THE NETWORKING SUICIDE PREVENTION HOTLINES—EVALUATION OF IMMINENT RISK

SUPPORTING STATEMENT

A. JUSTIFICATION

A1. CIRCUMSTANCES OF INFORMATION COLLECTION

Background

The Substance Abuse and Mental Health Services Administration's (SAMHSA), Center for Mental Health Services (CMHS) is requesting a revision from the Office of Management and Budget (OMB) for the approval of the Networking Suicide Prevention Hotlines – Evaluation of the Lifeline's Policies for Helping Callers at Imminent Risk. CMHS is requesting OMB approval of the data collection under SAMHSA's Networking and Certifying Suicide Prevention Hotlines grant program, which established the National Suicide Prevention Lifeline ("Lifeline").

The program is operated under authorization of Section 520A of the Public Health Service Act (42USC290bb-32.) 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 evaluation of the program.

A total of eight new centers will participate in this evaluation. SAMHSA is requesting OMB review and approval of the **National Suicide Prevention Lifeline--Imminent Risk Form** (OMB No. 0930-0333; Expiration Date 01/31/15) with revisions, hereafter referred to as the **Imminent Risk Form-Revised** (see attachment A).

This effort builds on a series of efforts previously reviewed and approved by OMB (Evaluation of Networking Suicide Prevention Hotlines Follow–Up Assessment, OMB No. 0930–0274 and Call Monitoring of National Suicide Prevention Lifeline Form, OMB No. 0930–0275) to evaluate crisis hotline practices, protocols and outcomes. The **Evaluation of the Lifeline Policies for Helping Callers at Imminent Risk** is being implemented to evaluate the management of imminent risk callers by hotline counselors, assess counselor adherence to *Lifeline Policies for Helping Callers at Imminent Risk of Suicide*, and identify the types of interventions implemented with imminent risk callers.

SAMHSA funds a National Suicide Prevention Lifeline ("Lifeline") Network, consisting of toll–free telephone numbers that route calls from anywhere in the United States to a network of local crisis centers. Since its inception, the Lifeline has received more than two million calls.

The crisis centers answering these calls provide invaluable services for callers who are and are not at imminent risk. Evidence to support the value of crisis hotlines to suicide prevention has grown (King et al., 2003; Gould et al., 2007; Kalafat et al., 2007; Mishara et al., 2007a & 2007b; Gould & Kalafat, 2009; Gould et al., 2012; Knox et al., 2012; Gould et al., 2013). Based

on the evidence, the Lifeline has emerged as a vital resource for a range of suicide prevention initiatives and programming, to include becoming central in public awareness messaging campaigns on a federal, community and advocacy level.

Previous hotline evaluations have shown that large numbers of callers have significant histories of suicidal ideation and attempts (Kalafat et al., 2007). While not every caller is at imminent risk for suicide, crisis hotlines will typically provide referrals to mental health and other services, and also will advise the caller that they may call back if they are in crisis or have additional needs. 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.

The Lifeline has recently developed the *Lifeline Policies and Guidelines for Helping Callers at Imminent Risk of Suicide.* The guidelines are comprised of two policies: (1) telephonic practices and (2) establishing and maintaining collaborative relationships with local crisis and emergency services. In addition there are nine supporting guidelines to assist crisis centers. These guidelines focus on three core areas:

- The use of ***active engagement***, which requires that callers are actively engaged in the process of ensuring their own safety, that there is collaboration between the caller and hotline staff, and that the least invasive approach is taken to ensure a positive outcome;
- The use of ***active rescue***, which requires that staff take all action necessary to secure the safety of a caller and initiate emergency response without the callers consent if they are unwilling or unable to take action on their own behalf; and
- A focus on ***collaboration*** with other community crisis and emergency services and the establishment of working relationships with entities that can serve to assist in the ongoing safety of the caller.

