

Peer-Operated Warm Lines Technical Experts Panel

Executive Summary & Report

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Realizing Recovery

Policy & Practice Improvement Series

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This document was developed by SAMHSA’s Office of Recovery, while the content and themes outlined within were identified by participants—including technical experts and those with lived experience—during the Peer-Operated Warm Line Technical Expert Panel. Please note that the views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Office of Recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

A special thanks to each participant for their time and dedication to advancing the field of recovery.

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EXECUTIVE SUMMARY

From July 10-11, 2023 the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Office of Recovery conducted the *Peer-Operated Warm Lines Technical Experts Panel*. During the convening, panel members were asked to showcase different types of warm lines from across the nation and engage in establishing a working definition of peer-operated warm lines. These technical expert panelists brought with them great passion for warm lines and their operation. Discussions explored the role of warm lines, the operation of warm lines and their unique needs, and how warm lines and crisis lines can support each other's work. In depth workgroups explored issues around the awareness of and sustainability of warm lines, the integrity of "peer-ness", equity, and research needs. The panel was asked for suggestions that the Office of Recovery and others may continue to move this forward.

Key Findings

Following are key suggestions from the panel that may guide the Office of Recovery, SAMHSA:

- Gain federal support for endorsing the value of and providing funding to warm lines so that they may be directly accessible as an option along the continuum of supports.
- Fund warm lines as an essential part of the U.S. health and social service system. Any funding through state financing systems should be structured to result in more funding for peer-run programs that follow the peer recovery model, and should not become a different, more medicalized "low-level crisis" or "patient monitoring" type service.
- Provide guidance on building a business case to fund, start and maintain warm lines.
- Continue outreach to educate community members about the value of warm lines and reduce stigma and barriers to accessing them.
- Conduct in-depth interviews with warm line managers and directors across the country to capture how supports are provided and funded.
- Create a national warm lines network that shares core services but allows for variation.
- Develop forums where warm line staff, particularly warm line program managers, can share expertise, experiences, barriers encountered, and solutions developed while operating warm lines.
- Promote MOUs between local warm lines and 988 contact centers.
- Define competencies for peer support specialists to operate warm lines and create a national accreditation. Panel members expressed concerns that other organizations have established accreditation programs without consensus from the warm line community.
- Conduct more outreach to engage marginalized communities both in using the warm lines but also in becoming peer support specialists.
- Build capacity and secure funding to expand access to warm lines in underserved areas.
- Provide guidance on how to recruit, hire, and train peers to staff warm lines. An example of such guidance could be a model standards document.
- Develop and fund leadership training for peers who operate warm lines.
- Promote appropriate compensation for peers who operate warm lines.
- Conduct a comprehensive environmental scan of known effectiveness and research related to warm lines.
- Develop a Warmline Center of Excellence or network to capture the wealth of wisdom that is available. Currently, there is no repository that warm line staff may access that

captures peer values, resources for warm lines staff, funding opportunities, and the current research. A federally funded technical assistance center could help fill this need as well. This information clearinghouse should include programming on how to provide a proper and supportive service for callers, and how to define, develop and support the warm line workforce. It should also cover business issues, including how to fund, sustain, and grow warm line provider organizations using both government and private-sector funded business models.

- Offer an annual conference for the warm line community.

MEETING REPORT

DAY ONE

Welcome and Opening Remarks

Paolo del Vecchio, Director of the Office of Recovery, provided background on the Office of Recovery and an overview of the purpose of the meeting.

Background on the Office of Recovery

In September 2021, the Assistant Secretary for Mental Health and Substance Use announced the establishment of the Office of Recovery to promote policies, programs, and services for those in and seeking mental health and substance use recovery. The Office of Recovery has a vital role to advance SAMHSA's commitment to and support of behavioral health recovery for all. The elevation of efforts to reduce barriers to recovery supports and advance systematic changes to promote access to mental health and substance use recovery supports is best strengthened through intra-agency coordination that aligns with the principles and values of recovery, and recognizing the expertise of individuals with lived experience, their families, and caregivers.

