



Helplines for Mental Health Support: Perspectives of New York State College Students and Implications for Promotion and Implementation of 988

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Abstract

Mental health and suicide are serious concerns in the U.S. Though many adults report struggling with their mental health, a significant proportion do not receive care for various reasons including stigma, limited availability, long wait times, inability to pay, and a lack of culturally appropriate options. Helplines can be used to fill gaps in care and, though currently underutilized, are a significant focus of the federal government in the implementation of 988. To better understand the factors that facilitate and impede the utilization of helplines, we conducted 14 focus groups with 95 college students attending a public university and two private colleges in upstate New York between April 2019 and October 2020. Participants included undergraduates, graduate students, LGBTQIA+ students, student-athletes, and international students. Participants shared several reasons for using helplines including convenience, comfort, immediate support, and privacy and anonymity. On the other hand, participants expressed hesitation as they expected ingenuine interactions with operators and a lack of continuity, they feared police involvement, and they felt that helplines are not for them, as they are marketed for those in a mental health or suicide crisis and their issues are not that severe. LGBTQIA+ participants provided additional reasons as to why they use and do not use LGBTQIA+-specific helplines. Together, our findings suggest the need for improved education, marketing, and training around helplines and may be used to inform the implementation and promotion of 988 in its early stages.

Keywords Mental health · Suicide · Suicide prevention · Mental health care · Crisis lines · 988

Introduction

Mental health and suicide are serious concerns in the U.S. In 2021, 47,646 Americans died by suicide, representing a 4% increase from 2020 alone (Curtin et al., 2022). Another 57.8 million had any mental illness (AMI) in the past year in 2021 – with 21.0 million reporting a past-year major depressive episode (MDE) – and 12.3 million had thoughts

of suicide, 3.5 million made suicide plans, and 1.7 million attempted suicide. Two-thirds reported that the COVID-19 pandemic affected their mental health (SAMHSA, 2022b).

Compared to other age groups, young adults ages 18–25 experienced more mental health-related morbidity in 2021. For example, 18.6% reported a past-year MDE compared to 8.3% of adults 18 and above. Another 13.0% had thoughts of suicide and 2.7% attempted suicide compared to 4.8% and 0.7% of adults 18 and above, respectively (SAMHSA, 2022b).

Though young adults ages 18–25 account for a greater proportion of MDE and suicidal thoughts and behaviors than the general adult population, they are less likely to receive mental health treatment and more likely to perceive an unmet need for care. For example, only half who had experienced a past-year MDE received mental health treatment in the past year (vs. 61.0% among adults 18+ with a past-year MDE) (SAMHSA, 2022b). In addition, almost

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half (44%) with AMI and two-thirds (65%) with a serious mental illness (SMI) reported an unmet need for mental health services (vs. 27.6% among adults ages 18+ with AMI and 51.5% among adults 18+ with SMI) (SAMHSA, 2022b).

While there is a significant need for mental health services, particularly among young adults, there are several access and utilization barriers – especially among rural communities, racial/ethnic minorities, veterans, and LGBTQIA+ populations – including stigma, limited access to services, long wait times and travel distances, lack of insurance and inability to pay, and care that is not culturally tailored to meet the needs of specific populations (Cummings et al., 2017; Harris et al., 2023). Mental health helplines, often referred to as crisis lines, are available to fill gaps in services and provide immediate, anonymous support to those facing access barriers. These helplines, such as the National Suicide Prevention Lifeline (NSPL) and Crisis Text Line (CTL), connect users with trained counselors and crisis resources via call, text, or chat 24 h per day, seven days per week (SAMHSA, 2022c). Though these helplines have been found to significantly reduce distress among individuals using call and chat functions (Gould et al., 2007, 2021) they remain underutilized. In fact, a recent national study found that only 2.5% and 0.5% of the U.S. population reported lifetime or past-12-month use of a crisis helpline; a majority of these callers were females (71.1%), non-Latino White (81.0%), between the ages of 35 and 49, reported having a clinical disorder (83%), and had previously accessed mental health care (96%). This suggests that a large group with unmet needs that may experience access barriers to traditional services are not utilizing helplines (Roth & Szlyk, 2021).

