MONITORING OF NATIONAL SUICIDE PREVENTION LIFELINE—REVISION (OMB NO. 0930-0274)

A. JUSTIFICATION

A1. CIRCUMSTANCES OF INFORMATION COLLECTION

Background

The Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), is requesting approval for a revision to the data collection associated with the Monitoring of National Suicide Prevention Lifeline (OMB No. 0930–0274) which expires on February 28, 2013. Out of the previously approved 11 data collection instruments and consents, only 6 of the previously approved instruments and consents will be utilized through this revision. The purpose of this program is to promote systematic follow-up of suicidal persons who call the National Suicide Prevention Lifeline (Lifeline). All instruments and consents for the current package have been previously reviewed and approved by OMB. The 6 instruments and consents are part of the 11 instruments and consents that have been previously reviewed and approved.

Telephone crisis services ("hotlines"), designed as resources for individuals at imminent risk for suicide, are playing an increasing role in the armamentarium of suicide prevention efforts in the United States. SAMHSA, CMHS funds the Lifeline, consisting of a toll–free telephone number (1–800–273–TALK) that routes calls from anywhere in the United States to a network of local crisis centers. In turn, the local centers link callers to local emergency, mental health, and social service resources. This national hotline number is currently providing back-up resources for a myriad of suicide prevention programs, including public awareness messaging campaigns, school-based suicide prevention programs, and federal-, community- and advocacy-information/referral documents and internet sites. Every day, the Lifeline answers more than 2,200 calls. While not every caller is at acute risk for suicide, past SAMHSA-funded hotline evaluations have shown that large numbers of callers have significant histories of suicidal ideation and attempts (Kalafat et al., 2007). Crisis centers provide invaluable services and for those at imminent risk for suicide, emergency intervention is frequently initiated and may result in a psychiatric hospitalization or other acute mental health service provision. For those not at imminent risk, crisis hotlines will typically provide referrals to mental health and other services, and will also advise the caller that they may call back if they are in crisis or have additional needs. While previous SAMHSA evaluations demonstrated that callers experienced a reduction in hopelessness and suicidal intent, evaluation also showed that 43% of suicidal callers, who completed follow-up assessments, experienced some recurrence of suicidality (ideation, plan, or attempt) since their crisis call (Gould et al., 2007).

This recurrence of suicidal thinking underscores the importance of callers' ongoing engagement with behavioral healthcare or other appropriate services or interventions. However, the hotline evaluations found that only a minority of suicidal callers set up an appointment. Upon evaluation follow-up 2-3 weeks after the crisis call, only 22.5% of suicidal callers had been seen by the behavioral health care system to which they had been referred and an additional 12.6%

had an appointment scheduled but had not yet been seen (Gould et al., 2007 & Kalafat et al., 2007). Clearly, there is a critical need to follow up with callers at risk for suicide after their initial crisis call, for the purposes of addressing recurrent suicide risk and promoting engagement with ongoing treatment. SAMHSA has sought to address this need by funding crisis centers in the Lifeline network to develop or expand programs to offer and provide follow-up to suicidal callers to the Lifeline. Crisis centers funded under the follow-up initiative also receive a training incorporating recent advances in motivational interviewing and safety planning (MI/SP), which is designed to enhance follow-up and assist in keeping callers safe after the call and before they are seen by a health care provider.

The proposed data collection activities will continue previously cleared efforts to evaluate the process and impact of crisis center follow-up with callers to the Lifeline who have reported suicidal desire during or within 48 hours before making a call to the Lifeline, as well as continue to examine the impact of MI/SP training on counselor and caller interactions and outcomes. The efforts associated will focus on the ongoing cooperative agreement between SAMHSA and funded centers in the Lifeline. Participating crisis centers have been chosen by SAMHSA to receive funding to support the development or expansion of a clinical follow-up program for suicidal callers and other suicidal individuals. Centers were chosen on the basis of a competitive application process in which attention was paid to centers' proposed plans for implementing follow-up, their experience and capacity to successfully implement their plans, their provision of services to special populations of interest including veterans, American Indians, and Spanish-speaking individuals, and their commitment to sustaining their follow-up programs after the termination of their grants. It was a stipulation of the centers' award funding that they also participate in the evaluation of these efforts, which is designed to provide SAMHSA with data on the feasibility and effectiveness of the centers' follow-up programs. Non-funded crisis centers are unlikely to have developed comparably extensive clinical follow-up programs, and unlikely to have the available personnel and incentive to participate in an evaluation. Moreover, evaluation of follow-up programs at non-funded centers will not generate data on the impact of SAMHSA's follow-up initiative, a key mandate of the evaluation