SAMHSA's objective through the Office of Recovery is to advance recovery from mental and substance use disorders across the nation. The purpose of this work is to forge partnerships with diverse stakeholders engaged in recovery support and services and to ensure that everyone who pursues recovery, and those yet to discover the value of recovery, can do so without obstacles to access recovery support and live a satisfying life of home, health, community, and purpose.

Paolo del Vecchio shared SAMHSA's National Recovery Agenda's five priorities and how warm lines fit within multiple SAMHSA's priorities including *Enhancing Access to Suicide Prevention and Crisis Care*, *Preventing Overdose*, and *Strengthening the Behavioral Health Workforce*. He discussed diversity, equity, and inclusion and data and evidence as a key strategies for SAMHSA and the Office of Recovery, highlighting how this meeting is aligned with many of SAMHSA's and the Office of Recovery's key goals and principles.

Mr. del Vecchio recognized members of the planning process, meeting organizers, the meeting facilitator, and SAMHSA staff. Welcoming remarks were followed by introductions.

Small Panel Discussion: The Range of Peer-Operated Warm Lines

Moderator:

Lisa St George, National Peer Support Expert

Panelists:

Trenda Hedges, Illinois Mental Health Collaborative
Beverly Ragland, Georgia Council for Recovery
Dunya Barash, Families Against Narcotics, Michigan

A group of panelists from different areas of the nation representing various perspectives including mental health, substance use, youth and families described their experiences in operating warm lines. After a moderated session with questions for the panel, discussion opened up to the larger group of technical experts. Participants are named in this section to recognize their participation in the smaller panel.

Question 1 posed to the small panel: Tell us about your warm line, including how it began, who you serve, and what specific assistance you provide to callers.

Trenda Hedges described the [Illinois Mental Health Collaborative's](#) experience in obtaining a contract from the state of Illinois in 2008. The warm line, which provides emotional and peer support to callers from across the state, provides resources and linkages to other services when requested using access to service system databases. Ms. Hedges pointed out that only seven percent of callers request referrals.

Beverly Ragland described the [Georgia Council for Recovery's](#) warm line founded in 2017 after a 21-year-old man being followed by a reporter died from an overdose of fentanyl. The Executive Director of the Georgia Council for Recovery (GC4R) was following his story and his death was the motivation behind GC4R and the Georgia Department of Behavioral Health and Developmental Disabilities forming the CARES Warm Line. The warm line, operated by Certified Addiction Recovery Empowerment Specialists (CARES), provides emotional and peer support to callers to share hope and help them navigate the recovery process. The warm line serves nationwide and international callers. Callers, upon request, are connected with community resources or offered weekly check-in calls with a recovery coach.

Ms. Barash described [Michigan's Families Against Narcotics](#), which was started by families impacted by opioid epidemic. It began with one support group meeting in church basement and has grown to 20 chapters across Michigan. The warm line, operated by peers and families, developed soon after to expand that work and provide support and resources to community members.

Question 2 posed to the small panel: How do you work with peers? How do you recruit and train people to answer calls? How do you finance your operations/pay peers? Include other relevant topics to peers.

Ms. Ragland shared that the [Georgia Council for Recovery's](#) warm line connects community members with peer support by text and calls. Marketing is conducted through an extensive social media presence and billboards throughout the state. They also conduct outreach to underserved communities.

Ms. Hedges stated that the [Illinois Mental Health Collaborative](#) is financed by a contract from the state Department of Mental Health and operates as a part of a health care company. They recruit certified peer recovery specialists and hire interns from colleges who are paid a competitive hourly wage. Peers hired without a credential are encouraged to get certified within two years.

Ms. Barash shared that [Michigan's Families Against Narcotics'](#) warm line began with volunteer staff and over time the warm line was able to pay peers. They fund the warm line through a state budget allocation and grants. As the organization expanded, they encouraged more continuing education for staff including motivational interviewing, trauma-informed practice

and helpline training. They have also developed policies and procedures to help staff understand boundaries and ethics.

Question 3 posed to the small panel: How do you keep your warm line authentic to recovery values and principles?

Ms. Hedges shared that the [Illinois Mental Health Collaborative's](#) warm line regularly reviews core values and discusses different concepts related to peer recovery to see if all are on same page with values. She emphasized that while they encourage training, peers bring experience that cannot be found in a book or through training. Unless they stay true to providing support based on their lived experience and the diversity across the team, the warm line is at risk for co-optation and drift. As a part of a health care company, they regularly advocate for their lived experience as the core value of the support they provide so as not to drift into become a managed care line. They infuse peer values by creating a culture of support for their peer staff. Peers use chat and gain support from each other.