We conducted a qualitative study with college students in upstate New York to examine the factors that facilitate and impede the utilization of helplines among young adults. Since we conducted our study, \$1 billion in federal funding was allocated to support the transition of NSPL to the 988 Suicide and Crisis Lifeline with the goal of increasing access to a national network of over 200 local, independent, and state-funded crisis centers (SAMHSA, 2022c). Our study sheds light on several themes – both positive and negative – that can be used to inform the implementation and promotion of 988 in its early stages. Though we focused our study

on college students to gain access to a young adult population that is experiencing disproportionate levels of mental health morbidity and unmet need, much of the conversation and results are applicable to the greater U.S. population and are included as part of our discussion.

Materials and methods

Participants

We conducted 14 focus groups with 95 racially and ethnically diverse college students ages 18 and above from one public university and two private colleges in upstate New York between April 2019 and October 2020. Participants were 67% female and included undergraduates, graduate students, student-athletes, LGBTQIA+ students, and international students. Table 1 provides a breakdown of participants by student group.

Materials

We developed a facilitation guide that included the purpose of the study, the informed consent process, mental health resources, and brief participant introductions. It also included several questions for students related to help-seeking: (1) what they would do if they or a peer were feeling overwhelmed, depressed, or suicidal; (2) what on- and off-campus services, resources, and supports they are aware of, which they have used, and what they thought of them; (3) who they turn to for support; and (4) situations in which they would use helplines in place of talking to a friend, family member, or counselor. For those who were not familiar with helplines, we described their purpose and provided CTL, NSPL (or what is now called 988), Trevor Project, and TransLifeline as examples.

Procedure

We created and distributed flyers about our study to students via professors and student listservs. Our full recruitment process is published elsewhere (Harris & Maher, 2022).

We conducted the first seven focus groups in person in a convenient location on campus and the remaining seven virtually via Webex for the safety of participants during the COVID-19 pandemic. We obtained consent from all participants to take part in the research prior to their participation. Our full consent process is published elsewhere (Harris & Maher, 2022).

We staffed each focus group with two to three study team members, two co-facilitators and one notetaker. Having an additional facilitator prepared us to assist any participant

Table 1 Focus group participants by student category

Student Group	n	%
Undergraduates	30	31.6
Graduate Students	22	23.2
Student-Athletes	20	21.1
LGBTQIA+ Students	19	20.0
International Students	4	4.2
TOTAL	95	

activated or challenged by the conversation. Facilitators also provided information about university counseling services, peer support lines, CTL, and NSPL. The focus groups lasted approximately 90 min and were audio-recorded and transcribed. We provided in-person participants with physical gift cards at the end of the focus group, and we mailed virtual participants their gift cards following the focus group. All research protocols were approved by the Nathan Kline Institutional Review Board (IRB) as research protocol ID 1401131-10; all participating college and university IRBs recognized the Nathan Kline Institute as the IRB of record.

We conducted a thematic analysis of the focus group transcripts. We engaged in a multi-stepped process including: (1) developing a codebook, (2) coding transcripts in Microsoft Word to organize the raw data, (3) discussing and coming to agreement on how the text was coded, and (4) categorizing and grouping the coded content into themes and sub-themes. Our detailed process is published elsewhere (Harris & Maher, 2022). The author certifies responsibility for the manuscript, and there are no known conflicts of interest.

Results

Participants described multiple sources of stress, a need for mental health services and supports, and several access barriers. When asked about their use of helplines (e.g., CTL, NSPL), many were unaware of these services and confirmed they had not seen any marketing or promotion either on campus or in the community. Once we described them, many had a preference for traditional face-to-face mental health services or support of family and friends but felt there were specific situations and reasons for which they would use or not use them. These reasons are summarized in Table 2 and described in detail below.