The Lifeline Crisis Center Follow-up grants are authorized under Section 520A of the Public Health Service Act as amended (42USC290bb-32). This announcement addresses Healthy People 2020 Mental Health and Mental Disorders objective.

Evaluation data provide the information necessary for shaping and influencing program and policy development through the systematic analysis and aggregation of information across the components of large-scale initiatives, thus contributing to an understanding of overall program effectiveness. Evaluation data on the reach, process and impact of crisis centers' follow-up programs will enable SAMHSA to determine whether to continue to advocate for and promote crisis center follow-up of suicidal individuals in its current form, and will provide the basis for shaping future follow-up programs so as to optimize their effectiveness. As an example of how evaluation data has influenced program and policy development in the past, data from earlier evaluations demonstrated the need for follow-up of suicidal individuals and contributed to SAMHSA's decision to develop the follow-up initiative. Without comprehensive monitoring information, the implementation, efficacy, and outcomes of these hotline services cannot be understood. Initial findings from the ongoing evaluation have been critical to understanding caller outcomes, identifying areas to improve caller outcomes, and have been utilized to enhance

and refine follow-up protocols. Specifically, initial findings that the majority of callers reported that the follow-up stopped them from killing themselves and kept them safe prompted the extension of SAMHSA's follow-up initiative beyond the first 6 funded centers to an additional 12 funded centers, and the expansion of the follow-up initiative to promote crisis center follow-up not only with suicidal Lifeline callers but also with suicidal individuals referred from hospital emergency departments and inpatient units. The ongoing evaluation will incorporate the monitoring of follow-up activities at the additional centers and with the additional types of follow-up client.

To underscore the scope and import of the Lifeline, the national network served its 3 millionth caller in October, 2011. In addition, it is estimated that 1 in 5 callers presses "1" to be routed to the Veterans Crisis Line. Again, it should be underscored that systematic monitoring of suicidal persons who call the Lifeline is necessary to understand caller outcomes and to identify and refine best practices for linking suicidal callers to ongoing behavioral health care. Through continued monitoring of suicidal callers and crisis center counselors and practices, additional areas for improvement in crisis intervention can be identified. By identifying these areas for improvement, crisis counselor training curricula and case management protocols can be refined and enhanced ensuring that front line workers have the most informed response protocols to meet the critical needs of a caller in crisis.

The overall goal of this data collection and monitoring effort is to inform and respond to SAMHSA's first strategic initiative—Prevention of Substance Abuse and Mental Illness—and to Goal 1.3 in particular: *Prevent suicides and attempted suicide among populations at high risk, especially military families, youth, and American Indians and Alaska Natives.* This will be accomplished by providing the empirical basis to improve crisis intervention services delivered to these vulnerable populations.

Clearance Request

SAMHSA is requesting approval for a revision of the previously approved monitoring package (OMB No. 0930–0274). The program is operated under authorization of SEC. 520A. [290BB-32] PRIORITY MENTAL HEALTH NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE of the Public Health Service Act. Each year, beginning with the 2001 appropriations bill, Congress directed that funding be provided for the Suicide Prevention Hotline program. In addition to the Suicide Prevention Hotline Program, funds have been continually allocated for the monitoring and/or evaluation of the program. The monitoring and continued data collection of the Lifeline is critical to ensuring continued feedback on interventions and enhancements of these efforts. Given that over 36,000 persons died by suicide in 2009 (CDC, 2012) and more than 2,000 calls are received a day through the Lifeline, monitoring and enhancing this crisis resource is critical to reducing this preventable cause of death.