Ms. Ragland stated that the [Georgia Council for Recovery](#) embraces education, advocacy, self-directed care, and the many pathways to recovery. They promote the message that recovery is possible for everyone and support dignity, compassion, integrity, and connection to the community. They combat discrimination and give hope that all community members can understand the joy and happiness of long-lasting recovery.

Ms. Barash shared that [Michigan's Families Against Narcotics](#) meet people where they are at. They created a family environment to help folks be their true authentic self and let staff lead. Ms. Barash stated that they are cognizant of burn out and emphasize self-care by encouraging peer staff to limit overtime and checking in on peers for their own recovery. They debrief and communicate with the team regularly.

Question 4 posed to the small panel: What are your hopes for the future for your warm line?

Ms. Barash stated that the warm line came out of necessity because it is so difficult to access services. Individuals with substance use conditions are often transient and Michigan is split into 10 regions which all operate differently. They advocate for change to reduce access barriers and stigma. Her hope is that the addictions system will follow a medical model for accessing services and access will improve for the people they serve.

Ms. Ragland shared that her hope is to more fully engage community members from underserved and rural communities in Georgia. She is interested in creating more opportunities for career paths that promote peer specialists from underserved areas to encourage more inclusion and diversity. Her hope is for more training initiatives to do this work.

Ms. Hedges shared that her hope is for the warm line to continue as an authentic peer model – not a crisis or medical model. She hopes for more financial services to promote connection through technology, specifically the creation of an app that would allow callers to press a button and connect to a national network of warm lines. Since a large part of Illinois is rural with no access to services or transportation, the use of technology is needed to enhance connections while staying grounded in an authentic peer model.

Open Discussion with All Technical Expert Panelists

- Panel members discussed the benefits and drawbacks of operating within a large health system versus sustaining a stand-alone peer run organization. While operating within a large health system provides sustainable funding, there is a tension with maintaining peer values and adopting the values of the larger system. Autonomy is one advantage to being a standalone organization. Two panelists benefited from being housed in a large nonprofit, which provided autonomy and also financial supporter of the warm line during a time when they experienced delays in receiving funding.
- One panelist shared her experience in losing funding and transitioning from paid peers to volunteers to sustain the warm line until funding was received to pay peers again. The warm line was financially supported during this time of instability by the nonprofit in which the warm line was housed. The participant gave this context to highlight the importance of warm line independence and issues with unstable funding from government and foundation support and value of paying peers.
- Panelists discussed whether warm lines should conduct suicide risk assessments and nonconsensual assessments. Most panelists shared that their warm lines do not conduct assessments or provide referrals unless the caller asked to be connected to other services. Several also indicated that they stay on the line with individuals who are actively using or purchasing drugs. There was general agreement in the importance of meeting callers where they are at and that calling the warm line to make a connection was a step towards recovery.
 - One panelist indicated that they have a crisis call support team that works together with the peers and callers to understand the best self-directed choice, which may mean staying on the line as the caller drives to the hospital or waits for a friend/family member.
 - One panelist indicated that they offer callers the opportunity to a higher level of care with a warm handoff because “it’s about saving lives.” Another panelist indicated that warm handoffs can be nonconsensual rescue. [Trans Lifeline](#) is an anti-nonconsensual rescue program that many warm lines use as a model.
 - Several panelists emphasized the need to avoid nonconsensual rescue since many callers have experienced trauma from the systems designed to help them and will not use other services or supports. Warm lines were developed from this history and understanding the need to create a safe zone where callers can explore their feelings and talk about suicidal thoughts without being referred to the police or mobile crisis. Panelists operating from an anti-nonconsensual rescue approach emphasize that these community members will not reach out for help out of a fear that the police may show up and they may be arrested or institutionalized. Callers with this experience would continue to be marginalized without warm lines as a safe space.
 - Warm lines operating from an anti-nonconsensual rescue approach reported that many callers can be engaged in a way that does not require calling the police or other services for safety reason.
- Another technical expert panelist informed all panelists that the National Empowerment Center helps co-host an ad-hoc learning community for warm lines. It has been operating for about one year with 30 members and all panelists were invited to join. The panelist noted that this learning community was initiated from within the warm lines community when needs for such a group were identified.