Table 2 Summary of themes around use of helplines

Reasons for Using Helplines	Reasons for Not Using Helplines
Increases comfort with sharing their struggles	Lack of connection and continuity
Convenient and provides help in the moment	Focus on suicide and crisis intervention too far downstream
Provides privacy and anonymity	Marketed and promoted for mental health and suicide crises
LGBTQIA+ services provide affirming support	Fear of police involvement
	LGBTQIA+ services focused only on LGBTQIA+ issues
	Not queer enough to use LGBTQIA+ services

Reasons for Using Helplines

Increases Comfort with Sharing their Struggles

Participants described discomfort and embarrassment as a barrier to seeking in-person mental health care. Because these issues are hard to talk about and many feel ashamed admitting they are struggling, they felt helplines could be a good way to get comfortable sharing their feelings. One participant explained:

I feel like people would be a lot more comfortable using the helpline first, and once they talk to someone there, it might open up their perspective and push them towards seeking in-person help, be more comfortable with that. I feel like talking to someone in person can be harder for someone to open up and actually discuss how they're feeling rather than if it were by phone or texting.

Convenient and Provides Help in the Moment

Most participants described their inability to get timely mental health care due to busy schedules, long wait times, and a cumbersome scheduling process, leading them to forego care.

One participant explained:

I thought it would be an immediate thing because, in that moment, I was immediately dealing with my negative feelings. You reach out to a person because you need help at that moment, and then you have to fill out all this paperwork and need to wait another two weeks to get help, that that just doesn't feel right. So, I didn't do it and just ended up being by myself, because I was like, "that's too much work in that moment."

Participants expressed that texting options help remove some of these barriers, as texting is easy to fit into their busy schedules. One participant explained:

Being college students, we don't have the time to sit for an hour. When I'm in my therapy session, I think about all the things I'm not getting done. The texting I could do while doing other things. Texting is just more beneficial to college students.

Participants further emphasized that helplines could provide "help in the moment" for a one-time need, while waiting for an intake appointment, or between appointments. Several

students stated that helplines are a last resort when unable to get timely care. One participant shared:

I had a depressive episode maybe a week and a half ago. I called the health center because I wanted an appointment, sorry if I cry, because I was feeling suicidal about a situation that happened on my campus, and the closest appointment they had was a month after. The only thing left was to call a suicide prevention hotline.

Provides Privacy and Anonymity

Many participants described the privacy and anonymity of helplines as beneficial, admitting that it can be hard to talk to friends and family about their mental health. One participant explained her preference for helplines over friends and family in certain situations:

I call hotlines because there are just some thoughts you shouldn't say to people; you know, I love my friends and they support me as much as they can, but there are just some thoughts that I know if I said to them, I would mentally scar them forever...so the idea of a stranger on the line is a lot better because that stranger can't judge me.

Participants went further and pointed out how texting adds additional privacy and anonymity, since people cannot hear you or recognize your voice, making it more comfortable and user-friendly when experiencing overwhelming emotions, especially for those living with others. One participant explained his preference for texting:

I've called crisis lines in the past. When I explain how I'm feeling they kind of jump to a conclusion that I need to be admitted to the hospital, and it's like "no no no I don't need that I just need to get through in this moment and I will be okay." But being in the hospital, I'm not being productive. I'm not able to keep studying, it just stops everything. When I text, I'm able to hide the urgency in my voice...It's more anonymous in a way, it's just more comfortable for me.

Reasons for Not Using Helplines

Lack of Connection and Continuity

Though they described helplines as convenient, participants were concerned about continuity and wondered what would

happen when the conversation ended. They also felt that operators "go by a script" and, as a result, they would not receive the personalized and empathic support they need. One participant explained:

You call a lifeline, and you don't know who you are talking to. It's this anonymous person who you're telling your feelings to, and they're just going by a script. People know you're going by a script at this point, so everything you're saying to me, I don't feel like it's genuine. I feel like you have to say this.

The Focus on Suicide and Crisis Intervention is Too Downstream

Participants overwhelmingly expressed a need for non-crisis mental health resources and supports and wondered why current efforts were focused more narrowly on suicide and crisis intervention. One participant lamented:

It's not to say that it's bad that people focus on suicide, but we're in a world where mental health is only tragic when you're about to kill yourself or you have killed yourself. Before that point, you are a burden to society, but you're not at a point where you should be helped. You're supposed to just man up and deal with it yourself.