This initiative is in keeping with SAMHSA's Strategic Initiatives, which are designed to reduce the impact of substance abuse and mental illness on America's communities. Specifically, Strategic Initiative Goal 1.3 addresses the emphasis on suicide prevention, "*prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives."* Objective 1.3.2 states *"increase public knowledge of the warning signs for suicide and actions to take in response."* The following two action steps relate specifically to the Lifeline and its services: (1) to increase the visibility and accessibility of suicide prevention services in States, Territories, Tribal entities and communities, and work to ensure the National Suicide Prevention Lifeline program is adequately funded, and (2) to increase awareness of suicide prevention and the suicide hotline among populations at higher risk for suicide, especially military families, Tribes and youth with a focus on racial and ethnic minorities and LGBT youth. It is also in keeping with SAMHSA's Strategic Initiative 7: *realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.*

Crisis counselors from eight new Lifeline centers will complete the **Imminent Risk Form-Revised** in an effort to continue ongoing evaluation activities aimed at providing a profile of imminent risk callers and assess the interventions used with these callers. The purpose of this

evaluation is to collect data, using an imminent risk form, to inform the network's knowledge of the extent to which counselors are aware of and being guided by Lifeline's imminent risk guidelines; counselors' definitions of imminent risk; the rates of active rescue of imminent risk callers; the types of rescue and non-rescue interventions used; barriers to intervention; and the circumstances in which active rescue is initiated, including the caller's agreement to receive the intervention. To capture differences across centers, the form also collects information on counselors' employment status and hours worked/volunteered, level of education, license status, training status, source of safety planning protocols, and responsibility for follow up.

The Need for Evaluation

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. With a comprehensive assessment of counselor implementation of imminent risk and active rescue protocols, counselor effectiveness can be monitored and adapted as needed, and ways in which program activities can be improved or differentially targeted can be identified.

A2. Purpose and Use of Information

The Lifeline seeks to instill hope; sustain living; and promote the health, safety, and well-being of the callers and community members it serves. Preventing the suicide of callers is the primary mission of the Lifeline; thus, all staff must act to secure the safety of callers determined to be attempting suicide or at imminent risk for suicide.

Analysis of the original data collection revealed important emerging trends. First, counselor completion of safety planning training was a marginal protective factor against voluntary rescue. Second, counselors who completed the safety planning training had about half the odds of asking for a voluntary rescue compared to those who did not complete safety planning training. And finally, the average number of suicide calls a counselor handled each week was a marginal predictor of voluntary rescue. Given the lessons learned, categories used to identify types of voluntary and involuntary rescue have been refined for the current effort. Specifically, counselor training and experience will be used to predict the implementation of voluntary rescue, the implementation of involuntary rescue, and the reduction of risk during the call (such that rescue was not needed). In addition, new questions have been added to assess caller outcomes based on knowledge the crisis centers may gain in the days or weeks following the crisis call. For example, if known and/or applicable, counselors will be asked to report on whether rescue resulted in the caller's hospitalization, as well as on whether the caller was successfully reached for follow-up.

The data to be collected will contribute to the evidence-base of suicide prevention hotlines. Through this effort, SAMHSA will enhance the efficacy and accountability of crisis intervention services, and ultimately optimize public health efforts that prevent suicidal behavior. More immediately, this effort will provide a risk profile of callers who are determined to be at imminent risk for suicide and who may require active rescue and assess the types of interventions counselors used with them. The evaluation will also assess whether a center's

follow-up practices have an impact on rates of active rescue By combining the data previously collected through this effort and the data to be collected, evaluation findings will provide sufficient statistical power to accurately inform future program practices and policy recommendations, as well as refine guidelines. The information will be compiled in a report for SAMHSA, which it may choose to disseminate. The specific areas of contribution for the **Evaluation of the Lifeline Policies for Helping Callers at Imminent Risk** efforts are detailed below.

- SAMHSA can use the results from the evaluation to develop policies and provide guidance regarding the handling of imminent risk callers to the Lifeline. Information and findings from the evaluation also can help SAMHSA refine the guidelines for imminent risk callers, if deemed necessary, to promote the systematic implementation of guidelines across crisis centers.

- Findings from the evaluation can be used by crisis centers to improve their services, assess the ability of counselors to implement the guidelines, train crisis counselors in center processes and functions related to imminent risk, and guide the use of voluntary and involuntary rescue. Centers also can use the information gathered to better identify imminent risk callers and improve their services and outcomes.