- Panel members agreed that families have a different lived experience than peers. Warm lines operating with staff who are both families and peers connect family members staff to family member callers and peer staff to peer callers.

Brainstorming Session: Definition of Peer-Operated Warm Lines

Lisa St George moderated a discussion and brainstorming session to establish a working definition of peer-led warm lines.

After reviewing the variety of definitions for warm lines, the panel reviewed the proposed definition drafted by members of the planning committee.

Proposed Definition

A peer-operated warm line is a phone and/or text line that provides connection and offers peer support to individuals to foster wellness and recovery without barriers. Peer-operated warm lines are operated and staffed by people who have personal experience living with mental health or substance use disorders. Warm lines operate using the peer values of choice, self-determination, respect, and hope to prevent future crises and provide overall support for their callers. They empower callers to be actively involved in their own decision-making. While warm lines differ from crisis lines, they work collaboratively and transparently with callers to support crises planning and prevention.

The in-depth discussion began with the following polling question:

What specific recovery-based values do you think are most important in the operationalization of warm lines and should be included in the definition?

There were 39 respondents from across the in-person and virtual participants answering the poll. The most frequent responses included the terms “support” and “self-determination.” Other values included stigma free, transparency, and respect.

Open discussion

- One panelist expressed an interest in using a term other than warm line stating that as compared to hotlines, the term warm lines sounds like it is a step down – that peer support specialists are receiving less serious calls, which is not true.
 - Another panelist offered that it should be called a peer support line, which removes any confusion on whether the person has lived experience. Many other panelists agreed with this name.
 - One panelist expressed concern that if the name is changed then managed care organizations will remove direct access to the warm line and may require callers to be referred through a clinician.
- One panelist stated that self-determination is the value that stands out to differentiate peer operated warm lines from other services. Peer recovery is not linear like clinical models that seek to understand the problem, provide an intervention and expect a solution. Peers operating warm lines offer multiple pathways and respect callers’ decisions even if they do not want to be sober, seek treatment or reconnect with their family.
- Some panelists questioned whether a peer needs to be defined more clearly in the definition.

- Discussion related to whether certified peer specialist should be the standard raised concerns due to difficulties meeting this standard. One panelist indicated that warm line staff have two years to become certified and others stated that individuals with backgrounds of being incarcerated may be ineligible for the certification. Panelists also mentioned that some certifications were still rooted in traditional clinical principles, and thus chose to avoid certifications for peers. Others agreed that certification is not the core but instead the peer approach, which minimizes power imbalances and promotes connections and relationships, is more important.
- Panel members discussed the target audience for the warm line definition.
 - They pointed out that the definition would be useful for funders. One panelist suggested that if the definition is intended for funders than outcomes should be included. She stated that their warm line projected costs and showed a 427% percent impact on those who do not use other systems indicating that states should invest in warm lines because they improve well-being.

Intersection of Peer-Operated Warm Lines and Crisis Lines (such as 988)

Lisa St. George moderated a discussion related to the differing roles of warm lines and crisis lines which began with the following polling question.

Do you work with a local crisis call center in your area? Include referrals or any other working arrangements.

Ten panel members responded “yes” and seven panel members responded “no.”

Open discussion

- Panel members shared various experiences with 988.
 - One respondent indicated that more data is needed to capture the effectiveness of 988.
 - Panel members highlighted the distinction between warm lines and other crisis lines is that warmlines promote a consensual approach.
- Some panelists shared that they attend collaborative meetings and have over time been able to educate each other on the distinctions between the warm lines and 988. Two panelists shared that they have memorandums of understanding (MOUs) in place and have established good relationships where callers are transferred between warm lines and 988 as needed.
- One panel member explained that 988 is not clearly designed to work with individuals with substance use conditions in crisis; it is not clear the supports and services that they are providing since individuals with substance use conditions are ineligible for mobile crisis.
- One panel member indicated that 988 should have mandatory education on peer values and peer support so they have more respect for what warm lines do.
- One panel member emphasized that while 988 is promoting access to services, the overall service system has not been improved (e.g., some people who are brought to the emergency room may be waiting for days in a hallway); panel members questioned the real benefits to community members in distress (i.e., evidence that suicide is decreasing).