Another participant further illustrated the need for helplines as a resource for non-crisis situations by explaining the significant, long-lasting impact suicidal intent and behavior can have on one's mental health:

When suicidal ideation turns into suicidal pre-actions, I think your brain never gets off that. If I had suicidal ideation, I can cope with that, but if I had the first thought of "I might actually do that," that terrifies you and changes your entire perspective on life and reality in general. I was taught "talk to your parents," but my parents are not supportive, so it's like who else am I supposed to talk to?

This participant and others underscored that, if helplines were more broadly available for mental health, not only would there be another resource to address mental health issues before they escalate into a crisis, but it would avoid the life-long anguish that follows the crisis.

Marketed and Promoted for Mental Health and Suicide Crises

Participants overwhelmingly indicated that the major helplines CTL and NSPL are marketed and promoted for suicide and mental health crises; simply including the words “crisis” and/or “suicide” in their names suggests they are only for those who are thinking about suicide or in crisis. As a result, most participants explained they would not use them, because their issues do not amount to a crisis; they did not want to take resources away from those who need them more. One participant explained:

I haven’t used the suicidal hotline, I’m not suicidal, I have mental health and stress issues, so I feel like none of those hotlines are made for me, that I’m taking that time away from someone who is about to kill themselves...People apparently...don’t need help unless they’re suicidal. It’s never like “oh let’s help them before they even get to the point of thinking of killing themselves.”

Participants emphasized the need for improved naming and marketing of these helplines so that people know they can use them for emotional distress and not just if they are in crisis. One participant commented specifically on the name Crisis Text Line:

I read the word crisis and it makes me feel like I’m not...able to call that hotline. I feel like someone needs to call who is about to kill themselves. That’s what the hotline’s made for and therefore I shouldn’t call it... Maybe I’m wrong that [mental health hotlines] don’t exist, but they need to be promoted as such. Not just for a crisis like you’re going to try to kill yourself but for a mental health hotline if you’re feeling depressed or if you’re having a panic attack or a mental breakdown, that’s a place you can call. That needs to be properly advertised.

Fear of Police Involvement

Participants described the potential for police involvement as a significant deterrent to using helplines. In fact, several had witnessed campus public safety officers retrieving students in crisis, describing it as traumatizing and explaining how it made the students’ issues worse. They were afraid this could happen to them if they used a helpline. One participant explained:

I’ve witnessed that happening where somebody was in crisis and reached out and [public safety] came in and got the person from their room...no warning and just came and told them they have to leave...That was, I think, even more dramatic than it should have been...I know personally that person really felt like that escalated the issue, because they drew too much attention to it. Clearly, they were having an issue, and now everyone knows [about it].

LGBTQIA + Helplines

We asked participants in the LGBTQIA+ focus groups about their use of LGBTQIA+ helplines (e.g., Trevor Project, TransLifeline). Reasons for and against using them are provided below.

Reasons for Using LGBTQIA + Helplines

Provide Affirming Support Participants in the LGBTQIA+ focus groups indicated they would use LGBTQIA+ helplines to avoid dealing with ignorant or judgmental friends, family, or counselors. One participant explained how these helplines could be a source of support for her.

I don’t feel like I can talk to my parents about any of my issues, because...my dad, he’s very homophobic...[He] is southern and, in the black community, it’s not as open to be gay. I remember a comment my dad made to me, like “your sister is in Atlanta, don’t let her come back gay,” and it’s just like, “what does a city have to correlate with sexuality?” And it’s like “my sister’s not gay, I am” so it’s just like, “well thanks, thanks so much.” So, I don’t feel like I can talk to my parents about any of the issues I experience being bisexual or anything of that matter. I feel like I have to go elsewhere.

Participants further explained that these helplines allow them to speak to someone who understands LGBTQIA+ experiences and terminology and stated that, for many, it could be their first opportunity to explore their identity and to express feelings to other LGBTQIA+ people.