- 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, evaluation of the implementation of the guidelines adds significantly to the developing research base about the use of hotline services. Second, the focus on imminent risk callers allows researchers to examine and understand the actions taken by counselors to aid imminent risk callers, assess the need for active rescue, determine caller risk and protective factors, and identify the types of interventions used. Finally, the analysis of evaluation data helps both researchers and service providers improve the delivery of crisis hotline services to imminent risk callers.

The **National Suicide Prevention Lifeline—Imminent Risk Form-Revised**, will be completed by hotline counselors based on the information discussed during crisis calls with imminent risk callers. No direct data collection will occur from imminent risk callers.

Counselor adherence to the Lifeline guidelines will be reflected in counselors' assessing the four dimensions of a caller's suicide risk, and implementing an intervention which is consistent with the caller's risk level. For example, in accordance with the Lifeline's imminent risk guidelines, counselors should seek to actively engage all callers in actions to help themselves, regardless of level of risk; counselors should refrain from initiating active rescues in the event that a caller's risk can be reduced using collaborative means; and counselors should initiate active rescues when the caller's risk is not successfully reduced using collaborative means.

The Guidelines were disseminated across the network in 2012, and Lifeline staff verified that each center's policy documents were modified accordingly. It was left to the centers to determine how best to incorporate the Guidelines into the centers' trainings for crisis helpers (which often include but are never limited to ASIST). Also in 2012, the Lifeline developed an online simulation training (the "Lifeline Simulation Training System"), which focuses on rapport-

building, adequate and accurate risk assessment, and the selection of an intervention appropriate to the caller's level of risk. However, use of this training material has to date not been widely promoted across the Lifeline network. To capture the possible impact of this training program on counselors' implementation of the Lifeline Guidelines, SAMHSA proposes to add to our Imminent Risk Counselor Information Form a question about the counselor's prior experience with this training (see Question #9 on the revised form, Attachment 1). Each counselor will submit one Imminent Risk Questionnaire for each imminent risk call s/he handles during the study period. SAMHSA did not propose to assess changes in an individual counselor's adherence to the Guidelines over time.

Questions on the **National Suicide Prevention Lifeline–Imminent Risk Form-Revised** examine whether the crisis counselor is following Lifeline's guidelines for helping callers at imminent risk of suicide, the counselor's experience and training, the criteria for counselors to identify a caller as being at imminent risk, and the interventions implemented with and without caller consent.. This protocol directs the counselor to note the following:

- Center information (collected once per center: whether call center is part of a larger behavioral health organization, what types of crisis services center provides, whether center has access to a mobile crisis team, the mobile crisis team's capacities and personnel)
- Counselor information (collected once per counselor: employment status, hours worked/volunteered per week, number of imminent risk callers per week, level of education, license status, training status, source of safety planning protocols, and responsibility for follow up)
- Line called (Lifeline or center line)
- Language spoken
- Participants on call (person at imminent risk, third party, or both)
- Whether person is a repeat caller (if known)
- Demographic information of the imminent risk caller (age, gender and military status)
- Ratings of the suicidal desire and suicidal intent of the person at risk
- Suicidal capability and history of risk behaviors (e.g., prior suicide attempt, violence, substance abuse, sleep problems)
- Protective factors/buffers (e.g., social supports, sense of purpose)
- Intervention type either undertaken by caller (e.g., collaborate on safety plan, get rid of lethal means) or undertaken by counselor with or without the caller's consent (e.g., send public safety officials for safety check, send mobile crisis unit)
- Demographic information of the participating third party (if any) (age, gender)
- Interventions involving the participating third party (if any)
- Barriers to getting help for caller at imminent risk
- Steps taken to confirm whether emergency contact was made
- Outcome of attempts to rescue person at imminent risk
- Outcome of attempts to follow-up on/obtain further information about the case

Changes

The revised form reduces and streamlines response options for intervention questions. Specifically, response items have been modified and reduced for 7 questions and one question deleted (outcome for non-imminent risk). The revised form also includes the addition of a total of 12 questions about the center (4 items), the counselor (1 item—an additional training type), the call (2 items- language and military service), interventions (2 items, e.g., supervisor contact, rescue initiation), and follow-up/outcome of the call (3). Given the length of the deleted versus additional questions and reduction of response options, the burden remains on average the same for the original and revised versions.