Crisis hotlines in the Lifeline network must be accredited by recognized bodies. To ensure quality, the vast majority of crisis centers do conduct periodic on-site monitoring of selected calls using unobtrusive listening devices, but information is generally used for supervisory purposes and does not contribute to the evidence-base of hotline services. The **Monitoring of National Suicide Prevention Lifeline—Revision** represents a continuing effort by SAMHSA to

improve the methods and standards of service delivery to suicidal callers by informing the development of staff training in networked crisis centers. In addition, SAMHSA uses monitoring efforts to collect data on follow-up assessments of individuals calling the Lifeline network. This effort will provide an empirical assessment of crisis hotline services, which is necessary to add to the evidence base and optimize public health efforts to prevent suicidal behavior. This data contributes to two of SAMHSA/CMHS's National Outcome Measures (NOMs)—"Perception of Care" and "Access to Care." The "Perception of Care" NOM is addressed through questions to participants about the outcomes of the help they received during calls to the network, including their emotional state and suicidal risk before, during, and after the call. The "Access to Care" NOM is addressed by determining whether the caller followed up with provided referrals.

This request is for revision of the previously approved data collection (OMB No. 0930–0274) to gather monitoring information from the Lifeline callers as well as assess the process and impact of crisis center follow-up with callers who have expressed suicidal desire. The grant-funded centers train counselors to implement an intervention with callers which incorporates aspects of motivational interviewing and safety planning (MI/SP). This data collection will also assess the impact of this training on counselor behaviors and caller outcomes.

SAMHSA is requesting OMB review and approval of six consents and data collection instruments. Table 1 provides an overview of the name of the consent or instrument, the attachment reference, and the method of data collection.

Table 1. Consent and Instrument Clearance Request

Data Collection Name	**Attachment Reference**	**Respondent**	**Method of Data Collection**
MI/SP Caller Initial Script	Attachment A	Caller	Recruitment material administered by counselor
MI/SP Caller Follow-up Consent Script	Attachment B	Caller	Consent Form administered by evaluation staff
MI/SP Caller Follow-up Interview	Attachment C	Caller	Interview administered by evaluation staff
MI/SP Counselor Consent	Attachment D	Counselor	Consent Form administered by evaluation staff
MI/SP Counselor Attitudes Questionnaire	Attachment E	Counselor	Self-Administered Survey
MI/SP Counselor Follow-up Questionnaire	Attachment F	Counselor	Self-Administered Abstraction Form based on already available clinical data

A2. PURPOSE AND USE OF INFORMATION

The data to be collected will contribute to the evidence-base of suicide prevention hotlines and will improve standards and methods of service delivery to suicidal callers by informing the development of staff training in networked crisis centers. The specific areas of contribution for the **Monitoring of National Suicide Prevention Lifeline—Revision** efforts are detailed below.

Information and findings from ongoing monitoring and data collection can help SAMHSA plan and implement other efforts related to suicide prevention. SAMHSA also can use the findings from the evaluation to provide objective measures of its progress toward meeting targets of key performance indicators put forward in its annual performance plans.

Findings can be used by crisis centers to improve their services, processes, and functions. Centers can use the information gathered to better identify their target populations and improve their services and increase caller follow-up to referral.

The research community, particularly the field of mental health services research, will continue to benefit in a number of ways from the information gathered. First, this effort will significantly add to the developing evidence base about the use of hotline services. Second, the focus on suicidal callers allows researchers to examine and understand who is being served with hotline services and the outcomes of receiving these services. Finally, the analysis of monitoring data aids in formulating new questions about the Lifeline network and helps improve the delivery of crisis hotline services.