Reasons for Not Using LGBTQIA + Helplines

Focused only on LGBTQIA+ Issues Many participants in the LGBTQIA+ focus groups admitted they would not use LGBTQIA+ helplines, because they are solely focused on

mental health issues related to LGBTQIA+ identity and discrimination. One participant explained.

That's primarily the reason why I have never used LGBTQ+specific hotlines or just services in general, because to me, it felt that all these services are for LGBTQ+people who are dealing with certain mental health issues because they faced discrimination or they don't feel right in their bodies or how they are feeling in their sexuality, and I've faced all of those problems, but I've never necessarily felt like my mental health issues were surrounded by the fact that I am part of the community.

Another participant agreed, pointing out that using LGBTQIA+ services prevents them from exploring the root causes of their issues:

Every time I've used an LGBTQ+hotline, I don't really prefer them, mostly because I feel like there is that idea that you're part of the LGBTQ+community, therefore you face discrimination, therefore that's the root of all your mental health issues, and it's not like that. With all of the therapists I have seen, there always has to be a distinction where I have to say "Yes I'm gay, but that has nothing to do with any of this other stuff." Like it's not even in the realm of the ballpark... Maybe some people are still suffering from that,...but I've been through that, I've done it, and I'm not doing it again.

Not "Queer Enough" Several participants in the LGBTQIA+ focus groups explained that they had experienced discrimination from within the LGBTQIA+ community and did not feel "queer enough" to use an LGBTQIA+ helpline. One participant explained her experience being asexual.

As an asexual person, I want to be part of the community, but we're so much at odds with it and who accepts us and who doesn't, sometimes I feel that I'm taking resources away from a community that I am not part of, and that's really awkward for me. I want to be part of the LGBTQ+community, and all of my friends say that I am, but I know there is a huge group of people who are like "you're not part of the community, you're not allowed to use these resources."

Discussion

In this qualitative analysis of focus group data collected from college students in upstate New York, we examined the use of helplines as a form of mental health help-seeking. Participants in our study stated several reasons for using helplines including getting them comfortable talking about their mental health, having an immediate need, and wanting to talk privately and anonymously. They also provided multiple reasons for not using them including a lack of awareness, scripted responses, a lack of continuity, a fear of police involvement, and that their issues are not serious enough. These findings are timely given the \$1 billion in federal funding allocated to 988 and have implications for marketing, promotion, and implementation of this important service.

First and foremost, participants in our study were largely unaware of helplines such as CTL and NSPL. This finding is consistent with national polls; in late summer of 2022, only 21% of Americans reported being very familiar with NSPL, only 11% were very familiar with 988, and 43% had not even heard of 988 (Harris Poll, 2022). In addition, participants in our study overwhelmingly reported wanting to help their friends who were struggling with their mental health but did not know what to say or do; they were not aware that they could contact a helpline to assist or guide them. Once informed of these helplines and their purpose, many participants in our study seemed interested in using or referring friends to them, especially for their anonymity, which is critical given the stigma associated with mental health and its role as a barrier to help-seeking (Harris et al., 2023). Participants suggested raising awareness of helplines in a non-stigmatizing manner via course syllabi, college and university websites, email communications, and on campus centers and including helpline numbers on student ID cards.

Beyond a basic lack of awareness, participants in our study provided input and feedback on the way helplines are currently marketed and promoted. They explained that CTL, NSPL, and now, the 988 Suicide and Crisis Lifeline, are all marketed for suicide and mental health crises. As a result, participants in our study felt these services were not for them, claiming that their issues do not amount to a crisis, and they do not want to take resources away from those who need them more. Our study is the first to capture a detailed account of how the names of the helplines alone would deter people from using them. Though a less detailed account than ours, this finding is consistent with a recent NAMI focus group study of individuals who had experienced a mental health crisis; these participants explained that their crisis does not rise to the level of being suicidal so felt that suicide hotlines are not for them (NAMI, 2022). This suggests our

results are generalizable outside of the college student and young adult population.