- Panel members discussed how 988 has been standardized across the country and networked so that if a 988 office in one state is unable to answer, the call rolls over to another area. Panel members agreed that warm lines need the same funding and endorsement to allow warm lines to be a directly accessible part of the continuum of support so that people have options to choose from.
- Several panel members stated that individuals who have lost power or who may be identified as a marginalized population will not access traditional care, and therefore, need alternatives. While 988 offers referrals to the traditional system (i.e., clinicians, mobile crisis, or crisis stabilization), warm lines offer a peer approach. Another panel member pointed out that some 988 are staffed by non-clinicians including peers.
- One panel member pointed out that the U.S. Surgeon General declared an epidemic of isolation and loneliness. The panel member also stated that warm lines, not 988, is meant to solve loneliness and fear. Another panel member agreed that the focus of warm lines is on prevention and promotion and reaching individuals (including marginalized populations) who will not access traditional care so that support is available to all individuals.
 - Another panel member agreed that warm lines were developed from the experience of those in the peer movement and the need to provide care options and support across a lifespan.

Suggested Action Steps: Day 1

- Gain federal support for endorsing the value of and providing funding to warm lines so that they may be directly accessible as an option along the continuum of supports.
 - Create a SAMHSA publication on warm lines that may be used for promotion, marketing and educational purposes.
 - Raise the visibility of warm lines.
- Fund warm lines as an essential part of the U.S. health and social service system. Any funding through state Medicaid systems should be structured to result in more funding for peer-run programs that follow the peer recovery model, and should not become a different, more medicalized “low-level crisis” or “patient monitoring” type service.
- Provide guidance on building a business case to fund, start and maintain warm lines.
- Continue outreach to educate community members about the value of warm lines and reduce stigma and barriers to accessing them.
- Conduct in-depth interviews with warm line users, managers and directors across the country to capture how supports are provided and funded.
- Use research findings to develop networks of warm lines.
- Create a national warm lines network that shares core services but allows for variation.
 - Consider coalitions such as [CalHope](#) as possible models.
 - Build on the work of [warmlines.org](#) and create a dedicated clearinghouse for research, best practices, and guidelines.
 - Create a three-digit code for warm lines.
- Develop forums where warm line staff, particularly warm line program managers, can share expertise, experiences, barriers encountered, and solutions developed while operating warm lines.
 - Use forums to build leadership capacity.
 - Need to broaden network and strengthen communications, define expertise/work history.
 - Conduct more outreach to engage technical experts not included in this first panel—specifically technical experts from lines representing underrepresented communities and those with no current direct relationship to SAMHSA partners.

- Define competencies for peer support specialists to operate warm lines and create a national accreditation. Panel members expressed concerns that other organizations have established accreditation programs without consensus from the warm line community.
- Conduct more outreach to engage marginalized communities both in using the warm lines but also in becoming peer support specialists.

DAY TWO

Welcome Back

Lisa St George provided a recap of Day 1 and shared two polling questions:

In 1-3 words, what are the most important benefits of peer warm lines?

There were 21 respondents answering the poll. The most frequent responses included the terms “connection” and “people are heard.” Other benefits included low- and no-barrier support, reducing loneliness, feeling known, validation, solving problems, and friendship.

In 1-3 words, what are the biggest challenges for peer warm lines?

There were 40 respondents answering the poll. The most frequent responses included the terms “funding” and “co-optation.” Other challenges included repeat caller volume, awareness, marketing, burnout and compassion fatigue.

Transition to Breakout Sessions

Panel members were asked to choose two of the four topics and participate in small group discussions. Topics included awareness/sustainability of warm lines; research needs and quality data collection; integrity of “peer-ness”; and equity. Each topic was defined for panel members by group facilitators. Breakout discussions occurred simultaneously and one member from each group provided highlights from the discussion during the final session with the full panel at the end of the day. Highlights from the four breakout topics are summarized below.