The specific data collection activities are listed below and followed in order of reference by descriptions of purpose:

- MI/SP Caller Follow-up Interview
- MI/SP Counselor Attitudes Questionnaire
- MI/SP Counselor Follow-up Questionnaire

The telephone scripts associated with the data collection instruments are intended to provide potential participants with standardized information to inform their consent decision. Using the **MI/SP Caller Initial Script**, trained crisis counselors will ask for permission to have data collectors re-contact the caller. The **MI/SP Caller Follow-up Consent Script**, used at the time of re-contact, incorporates the required elements of a written consent form, such as:

- A statement that the study involves research, an explanation of the purposes of the data collection and the expected duration of the subject's participation, and a description of the procedures to be followed;
- A description of any reasonably foreseeable risks or discomforts to the subject;
- A description of any benefits to the subject or to others which may reasonably be expected from the research;
- A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;

- A statement describing the extent, if any, to which privacy of records identifying the subject will be maintained; and
- A statement that participation is voluntary.

The **MI/SP Caller Follow-up Interview** will be conducted by evaluation team staff with the caller approximately six weeks after the initial call to the center. The purpose of the interview is to collect:

- demographic data (to be used as a potential modifier of the efficacy of the follow-up);
- caller feedback on the initial call made to the center (to be used as a potential modifier of the efficacy of the follow-up);
- caller feedback on the follow-up call received (to be used as an outcome measure of the efficacy of the follow-up);
- suicide risk status of the caller at the time of the initial crisis call and during the course of follow-up; (to be used as a predictor of the efficacy, and as a potential modifier of the efficacy of the follow-up);
- suicide risk status at the time of the interview (to be used as an outcome measure of the efficacy of the follow-up);
- depressive symptomology at the time of the interview (to be used as an outcome measure of the efficacy of the follow-up);
- caller's follow through with the safety plan and referrals made by the crisis counselor (to be used as an outcome measure of the efficacy of the follow-up);
- barriers to caller's service use (to be used for future program development to enhance the caller's use of services).

In addition to using the above measures to examine the efficacy of the follow-up program, they will also be used to determine the impact of the MI/SP training. Centers will receive MI/SP training mid-way through the data collection period, enabling a comparison of pre-training and post-training follow-up outcomes.

In addition to data collection with Lifeline callers, **MI/SP Counselor Attitude Questionnaire** will be completed by hotline counselors at the conclusion of the MI/SP training and be used as an assessment of the acceptability and feasibility of a large-scale MI/SP training initiative across the Lifeline network. Prior to collecting of these data, crisis counselors must have read and signed a **MI/SP Counselor Consent**. This form explains the purpose of the research, privacy, risks and benefits, what the study entails, and participant rights.

The **MI/SP Counselor Follow-up Questionnaire** will be completed by counselors who follow-up with or attempt to contact crisis callers after the initial call. This instrument provides:

- information about the counselor's employment, education and training status (to be used as a potential modifier of the efficacy of follow-up);

- counselor's assessment of caller's suicide status during the initial call and during follow-up, independent of the caller's self-reports (to be used as a predictor and potentially as a modifier of the efficacy of the follow-up);

- counselor's assessment of caller's suicide risk status at the last follow-up call, independent of the caller's self-reports (to be used as an outcome measure of the efficacy of follow-up);

- a description of clinical activities during follow-up, including whether MI/SP was implemented (to be used to describe the clinical course of follow-up and also to predict its efficacy);

- counselor's understanding of whether the caller followed through with referrals or resources provided during the initial call or during follow-up (to be used as an outcome measure of the efficacy of follow-up);

- obstacles to follow-up and any changes needed to the implementation of the follow-up protocol (to inform future program development).

In addition to using the above measures to examine the process of follow-up and its efficacy, they will also be used to determine the impact of the MI/SP training. As noted above, centers will receive MI/SP training mid-way through the data collection period, enabling a comparison of pre-training and post-training follow-up processes and outcomes.

Changes

The revision of the previously approved request includes the removal of the following instruments and consents as those data collection efforts have ended:

- National Suicide Prevention Lifeline—Call Monitor Form
- Crisis Hotline Telephone Initial Script
- Crisis Hotline Telephone Consent Script
- Crisis Hotline Telephone Follow-up Assessment
- MI/SP Silent Monitoring Form

A3. Use of Information Technology

The **MI/SP Caller Follow-up Interviews**, which involves human subjects, will be conducted by a trained crisis worker who is part of the Columbia University evaluation team, and is not affiliated with any of the participating crisis centers. The interview will be facilitated by telephone with computer assisted interviews utilized to collect/record the data. CMHS believes that computer-assisted telephone interviews are the most professional, simplest, and convenient, and the least time-consuming collection method.