In addition, participants did not feel that the mental health challenges they were facing were serious enough to use CTL or NSPL and that a non-crisis “mental health hotline” would be more appropriate. They were surprised to hear that CTL, NSPL, and other helplines can and should be used for non-crisis concerns such as depression, anxiety, substance use, and relationship issues. This finding is significant, as it is the first to examine awareness of and need for helplines as general mental health resources rather than crisis-only services. Existing polls and qualitative studies have not measured this (Harris Poll, 2020; Harris Poll, 2022; NAMI, 2021; NAMI 2022), though one uncovered that only 23% reported they would call or text 988 for a substance use issue compared to 51% for thoughts of suicide (Harris Poll, 2022). This suggests a lack of awareness of the upstream uses of helplines and implies that marketing and promotional strategies advertise them accordingly while minimizing the appearance of “suicide” and “crisis” in logos and other marketing materials.

Participants described several other reasons they would hesitate to use a helpline. First, they were concerned they would not receive personalized or empathic care, confirming the findings of another study (NAMI, 2022). This concern is valid and inherent in the functioning of a helpline, as operators are unable to read a caller’s non-verbal behavior and are challenged to deliver culturally relevant counseling due to caller anonymity (Stoll et al., 2020).

Building upon the literature, several participants who identified as LGBTQIA+ voiced a preference for general helplines, explaining that operators of LGBTQIA+ helplines assume their issues are related to their sexual orientation or gender identity rather than genuinely assessing their needs in the moment. This is an important finding, as the new LGBTQIA+ function of 988 routes LGBTQIA+ callers to the Trevor Project (Chatterjee, 2023), underscoring the need to provide clear guidance to 988 operators on who should be routed to this service and when. It is also suggested that operators receive recurring training on empathy, active listening, motivational interviewing, and culturally appropriate and affirming support, regardless of whether they work on a general helpline or an LGBTQIA+-specific helpline.

Participants in our study also expressed concern that police would get involved if they used a helpline, consistent with the findings of another study (NAMI, 2022) and with the common concerns and misperceptions about 988 voiced on social media. The social media posts urged people not to use or share 988 due to risk of police involvement, involuntary treatment, and the negative outcomes this can cause (Pattani, 2022) such as a higher risk of suicide after discharge (Jordan & McNiel, 2019) and a future reluctance

to disclose thoughts of suicide (Jones et al., 2021). Alleviating this concern, NSPL data indicate that, prior to the launch of 988, emergency services were only dispatched in 2% of NSPL interactions and, in many of those cases, these were mobile crisis teams (Pattani, 2022). Furthermore, 988 operators now receive training on alternatives to police involvement and the impact that involving police may have (Pattani, 2022). Therefore, it is important that 988 and other helplines educate the public and their callers so that their process is clear and transparent prior to and at the outset of a call or text; this may include how the call will proceed, when active rescues are initiated and what they entail, the process of referral and connection to community-based care, and any testimonials from past callers.

A last hesitation expressed by participants in our study was a lack of continuity, consistent with the findings of another study (NAMI, 2022). First and foremost, concerns have been raised about a lack of trained personnel to answer and manage calls to 988. Capacity to answer calls in-state varies, ranging from 51% in Alabama to 98% in Rhode Island and Mississippi (Saunders, 2023). Furthermore, though 988 is supposed to connect callers with local providers for follow up appointments, the NAMI study reported skepticism that appointments will be available (NAMI, 2022). The skepticism is valid, as the 45% increase in call volume to 988 is expected to create a significant burden on an already strained behavioral healthcare system (Saunders, 2022). In fact, a recent study highlights significant gaps in crisis care within communities across the country (Harris et al., *under review*), while several smaller studies highlight inconsistent delivery of evidence-based mental health and suicide care within local and regional health systems (e.g., Gamarra et al., 2015; Harris et al., 2021; Vanoy & Robbins, 2011). Though increasing community capacity to support the rollout of 988 is a goal of the Substance Abuse and Mental Health Services Administration (SAMHSA), it will take significant time and effort to achieve it (SAMHSA, 2022c). To begin working toward this goal, it is suggested that communities plan to build their infrastructure using methods such as Crisis Intercept Mapping (SAMHSA, 2022a) and that health systems take inventory of their policies and procedures using tools such as the Zero Suicide Organizational Self Study (EDC, *n.d.*).