Breakout: Awareness/Sustainability of Warm Lines

Laurisa Guerrero from the Georgia Council for Recovery moderated two breakout sessions focused on two topics; the public’s awareness of warm lines and the sustainability of warm lines as they are currently operating. Participating panel members were encouraged to discuss both issues and innovations. Additionally, participants were encouraged to consider how awareness of warm lines intersects with sustainability.

Awareness of Warm Lines

Panel members shared their outreach and awareness activities. Panel members raised awareness about their warm lines through a full array of outreach activities including community events, marketing to colleges, faith-based organizations, conferences, social media, working with local NAMIs, and listings on the National Empowerment Center website. Word of mouth is how many community members obtained information about warm lines.

One perspective shared was that the language used during awareness activities included promoting an understanding that substance use conditions are a disease. Some panel members stated that warm lines do not offer clinical services. Others asserted that marketing solely as a social connection is dismissive and believed that warm lines should be marketing as a health care option.

Panel members reported that more marketing is needed to engage youth and individuals from marginalized backgrounds. One panel member emphasized the need to engage target

audiences in the development of marketing materials. For example, for one warm line, young adults assisted with the graphic design and wording of their marketing materials and recommended promoting the teen line through school-issued tablets. Other panel members used translation services or expanded language support and emphasized the need to market in underserved areas.

Panel members discussed and agreed that marketing should continue even when warm lines are stretched to capacity. Panel members were able to advocate for additional funding by showing the high volume of calls received and missed call data.

One panel member expressed an interest in marketing warm lines as a viable response to the recent U.S. Surgeon General's report outlining the epidemic of loneliness and isolation. He suggested that the message to state funders is that warm lines decrease the loneliness epidemic.

Sustainability of Warm Lines

Panel members describe the ebbs and flows of funding and its impact. In general, panel members were able to expand warm line support when funding was received and required to scale down as funding was lost. Others needed to stop paying peers for periods of time while the warm line awaited further funding.

Funding was obtained through federal, state and county grants, including temporary funds through executive orders during the COVID-19 pandemic, Mental Health Block Grant, Recovery-Oriented Systems of Care (ROSC), health care organizations, community hospital systems, certified community behavioral health organizations, and private insurance.

Other ideas for funding options offered for consideration included obtaining state approval to include warm lines as an optional service under Medicaid or using opioid settlement funds. Additionally, one panel member suggested joining with AmeriCorps so peer support specialists can receive payments without disrupting their social security benefits.

Panel members expressed concerns that some types of funding may bring them away from being peer-centered. For example, a panelist from Michigan explained that the warm line was not sustainable through the Mental Health Block Grant funding. Instead, they advocated for and obtained crisis funding for the warm line. With this funding they no longer have concerns about sustainability. However, embedding the warm line into a crisis line has presented barriers to maintaining the authenticity of the peer warm line.

Panel members discussed that repeat callers tax the capacity of warm lines and several panel members have set limits on repeat callers to ensure that new callers are able to access support. Warm lines with limit setting were able to track callers through the computerized system despite anonymity. Panel members shared a range of call limits such as:

- Callers were limited to 2 – 20 minutes calls a day; unlimited for callers in crisis.
- Repeat callers were limited to once a day for 20 minutes; new callers were limited to 30 minutes a day.
- Callers were limited to one call per day per peer support specialist (with 8-10 peers working per shift the callers were able to call multiple times and speak with different peers).
- Callers were limited to 20 minutes up to six times a day; unlimited for callers in distress.

Panel members agreed that SAMHSA promotions and supportive of warm lines would facilitate their ability to both market and obtain sustainable funding.

Breakout: Research Needs and Quality Data Collection

Raina Daniels from the Mental Health Association of San Francisco moderated a breakout session focused on the research needs surrounding warm lines. Discussion included different ways warm lines collect data, gaps in research, and current data collection/research that is underway.

Panel members emphasized that collecting caller data can be disruptive to the goals of peer support (i.e., connecting with the caller). If callers are required to share standardized data before receiving support through the warm line, it would also violate the peer support approach of providing low barrier access to the warm line.