The **MI/SP Counselor Attitudes Questionnaire** and **MI/SP Counselor Follow-up Questionnaire** will be completed by the crisis counselors at the participating crisis centers. The MI/SP Counselor Attitudes Questionnaire is completed in hard copy and individual forms are submitted to the evaluation team by facsimile, with data entry completed by evaluation staff. Crisis centers are given the choice of completing the MI/SP Counselor Follow-up Questionnaire in hard copy or electronically, using an interactive Microsoft Word document. Hard copy forms are submitted to the evaluation team by facsimile, with data entry completed by evaluation staff. Electronic forms are submitted via email, and imported into project databases using an automated program. No full names or other identifying information are included on forms submitted via email.

A4. Efforts to Identify Duplication

The information will be collected only for the purposes of this program and is not available elsewhere.

A5. Involvement of Small Entities

The information collected will not have a significant impact on small entities.

A6. Consequences if Information Is Collected Less Frequently

The current request represents ongoing data collection and monitoring that is used by SAMHSA to assess progress and process of their lifesaving crisis intervention program.

A7. Consistency With Guidelines of 5 CFR 1320.5

This information collection fully complies with 5 CFR 1320.5 (d) (2).

A8. Consultation Outside the Agency

SAMHSA published a 60-day notice in the *Federal Register* on December 11, 2012 (Vol. 78, page 73668), soliciting public comment on this study. No public comments were received on the planned data collection.

Consultation on the design, instrumentation, data availability and products, and statistical aspects of the evaluation occurred throughout the development of the evaluation design process and throughout the first 3 years of the evaluation. Directors and representatives to the Lifeline Steering Committee also provided feedback to the evaluation design and data collection instruments. Steering committee members have been regularly updated and apprised of milestones and accomplishments of the evaluation. Although this monitoring does not directly affect current initiatives in any other Federal agency, a number of Federal agencies are concerned about suicide prevention. CMHS briefed representatives from the following agencies on the evaluation's design and goals:

- Centers for Disease Control and Prevention
- Indian Health Service
- National Institute of Mental Health

- Health Resources and Services Administration
- Veterans Administration

A9. PAYMENT TO RESPONDENTS

As previously approved (OMB No. 0930-0274), crisis center callers will receive $50 for the follow-up interview. Based on experience in the previous evaluation, if callers on this project are not offered at least $50 for participating in this lengthy assessment, it is anticipated that only 25–30% of callers would agree to receive a follow-up call and that only 50% of that group would actually participate in the follow-up interviews. This level of participation would constitute a biased sample, which would be unrepresentative crisis and suicide callers. The consultants' Institutional Review Board considers this amount of payment to be consistent with that given in other studies using interviews of similar length.

The participating crisis centers will not receive a financial incentive through the evaluation as they are currently receiving SAMHSA funding through their cooperative agreements.

A10. ASSURANCE OF CONFIDENTIALITY

All reports and publications from these data collection efforts include only group-level analyses that fully protect the privacy of individual participants, and no data have been or will be stored with identifying respondent information.

Strict measures to ensure privacy will be followed. Counselors' and centers' names will be temporarily recorded on the Counselor Attitudes and Counselor Follow-Up Questionnaires. Only counselors' first names and/or initials are to be used on any form that is submitted via email. Clients' first names and/or initials will be temporarily recorded on the Counselor Follow-Up Questionnaire. When we receive the questionnaires, we will remove the client's, counselor's and center's names, and replace them with client, counselor and center ID numbers. All identifying information on the subjects (i.e., name, address, telephone number, and signed informed consent forms) will be stored by the RFMH PI either in locked files at the study headquarters at the N.Y. State Psychiatric Institute, or in administrative files maintained on the Child Psychiatry server, which is behind a firewall. The Access database will also be password protected. Only the PI, Project Director, Database Administrator/Data Analyst, and Research Assistant will have knowledge of this password. This administrative database is the only linkage between specific individuals or families and the data from the battery of assessment instruments to be collected. The battery of instruments for each participant is identified by the case number. Once the data from the entire battery of instruments has been gathered, they will be stored in separate locked files at the study headquarters at the N.Y. State Psychiatric Institute.