A3. Use of Information Technology

The **National Suicide Prevention Lifeline--Imminent Risk Form-Revised** will be completed by trained crisis workers in hard copy or as an interactive Microsoft Word document. Counselors will complete the form for imminent risk callers during or after the call based on information provided by the caller. There is no direct data collection involved and callers will not be asked to answer the questions on the form. Hard copy forms will be transferred via standard mail or fax to the evaluation team where they will be entered into a secure database by the evaluation team. Interactive Microsoft Word documents will be transmitted to the evaluation team via encrypted 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 application represents a one-time data collection effort.

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

A 60-day notice was published in the *Federal Register* on Oct. 23, 2014 (FRN Volume 79, Page 63415). No public comments were received from the 60-day notice.

Directors and representatives to the National Suicide Prevention Lifeline Steering Committee provided feedback to the evaluation design and data collection instrument. These steering committee members have been involved in related hotline evaluations.

A9. Payment to Respondents

There will be no payment to respondents.

A10. Assurance of Privacy

All reports and publications from data collected on imminent risk callers will 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. Due to the anonymity of the callers and the nature of the data collected, a certificate of confidentiality was deemed unnecessary by the evaluation team in collaboration with the IRB of record.

The first name and last initial of counselors who complete imminent risk forms in hard copy will be included on forms sent to the evaluation team, but will not be entered into any databases. Names and initials will be replaced with an ID number, following routine practice recommended by the IRB of record. The names and initials are included temporarily so that the evaluation team is able to contact counselors if information is missing or internally inconsistent. Because the forms include information already available to supervisors through their own routine quality control monitoring, do not request personal information about counselors, do not identify imminent risk callers, and will be used to provide feedback to counselors on performance when necessary, the provision of privacy has been deemed unnecessary. Nevertheless, SAMHSA will maintain the privacy of participants through the privacy protocol described (e.g., removing names or initials and replacing with an ID number).

Data from hard-copy forms will be entered into a secure database by the evaluation team and hard copies 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. Data submitted online will be encrypted at rest and transmitted using Transport Layer Security (TLS) encryption (also known as HTTPS).All files will be destroyed at the end of the project.

New York State Psychiatric Institute, Department of Psychiatry of Columbia University serves as the Institutional Review Board of record for the **Evaluation of the Lifeline Policies for Helping Callers at Imminent Risk**.

A11. Questions of a Sensitive Nature

The items included on the imminent risk form, while related to a sensitive topic, will not be asked directly of callers, but filled in by counselors during calls or after the completion of the call. Therefore, the counselor will be discussing sensitive issues with the caller as a function of the crisis call. Counselors will not be asking sensitive questions as a function of the evaluation. The content of the form includes dimensions such as suicidal desire, intent, capability, protective factors, interventions, barriers to getting help, and steps taken with a person at risk. The answers to these questions will be used to understand and assess the actions taken by counselors in response to imminent risk callers.

A12. Estimates of Annualized Hour Burden

Table 1 shows the annualized burden associated with the evaluation, which will occur across three years, the period for which OMB clearance is being sought.

An average of 16 to 17 counselors at each of eight centers will interact with imminent risk callers for a total of 132 respondents per year of data collection. It is expected that a total of 750 imminent risk forms will be completed across the three year data collection period, which is equal to 250 annual responses from the 132 respondents, or on average 1.9 per respondent annually. The respondent indicated in the estimate of burden is the counselor. The response represents the imminent risk call/form.

During the first imminent risk form completion only, counselors will complete 10 questions about their experience and training in addition to information about the person at imminent risk. Therefore, over the three years, the burden associated with the first imminent risk form completion is 17 minutes, while the remaining 4.7 completions of the form are estimated at 15 minute burden. Together, when averaged across the 5.7 form completions (estimated as 1.9 forms/calls per year per counselor), the imminent risk form burden is 15.4 minutes. Four questions about the center will be completed once by one respondent per center. SAMHSA did not think this will increase burden to a measurable degree.

