MONITORING OF NATIONAL SUICIDE PREVENTION LIFELINE FORM SUPPORTING STATEMENT

A. STATISTICAL METHODS

B1. RESPONDENT UNIVERSE AND SAMPLING METHODS

There are 106 crisis centers in the National Suicide Prevention Lifeline Network. The monitoring will continue with 18 of those centers. The centers were selected based on the geographic region(s) they serve. The first type of center only takes calls from a metropolitan or county area ("local" centers); the second type of center take calls from their entire state ("within state" centers); the third type of center takes calls from outside of their state ("outside state" centers). All crisis counselors at participating centers will be invited to participate. If even one counselor on a shift chooses not to participate, no calls will be monitored during that shift.

Eligible calls will include those involving a suicide or crisis situation, using a broad definition of "crisis."

SAMHSA funded crisis centers will participate in the MI/SP monitoring. Calls to the funded centers, occurring within the 6 p.m. to midnight shift (local center times), will be monitored. While all calls will be initially monitored, only calls from suicidal callers will be subject to a complete abstraction by the monitors and potentially included (e.g., coding presence and adequacy of risk assessments; whether components of MI/SP were conducted; whether referrals were given, and if so, the type of referral, etc.). Calls in which the caller is seeking information and referral, third party calls, obscene calls, and non-suicidal crisis calls will not be abstracted. It is anticipated that there will be three eligible calls per center per week for a total of 78 monitored calls per center. Eligible calls are those calls from suicidal callers.

B2. INFORMATION COLLECTION PROCEDURES

Data are collected during calls to a participating suicide crisis hotline. Silent monitors listen to the calls and collect data in hard copy format. For standard collection of these data across sites, the **National Suicide Prevention Lifeline—Call Monitoring Form** was developed and previously approved by SAMHSA (OMB No. 0930–0274). Additional data are collected through the **Crisis Hotline Follow-up Assessment**. The assessment includes an evaluation of the caller's suicide risk status at the time of and since the call, depressive symptoms at follow-up, service utilization since the call, barriers to access, and the clients' perception of the efficacy of the hotline intervention.

Silent monitors listen to the calls and collect data in hard copy format. For standard collection of these data across sites, the **MI/SP Silent Monitoring Form** was developed. Approximately six weeks after the initial call to the hotline, at which time initial consent to contact is obtained, a trained counselor contacts the caller and obtains data through the **MI/SP Caller Follow-up Interview**. Demographic and historical data are collected along with indicators of the efficacy of the intervention, including the safety plan and provision of resources for help.

In addition, once counselors are training in MI/SP, they will provide structured feedback in hard copy form through the **MI/SP Counselor Attitudes Questionnaire**. The data collected will include utility of the training, likelihood of implementation of MI/SP with crisis callers, and the extent to which the counselor will be able to execute MI/SP as intended.

Table 2 summarizes the information collection procedures

TABLE 2

Procedures for the Collection of Information

Measure	Indicators	Data Source(s)	Method	When Collected
National Suicide Prevention Lifeline —Call Monitoring Form	▪ Demographic information ▪ Presenting problems ▪ Present drug and alcohol use ▪ Access to lethal means ▪ Severity of problems ▪ Risk assessment	Hotline caller recorded via data collection staff	Silent monitoring of suicidal caller to crisis hotline	At time of the call to the crisis hotline
Crisis Hotline Telephone Follow-Up Assessment	▪ Demographic information ▪ Historical data ▪ Risk status – current and at the time of the call ▪ Efficacy of the hotline intervention ▪ Perceptions of crisis counselor	Hotline caller	Interview	Approximately one week after initial consent to contact is obtained
MI/SP Silent Monitoring Form	▪ Demographic information ▪ Presenting problems ▪ Present drug and alcohol use ▪ Access to lethal means ▪ Risk assessment ▪ Severity of problems ▪ Referrals provided	Hotline caller recorded via data collection staff	Interview	At time of the call to the crisis hotline.

	▪ Resources identified ▪ Safety plan provision			
MI/SP Caller Follow-up Interview	▪ Demographic information ▪ Historical data ▪ Risk status – current and at the time of the call ▪ Efficacy of the hotline intervention ▪ Perceptions of crisis counselor ▪ Safety plan assessment ▪ Resources provided ▪ Crisis counselor follow-up call(s) assessment	Hotline caller	Interview	Approximately six weeks after initial hotline call
MI/SP Counselor Attitudes Questionnaire	▪ Ease of implementing MI/SP with callers ▪ Perceived helpfulness of MI/SP with potential callers ▪ Whether counselor will supplement MI/SP with other resources ▪ Potential challenges to implementation of MI/SP with callers ▪ Reactions and response to MI/SP training and utilization	MI/SP trained crisis counselor	Hard copy survey	Immediately following the training
MI/SP Counselor Follow-Up Questionnaire	▪ Callers demographic information ▪ Follow-up counselor's experience and training ▪ Crisis center follow-up protocols ▪ Contact protocol employed ▪ Barriers to follow-up implementation ▪ Topical areas if follow-up completed ▪ Referrals/resources utilized by caller since initial call	MI/SP trained crisis counselor	Hard copy survey	Immediately after the follow-up call with the crisis caller