Panel members discussed the importance of collecting data to demonstrate warm lines as an integral part of the continuum of support providing a pre-crisis response and diverting community members from other acute care options. The National Empowerment Center co-hosts a community of learning that has significant data to share. Panel members recognized the benefits of a Center of Excellence for warm lines and/or a clearinghouse to compile and share data. Panel members stated that technical assistance and training is needed to build the evidence base for warm lines.

Panel members discussed the need to come to consensus on the types of outcomes that can be expected from warm lines. One panel member stated that outcomes can influence the program's goals. Outcomes should capture the benefits to individuals and not the reduction of costs to the system. Increased access does not necessarily translate to quality care. Each caller presents with unique needs. Focusing on capturing callers' stories or asking "Did XXX come up in the conversation?" would better represent the warm line experience. Warm lines help empower individuals and promote self-determination.

Another panel member shared that they report on reasons for calling based on the eight dimensions of wellness such as landlord disputes, losing a job, etc. She suggested that data collection could be facilitated with integrated software that merges data from the phone system with other data that is collected. Some other panelists noted that this type of technology does exist for some warm lines, but would be beneficial if more operations had access to such technology.

Panel members recognized the gaps in understanding how many callers are calling multiple hotlines and warm lines as well as the number of repeat callers versus unique callers. Panelists indicated more research was needed on calls transferred from 988 to warm lines. Panel members also discussed the benefits of training individuals as peer specialists and building a peer workforce. Discussions highlighted the supports and listening skills that peers gain through training as benefiting the community as a whole.

Breakout: Integrity of "Peer-ness"

Trenda Hedges from the Illinois Mental Health Collaborative (Carelton Behavioral Health) moderated two breakout sessions focused on how warm lines maintain the integrity and spirit of peer work. The discussion included how peer values impact and sustain warm lines, and the critical differences of having peer staff answer calls.

Panel members discussed how peer values are interwoven with everything that they do including recruiting, hiring, training, onboarding, and completing appraisals/annual performance reviews. Panel members shared examples of training that they provided to peer specialists including intentional peer support training, which focuses on listening skills, developing a trusted space and making a mutual connection with callers.

Some panel members discussed providing [Applied Suicide Intervention Skills](#) (ASIST) training. Others found [Alternatives to Suicide](#) and [Intentional Peer Support](#) more helpful as a peer support practice to train peers how to help callers voice and move through suicidal thoughts with understanding. Multiple panelists also shared that they use internally developed models based on peer values.

Panel members talked about having to “untrain” peer support staff who may be accustomed to a crisis and clinical model. The VCVC training (Validation-Curiosity-Vulnerability and Community), a component of the Alternatives to Suicide training developed by Wildflower Alliance, was discussed as helpful to promote a connection with callers by using an approach that embodied the peer values instead of simply asking questions.

The discussion included how funding conflicts or aligns with values. Some panel members shared that they turned down funding opportunities if it required data collection or other practices that were not in line with peer values. Panel members also spoke of the restrictions in peers’ ability to advocate as state or federal employees and viewed both positives and negatives in facilitating changes from “inside” government or health care systems.

Panel members also spoke of the importance of paying peers referring to the history of the mental health consumer/survivor movement when individuals were forced into volunteering in institutional settings. Volunteers would need the same qualifications as peer supporters who are being paid. Volunteer-run warm lines compete with warm lines that are operated by paid peers making it harder to secure appropriate compensation for peer support specialists. (Note: These points were made during this breakout session and also during the equity breakout as this is viewed as an equity issue). Also discussed was how people with psychiatric histories continue to be taken advantage of with lack of or too low compensation for sharing their knowledge and skills, and the reality that many may be living on fixed incomes or struggling with poverty that has resulted from years of living in that manner.

Panel members discussed the importance of having clear definitions of “peer” and “warm line.” The definitions would help to market warm lines and allow for a greater understanding among the general public on what a peer support person offers when community members call for warm line support.

Breakout: Equity

Beverly Ragland from the Georgia Council for Recovery moderated a breakout session focused on equity and warm lines. Participants discussed how they put equity at the forefront of the work they do with their warm lines and the ways warm lines can improve their equity work.

The discussion began with an understanding that equity refers to the misalignment in the allocation of resources according to needs. Based on the social determinants of health, equity relates to racial and social justice.

