,[21] and removing insurance as a barrier to receiving mental health services.

Conclusion

988 should be connected to mobile response teams, and these teams must be sufficiently funded to operate at their full capacity. Responders should have access to the support that they need, including livable wages and mental health care, to effectively offer services to youth experiencing crisis. Provisions to expand the mental and behavioral health workforce and create opportunities for peer support[22] and other community-based entities to fill in the gaps will help address the mental and behavioral health crisis.

In particular, peer support should be instituted as a sustainable career option for young people where reimbursement rates reflect market rates and a living wage. States should pursue a diverse array of funding sources for youth peer support, both within and outside of Medicaid, and youth peer supporters must have strong career ladders.[23] When states do not have the infrastructure for effective and equitable implementation, law enforcement becomes the default response. To safely implement police-free mobile response teams, policymakers and care providers must address the mental and behavioral health workforce shortage.

[18] https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep22-06-02-005.pdf.
[19] https://www.clasp.org/wp-content/uploads/2023/07/2023.7.27_Youth-Peer-Support-Report.pdf.
[20] https://www.clasp.org/wp-content/uploads/2022/01/Youth-Mobile-Response-Services_0.pdf.
[21] https://newdealforyouth.org/wp-content/uploads/2022/09/ND4Y-Response-to-Finance-RFI_Young-Adult-Mental-Health_final.pdf.
[22] https://www.clasp.org/wp-content/uploads/2023/07/2023.7.27_Youth-Peer-Support-Report.pdf.
[23] Ibid.