Respecting participants' preferences for contact method

At the end of the call, appropriate callers will be asked for permission to be contacted by the evaluation team (see **MI/SP Caller Initial Script**, Attachment A). The **MI/SP Caller Initial Script** protects the privacy of callers by asking the caller how and when they want to be contacted, and what type of message (if any) can be left on an answering machine or with the person picking up the telephone.

After an initial message is left, unreachable potential participants will be called back at a later time. A potential respondent will be given the PD and/or interviewers' office phone numbers, for which they alone have access.

Maintaining secure procedures for private information

Secure procedures will be maintained for personal identifiers/call back information provided by potential participants. Crisis centers will transfer this private contact information to the evaluation PD by telephone (speaking directly to the PD) or by secure faxes. A fax machine devoted to the project has been set up in a locked room that is only accessible to research staff. In turn, the PD will provide contact information to the follow-up interviewers in person or by telephone.

All hard-copy forms containing personal identifiers will be stored under lock and key in the PD's office; only the PI, PD, and Database Administrator/Data Analyst will have access to those files. All files containing personal identifiers will be destroyed at the end of the project.

A case number, rather than a caller's name, will be used for the computerized follow-up assessment instruments. The instruments will be on a computer that is password protected and kept secured at all times.

All computerized identifying information on participants (i.e., name, address, telephone number, and telephone consent scripts) will be stored by the PI in password-protected administrative files maintained on the Columbia University Child Psychiatry server, which is behind a "firewall." Only the PI, PD, and Database Administrator/Data Analyst will know the password. This is the only linkage between specific individuals and the assessment instruments to be collected. All project staff will sign a privacy agreement saying that they will keep the participants' answers private.

Once the assessment instruments have been gathered, they will be stored in separate locked files at the evaluation headquarters at the New York State Psychiatric Institute.

Statement to respondents

The telephone script used when the evaluation team contacts the participant for their follow-up interview (**MI/SP Caller Follow-up Consent Script**, see Appendix B) includes (1) the fact that the information collection is sponsored by an agency of the Federal Government, (2) the purpose of the information collection and the uses which will be made of the results, (3) the voluntary nature of participation, and (4) the extent to which responses will be kept private.

A11. Questions of a Sensitive Nature

Because this project concerns suicide prevention, it is necessary to ask callers questions that are potentially sensitive. However, only information that is central to the study is being sought. Questions address dimensions such as suicidality and other self-injurious behaviors, drug and alcohol use at the time of the call, and access to lethal means. Research has demonstrated that asking individuals about suicide does not create distress or "put ideas into their heads." Quite the contrary, it has been shown that *not* asking suicidal individuals about suicide creates distress

(Gould et al., 2005). The answers to these questions are used to understand who is being served by the hotlines, correlates of help-seeking after the initial crisis intervention, and hotline intervention outcomes. The counselor will be discussing sensitive issues with the caller as a function of the crisis call; however, they will not be asking sensitive questions as a function of the monitoring.

Additionally, the purpose of the monitoring of suicidal callers is to collect follow-up information on participants' mental health status six weeks after their call to a hotline. This information is sensitive, but important to expanding the evidence base for suicide prevention hotlines.

The crisis counselors at participating centers will ask callers' permission to be re-contacted by evaluation staff, using the **MI/SP Caller Initial Script.** Counselors will use this script during a follow-up call, rather than during the caller's initial crisis call. They will only make this request if, at the end of the telephone crisis counseling intervention they believe that the caller has the cognitive capacity to understand the script/request, and is not so acutely distressed that making the request would be clinically inappropriate. During the follow-up call, the counselor will be able to decide whether the caller is able to follow the conversation and respond in a meaningful manner, and whether they are sufficiently calm at the end of the call to consider the request. Only then would the caller be approached for a follow-up contact. (Note that callers who are under 18 years old are screened out at the beginning of the script. Non-English speakers will also be screened out.)