Limitations

Our findings should be interpreted in light of several limitations. First, this research was conducted in three colleges and universities in Upstate New York with a sample size of 95, making it difficult to generalize our findings to college students or young adults across the country or to the general public. However, findings from our sample of college

students were consistent with and built upon findings from the general public, making them useful for informing future education and promotion around helplines. Second, because participants self-selected into the study, they may have had more personal experience with mental health than those who did not participate, biasing the responses we received toward the negative. Third, because of the nature of focus groups, participants may have been influenced by the responses of others, leading them to provide positive or negative experiences or feedback depending on what others were sharing. Last, half of the sessions were conducted in person while the other half were conducted virtually during the COVID-19 pandemic, a time when students were faced with unique challenges. The impact of this limitation was minimal, as we did not probe for issues related to the pandemic, and participants were as open and honest via Webex as they were in person.

Conclusions

Despite these limitations, our findings identified multiple reasons for and against using helplines and suggested several recommendations for increasing utilization including improved education, marketing, and training. Given the significant amount of federal funding appropriated to 988, these recommendations are timely and may inform the implementation and promotion of this important service. Future research should examine the use of 988 for non-crisis situations, test different marketing strategies to identify what is most effective in attracting non-crisis callers, and explore approaches for marketing campus-specific helplines to college students.

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References

- Chatterjee, R. (2023). 988 lifeline sees boost in use and funding in first months. *NPR*<https://www.npr.org/sections/health-shots/2023/01/16/1149202586/988-lifeline-sees-boost-in-use-and-funding-in-first-months>.
- Cummings, J. R., Allen, L., & Clennon, J. (2017). Geographic access to specialty mental health care across high- and low-income US communities. *JAMA Psychiatry*, 74(5), 476–484. <https://doi.org/10.1001/jamapsychiatry.2017.0303>.
- Curtin, S. C., Garnett, M. F., & Ahmad, F. B. (2022). Provisional numbers and rates of suicide by month and demographic characteristics: United States, 2021. <https://www.cdc.gov/nchs/data/vsrr/vsrr024.pdf>.
- Education Development Center (EDC). (n.d.). Zero Suicide toolkit. Retrieved October 13 (2022). from <https://zerosuicide.edc.org/toolkit>.
- Gamarra, J. M., Luciano, M. T., Gradus, J. L., & Wiltsey-Stirman, S. (2015). Assessing variability and implementation fidelity of suicide prevention safety planning in a regional VA Healthcare system. *Crisis*, 36(6), 433–439. <https://doi.org/10.1027/0227-5910/a000345>.
- Gould, M. S., Chowdhury, S., Lake, A. M., Galfalvy, H., Kleinman, M., Kuchuk, M., & McKeon, R. (2021). National suicide Prevention Lifeline crisis chat interventions: Evaluation of chatters' perceptions of effectiveness. *Suicide & life-threatening behavior*, 51(6), 1126–1137. <https://doi.org/10.1111/sltb.12795>.
- Gould, M. S., Kalafat, J., Munfakh, J. L. H., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide and Life Threatening Behavior*, 37, 338–352. <https://doi.org/10.1521/suli.2007.37.3.338>.
- Harris, B.R., Gallant, K.C., & Mariani, A. (2023) Mental health in rural New York: Findings and implications of a listening tour with residents and professionals. NORC Working Paper Series, WP-2023-001. <https://sbirt.webs.com/Rural-NY-Listening-Tour-Report.pdf>.
- Harris, B.R., Harris, D., Flanagan, E., Mariani, A., Hay, T., & France, D. (under review). Crisis Intercept Mapping for community-based suicide prevention: An assessment of the crisis infrastructure and implications for the rollout of 988. *Crisis*.
- Harris, B.R. & Maher, B.M. (2022) Student-athlete mental health, help-seeking, and service utilization: Implications for a multi-tiered, public health approach on college campuses. *Journal of College Student Psychotherapy*. <https://doi.org/10.1080/8756822.2022.2109548>.
- Harris, B. R., Tracy, M., Comber, K. G., Pechenik, S., & Carruthers, J. W. (2021). Suicide safer care in behavioral health settings: A comparative analysis of perceptions, training completion, and practice between mental health and substance use disorder treatment providers. *Journal of Substance Abuse Treatment*, 126, 108330. <https://doi.org/10.1016/j.jsat.2021.108330>.
- Harris Poll (2020). Public perception of mental health and suicide prevention survey results. https://theactionalliance.org/sites/default/files/suicide_and_mental_health_public_perception_survey_final_report_august_2020.pdf.
- Harris Poll (2022). Public perception of mental health and suicide prevention survey results. <https://suicidepreventionnow.org/static/executive-summary-2022-9c5a59e0f8016f1803570b11cfd3cb29.pdf>.
- Jones, N., Gius, B. K., Shields, M., Collings, S., Rosen, C., & Monson, M. (2021). Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care. *Social Psychiatry and Psychiatric Epidemiology*, 56, 2017–2027. <https://doi.org/10.1007/s00127-021-02048-2>.