Table 1. Evaluation of Imminent Risk—Estimated Annualized Burden

Instrument	Number of Respondents	Responses / Respondent	Total Responses	Hours per Response	Total Hour Burden	Hourly Wage Cost	Total Hourly Cost
National Suicide Prevention Lifeline—Imminent Risk Form-Revised	132	1.9	250	.26	65	$21.01*	$1,366

*Assuming mean hourly wage of mental health counselors taken from U.S. Department of Labor, Bureau of Labor Statistics, *May 2013 National Occupational Employment and Wage Estimates*. http://www.bls.gov/oes/current/oes_nat.htm#21-0000

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 centers participating in the evaluation, the contract with the evaluator, and Government staff to oversee the evaluation, the annualized cost to the Government is estimated at **$248,244**. These costs are described below.

A total of $13,334 per federal fiscal year for three years has been allocated toward stipends for crisis centers participating in the Evaluation of the Lifeline Policies for Helping Callers at

Imminent Risk, which results in an annualized stipend of $1,667 per crisis center. Awards or plans for future awards have been made to cover the evaluation in the annualized cost of $231,910. An estimated 72 hours per year of a senior GS-14 level federal staff member will be required for oversight to the evaluation efforts for an annualized cost of $3,000.

A15. Changes in Burden

Currently there are 180 hours in the OMB inventory. CMHS is requesting 65 hours. The decrease adjustment of 115 hours is due to a reduced number of respondents.

A16. Time Schedule, Publication, and Analysis Plans

Time Schedule

The time schedule for the evaluation is summarized in Tables 2.

Table 2. Time Schedule

Activity	Timeline
Receive OMB approval for study	**January 1, 2015**
Data collection period	**February 1, 2015 – January 31, 2018**
Analysis complete	**September 2018**
Final report written	**August 2019**

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*.

Data Analysis Plan

SAMHSA expects to be able to answer the following questions from this evaluation:

- What is the extent to which counselors are aware of and being guided by Lifeline's imminent risk guidelines?
- How do counselors across and within centers define imminent risk? Are counselors' definitions of imminent risk impacted by their training histories?
- What are the rates of active rescue of imminent risk callers and the types of rescue?

- What are the circumstances in which active rescue is initiated, including the caller's agreement to receive the intervention and the extent to which counselors' experience, including their training histories, influences the rates of active rescue among callers at imminent risk?
- What is the risk profile(s) of callers identified by counselors as being at imminent risk?
- How do counselor training and experience affect the types of callers identified as being at imminent risk and the types of interventions implemented with these callers?

Statistical Analyses

Analyses will be modeled after those employed in our previous Imminent Risk Evaluation data collection effort. Mixed effect logistic regression model will be used with random effects for counselors nested into the random center effects. Counselor training and experience will be used to predict outcomes including the implementation of voluntary rescue, the implementation of involuntary rescue, and the reduction of risk during the call such that rescue was not needed. Latent class analyses will be conducted in order to generate a set of profiles of callers deemed by NSPL counselors to be at imminent risk, and these profiles will be used as predictors of the interventions used. In analyses conducted for our earlier evaluation, counselors' having completed safety planning training was a marginal protective factor against voluntary rescue (OR = 0.54, t359 = -1.73, p = 0.08); yet counselors who competed safety training had about half the odds of asking for a voluntary rescue compared to those who did not complete safety planning training. Another important trend to emerge was the finding that the average number of suicide calls a counselor handled each week was a marginal predictor of voluntary rescue (b = -0.045, t356 = -1.83, p = 0.068). For every number increase in the average number of suicide calls handled each week by a counselor, SAMHSA expects to see about a 4 percent reduction in the odds of asking for a voluntary rescue. Combining the data collected during our previous evaluation with the data collected during our proposed evaluation (combined N=1240 imminent risk forms) should provide the increase in statistical power needed to achieve statistical significance. For example, assuming 79% of all counselors complete safety plan training, SAMHSA will have 80% power to detect a voluntary rescue rate difference between 25% (without safety plan training) and 17% (with safety plan training). SAMHSA also intend to perform qualitative analyses of open-ended responses to further understand how counselors are interpreting "imminent risk".

A17. Display of Expiration Date

The expiration date for OMB approval will be displayed.

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.