Approximately six weeks after a caller's initial crisis call, they will talk to an evaluation interviewer who is a trained crisis counselor, who will use the **MI/SP Caller Follow-up Consent Script**, which incorporates all elements normally included in a written informed consent form. The script will ask for consent to participate in the **MI/SP Caller Follow-up Interview**, as well as permission for the evaluation staff to obtain baseline information on referral recommendations by the counselor who helped them during their crisis call. The caller's consent will be audio taped. At that point, ten percent of the callers will also be asked whether they would agree to the audio taping of their actual **MI/SP Caller Follow-up Interview**; the counselor will explain that this will be done for quality control purposes and that it is not a requirement for their participation. The caller's response to this request will also be audio taped.

A12. Estimates of Annualized Hour Burden

Burden estimates presented in Table 2 are based on information supplied by various sources. Measures that were developed were piloted by the contractor to determine average burden estimates and have since been implemented in the field, allowing for updated burden estimates. These measures include the **MI/SP Caller Follow-up Interview, MI/SP Counselor Attitudes Questionnaire,** and the **MI/SP Counselor Follow-up Questionnaire**. In addition, estimated burden for non-respondents is provided for each activity. There is no non-response burden associated with any of the counselor instruments or the counselor consent form.

A total of 250 counselors per year (750) will be trained to implement MI/SP with callers and complete the **MI/SP Counselor Attitudes Questionnaire.** The MI/SP Counselor Follow-up Questionnaire will be completed by counselors who follow-up with or attempt to contact crisis callers after the initial call. It is estimated (annualized) that the trained counselors (250 per year)

will complete this questionnaire 5 times a year. Approximately 6 weeks after the initial call, and follow-up consent is obtained, interviews will be conducted with no more than 1,107 callers throughout the study period utilizing the **MI/SP Caller Follow-up Interview**. The total burden number of respondents that will complete the MI/SP Follow-up Interviews during the data collection period is 1,107—representing the total number of completed interviews to be completed for this clearance request. As a result, the estimated annualized burden is 369 respondents per year (i.e., 1,107/3).

The current instruments and consents have been implemented in the field through the previously reviewed and approved clearance (OMB No. 0930-0274). The only change (i.e., revision) to the current package is the reduction in the number of instruments and consents. The previously reviewed and approved consents and scripts have not been changed (just the total data collection and burden has been reduced). As a result, the evaluation team is able to update burden estimates based on actual burden from the previous clearance request

Table 2

Evaluation of Networking Suicide Prevention Hotlines—Revision

Estimated Annual Burden

Note: Total burden is annualized over the 3-year clearance period.

Instrument/Activity	Number of respondents	Responses / Respondent	Total number of Responses	Burden/ response (hours)	Annual burden (hours)	Hourly Wage	Total Hourly Cost
MI/SP Caller Initial Script	500	1	500	.08	40	$22.01[2]	$880
MI/SP Caller Initial Script Refusal	121	1	121	.02	2	$22.01[2]	$44
MI/SP Caller Follow-up Consent Script	369	1	369	.17	63	$22.01[2]	$1,387
MI/SP Caller Follow-up Consent Script Refusal	21	1	21	.03	1	$22.01[2]	$22
MI/SP Caller Follow-up Interview	369	1	369	.67	247	$22.01[2]	$5,437
MI/SP Caller Follow-up Interview Refusal[3]	1	1	1	.25	.25	$22.01[2]	$6
MI/SP Counselor Consent	250	1	250	.08	20	$20.81[4]	$416
MI/SP Counselor Attitudes Questionnaire	250	1	250	.25	63	$20.81[4]	$1,311
MI/SP Counselor Follow-up Questionnaire	250	5	1,250	.17	213	$20.81[4]	$4,433
	Total						
Total	**2,131**	**–**	**3,131**	**–**	**649**	–	$13,936