	▪ MI/SP utilization ▪ Challenges/benefits to MI/SP utilization			

B3. METHODS TO MAXIMIZE RESPONSE RATES

The directors of crisis centers that agree to participate will be asked to talk to their supervisory staff about describing the study to their staff, noting its private/anonymous nature, and encouraging counselors to participate. Most counselors will be accustomed to "silent monitoring," since most crisis centers use this method for supervisory and quality assurance purposes. Since the counselors will never know whether one of "their" calls has been monitored, and since the data collected will not identify the crisis center or consenting counselor, it is anticipated that counselors will feel "safe" and be willing to participate. CMHS anticipates an 80% response rate.

To increase participation of callers in follow-up interviews (i.e., **Crisis Hotline Telephone Follow-up Assessment** and **MI/SP Caller Follow-up Interview**), callers are being offered a $50 remuneration for their participation.

B4. TESTS OF PROCEDURES

The **National Suicide Prevention Lifeline—Call Monitor Form** was pilot tested with four different graduate students during May 2005. To review the form, the students received a training (similar to the one that the actual monitors receive), then completed it while listening to two other students role playing a crisis telephone call. The students found the form easy to complete and felt it was understandable.

The **Crisis Hotline Telephone Initial Script** and **Crisis Hotline Telephone Consent Script** were both pilot tested during a previous effort conducted by Columbia University. At that point, the scripts were refined to make them as clear as possible. A number of items in the **Crisis Hotline Telephone Follow-up Assessment** were also included in the previous effort, during which they were piloted and refined.

The **Crisis Hotline Telephone Follow-up Assessment** was developed by a team of suicide prevention data collectors as well as experienced crisis center directors. During the week of April 11, 2005, three crisis center workers at the Mental Health Association of New York City's LifeNet crisis center pilot tested the scripts and **Crisis Hotline Telephone Follow-up Assessment** on nine acquaintances. No changes were made to the scripts as a result of the pilot testing. However, several items were deleted from the **Crisis Hotline Telephone Follow-up Assessment** because they were found to be redundant. Additionally, two sets of questions were each collapsed from four items to two items (now #17 and 18, and #104 and 105).

The **Crisis Hotline Telephone Follow-up Assessment** includes the *Center for Epidemiological Studies Depression Scale* (CES-D, Radloff, 1977), a 20-item measure of current (past week) depressive symptomatology. It is one of the most frequently used and well-validated measures of depression. We had considered using the Beck Depression Inventory (BDI-II, Beck, Steer &

Brown, 1996), another frequently used measure with similar psychometric properties and highly correlated with the CES-D (e.g., Roberts et al., 1991; Skorikov & VanderVoort, 2003); however, in our experiences with using the BDI in our earlier studies, we found that its response format - one of four graded responses reflecting different degrees of severity of each of its 21 symptoms – was difficult to administer over the telephone, and was taking approximately 30 minutes. The CES-D's response format - a 4-point scale of the frequency with which the participants experienced the symptoms in the past week – is simpler to administer over the telephone. In addition to being used as a continuous indicator of severity, recommended cutoff points are available to detect clinical depression. Some references include:

Radloff, L.S. (1977). The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. *Applied Psychological Measurement, 1(3),* 385-401.

Roberts, R.E., Lewinsohn, P.M., & Seeley, J.R. (1991). Screening for adolescent depression: a comparison of depression scales. *Journal of the American Academy of Child and Adolescent Psychiatry, 30,* 58-66.

Skorikov, V.B., & VanderVoort, D.J. (2003). Relationships between the underlying constructs of the Beck Depression Inventory and the Center for Epidemiological Studies Depression Scale. *Educational and Psychological Measurement, 63*, 319-335.

B5. Statistical Consultants

The contractor has full responsibility for the development of the overall statistical design and assumes oversight responsibility for data collection and analysis. Training and monitoring of data collection will be provided by the contractor. The following individuals are primarily responsible for overseeing data collection and analysis:

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References

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Kalafat, J., Gould, M.S., Harris–Munfakh, J.L., and Kleinman, M. (2007). An evaluation of crisis hotline outcomes part 1: Nonsuicidal crisis callers. *Suicide and Life–Threatening Behavior*, *37*(3), 322–337.

Radloff, L.S. (1977). The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. *Applied Psychological Measurement, 1(3),* 385-401.

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Skorikov, V.B., & VanderVoort, D.J. (2003). Relationships between the underlying constructs of the Beck Depression Inventory and the Center for Epidemiological Studies Depression Scale. *Educational and Psychological Measurement, 63,* 319-335.

List of Attachments