- Jordan, J. T., & McNiel, D. E. (2019). Perceived coercion during admission into psychiatric hospitalization increases risk of suicide attempts after discharge. *Suicide and Life-Threatening Behavior*, 50(1), 180–188. <https://doi.org/10.1111/sltb.12560>.
- National Alliance on Mental Illness (NAMI) (2021). NAMI 988 crisis response research. <https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/NAMI-988-Crisis-Response-Report-11-12-2021-For-Release.pdf>.
- National Alliance on Mental Illness (NAMI) (2022). Crisis services: Focus group study report 2022. <https://www.nami.org/NAMI/media/NAMI-Media/Research/NAMI-Crisis-Services-Focus-Group-Study-Report-FA.pdf>.
- Pattani, A. (2022). Social media posts warn people not to call 988. Here's what you need to know. *NPR*. <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>.
- Roth, K. B., & Szlyk, H. S. (2021). Hotline use in the United States: Results from the collaborative psychiatric epidemiology surveys. *Administrative Policy in Mental Health*, 48(3), 564–578. <https://doi.org/10.1007/s10488-020-01089-0>.
- Saunders, H. (2022). Taking a look at 988 Suicide & Crisis Lifeline data, one month after launch. *Kaiser Family Foundation*. <https://www.kff.org/other/issue-brief/taking-a-look-at-988-suicide-crisis-lifeline-data-one-month-after-launch/>.
- Saunders, H. (2023). Taking a look at 988 Suicide & Crisis Lifeline implementation. *Kaiser Family Foundation*. <https://www.kff.org/other/issue-brief/taking-a-look-at-988-suicide-crisis-lifeline-implementation>.
- Stoll, J., Muller, J. A., & Trachsel, M. (2020). Ethical issues in online psychotherapy: A narrative review. *Frontiers In Psychiatry*, 10, 993. <https://doi.org/10.3389/fpsy.2019.00993>.
- Substance Abuse and Mental Health Services Administration (SAMHSA) (2022a). Crisis Intercept Mapping for Service Members, Veterans and their Families (SMVF) suicide prevention. <https://www.samhsa.gov/smvf-ta-center/activities/crisis-intercept-mapping>.
- Substance Abuse and Mental Health Services Administration (SAMHSA) (2022b). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report>.
- Substance Abuse and Mental Health Services Administration (SAMHSA) (2022c). 988 Partner Toolkit. <https://www.samhsa.gov/find-help/988/partner-toolkit>.
- Vannoy, S. D., & Robins, L. S. (2011). Suicide-related discussions with depressed primary care patients in the USA: Gender and quality gaps. A mixed methods analysis. *British Medical Journal Open*, 1(2), e000198. <https://doi.org/10.1136/bmjopen-2011-000198>.

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