1. Rounded to the nearest whole number.
2. Assuming mean hourly wage of all occupations taken from Bureau of Labor Statistics, *May 2012 National Occupational Employment and Wage Estimates*. http://www.bls.gov/oes/current/oes_nat.htm
3. MI/SP Caller Follow-up Interview Refusal represents the non-response burden for those who provide consent to and begin the interview but do not complete the interview.
4. Assuming mean hourly wage of mental health counselors taken from Bureau of Labor Statistics, *National Compensation Survey: Occupational Earnings in the United States, 2007, Summary*. http://www.bls.gov/oes/current/oes211014.htm

A13. Estimates of Annualized Cost Burden to Respondents

The respondents will not incur any capital, startup, operational, or maintenance costs.

A14. Estimates of Annualized Costs to the Government

SAMHSA has planned and allocated resources for the management, processing, and use of the collected information in a manner that enhances its utility to agencies and the public. Including the Federal contribution that funds the grantees participating in the monitoring, the contract with the monitoring team and Government staff to oversee the effort, the annualized cost to the Government is estimated at $306,261 that include the evaluation costs and the cost of Federal staff. These two costs are described below.

Approximately $303,861 per federal fiscal year for two of the next three years has been awarded to fund the expenses related to developing and implementing the Monitoring of the National Lifeline protocols. Awards or plans for future awards have been made to cover the continuation of the annualized cost. An estimated 72 hours per year of a senior GS-14 level federal staff member will be required for oversight to the data collection efforts for an annualized cost of $2,400.

A15. Changes in Burden

Currently there are 1,181 total burden hours in the OMB inventory. SAMHSA is requesting 649 hours. This represents a decrease of 532 hours due to a program change involving the elimination of 5 previously approved data collection forms. The reduction in the total burden is a result of the decreased number of instruments.

A16. Time Schedule, Publication, and Analysis Plans

Time Schedule

The time schedule for continuing the data collection is summarized in Table 3. A 3-year clearance is requested for this project.

TABLE 3
Time Schedule

Activity	Timeline
Receive OMB re-approval for study	February 2013
Data collection	February 2013–May 2016
Ongoing analysis	February 2013–May 2016
Final Report	No more than one annual report

Publication Plan

A final report will be submitted to SAMHSA with anticipated subsequent dissemination to other interested parties, such as researchers, policymakers, and program administrators at the Federal, State, and local levels. Although not required under the evaluation contract, it is also anticipated that results from this data collection will be published and disseminated in peer-reviewed publications such as *Suicide and Life Threatening Behavior*, similar to the published articles from prior phases of the hotline evaluation efforts (i.e., Kalafat et al., 2007; Gould et al., 2007 and Gould et al., 2012).

Data Analysis Plan

All of the data collection and analytic strategies detailed in this package are linked to the main questions of interest, which are to determine the efficacy of follow-up, what factors might modify its efficacy, and whether the MI/SP training has an impact on the process and efficacy of follow-up. Centers will receive MI/SP training mid-way through the data collection period, enabling a comparison of pre-training and post-training follow-up outcomes. The burden for MI/SP and non-MI/SP trained counselors is included in the annualized burden (i.e., there are not separate groups of trained and not trained counselors; rather, training is introduced with the same group mid-way through the data collection period).

The statistical analyses will take into account the hierarchical structure of our sampling design. Mixed effects linear models will be estimated. The data analyses will be based on a two-level model, which has the benefit of accounting for the clustering of observations within center (callers or counselors nested within center). Analyses will be performed using SuperMix version 1.2 (Hedeker et al., 2009). SuperMix can fit models with continuous, count, ordinal, nominal, and survival outcome variables with nested data, allowing up to three levels of nesting. For analyses of covariance that includes covariates with missing data, we will use multiple imputation (Allison, 2001; Little & Rubin, 2002) for missing values to avoid information loss and potential non-response bias that might arise with complete case analysis that excludes cases with missing data by default.

A17. Display of Expiration Date

The expiration date for OMB approval will be displayed on all data collection instruments for which approval is being sought.

A18. Exceptions to Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions. The certifications are included in this submission.