Panel members discussed the need to look at community needs and how budgets are spent. Discussion included the importance of not confusing equity and equality. For example, equity is not about providing allocations proportional to community representation but instead addressing the power differential. Power inequity may emerge from socio-economic status or other factors such as LGBTQI+ or backgrounds of being incarcerated.

Panel members expressed the need for training and hiring peers from underserved areas, understanding community members' needs, and providing services better matched to meet the needs of individuals from marginalized backgrounds.

Panel members spoke of how warm lines emerged from the peer movement that sought alternatives to traditional care. The peer approach is centered on self-determination and connecting with callers as they make their own choices and decisions. Peer support can look different depending on the culture of the peer supporter.

Panel members discussed the importance of providing leadership training to peer support specialists to ensure staff have upward mobility since peer support positions are often not paid well. Panel members agreed that providing opportunities to allow peers to learn leadership skills, budgeting and grant writing will promote equity and recovery values that community members can recover, become educated, work, and advance their careers.

Panel members highlighted initiatives that promote equity such as the Wildflower Alliance's [Black Movement History Leaders: Past and Present](#), a call to action to elevate the stories of Black leaders with lived experience. Panel members discussed how to make sense from the impact and potential harms that may come from good intentioned work. One strategy that was shared was Black and White presenters co-facilitating discussions as a way to build trusting relationships, allowing individuals to explore and be open to their own biases, and reach individuals who may feel unreachable.

Panel members highlighted the need to understand that every community has different needs, that is it important to meet community members where they are at, add more people to the table that reflect the communities, and develop leadership from within. Need was identified for more outreach to include warm line technical experts that may not have existing relationships with SAMHSA or other federal partners. A panelist reminded the group of Maya Angelou's words: "Do the best you can until you know better and when you know better -- do better."

Suggested Action Steps: Day 2

- Build capacity and secure funding to expand access to warm lines in underserved areas.
- Provide guidance on how to recruit, hire, and train peers to staff warm lines. An example of such guidance could be a model standards document.
- Develop and fund leadership training for peers who operate warm lines.
- Promote appropriate compensation for peers who operate warm lines.
- Conduct a comprehensive environmental scan of known effectiveness and research related to warm lines.
- Develop a Center of Excellence or network to capture the wealth of wisdom that is available. Currently, there is no repository that warm line staff may access that captures peer values, resources for warm lines staff, funding opportunities, and the current research. A federally funded technical assistance center could help fill this need as well. This information clearinghouse should include programming on how to provide a proper

and supportive service for callers, and how to define, develop and support the warm line workforce. It should also cover business issues, including how to fund, sustain, and grow warm line provider organizations using both government and private-sector funded business models.

- Offer an annual conference for the warm line community.

Closing Remarks and Next Steps

Lisa St George and Miranda Gali shared some closing remarks and the results of the last polling question:

In 1-3 words, what would you say is the most important action item from today's discussion for SAMHSA and other federal partners?

There were 24 respondents answering the poll. The most frequent responses included the terms "collaboration" and "funding."

Appendix A – Participant List

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Appendix B – Description of 988 Lifeline Services

Simply calling or texting 988 or chatting 988lifeline.org will connect a person in crisis to compassionate care and support for any mental health or substance use-related distress. Anyone—a person in crisis, or someone supporting a person in crisis—can reach 988 in the United States through any land line, cell phone, and voice-over internet device.

The 988 Lifeline was established to improve access to immediate support to meet the nation's growing mental health, suicide, and substance use distress needs. The 988 Lifeline provides easy access to emotional distress care, which is distinct from 911, where the focus is on dispatching emergency medical services, fire, and police, as needed.

Only a small percent of 988 Lifeline calls require activation of the 911 system. Most of those are done with the consent and cooperation of the caller. This occurs when there is imminent risk to someone's life that cannot be reduced during the call. In these cases, the crisis counselor shares information with 911 that is crucial to saving the caller's life.

SAMHSA is working towards a long-term vision of strong coordination between 988 and 911 so people in crisis get to the most appropriate care needed in that moment. SAMHSA is actively working with 911 counterparts at federal, state, and local levels as our country continues to improve response.

988 Suicide & Crisis Lifeline Fact Sheet can be downloaded at <https://www.samhsa.gov/sites/default/files/988-factsheet.pdf>