

Monitoring of the National Suicide Prevention Lifeline Supporting Statement

A. Justification

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) is requesting approval for the revision of data collection associated with the previously-approved Monitoring of the National Suicide Prevention Lifeline (OMB No. 0930-0274; Expiration, July 31, 2016). The current request will continue previously-cleared efforts to evaluate process and impacts of follow-up services provided to suicidal individuals through the National Suicide Prevention Lifeline (NSPL) Crisis Center Follow-Up (NSPL Follow-Up) program. The program operates 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 has directed that funding be provided for the “Suicide Prevention Hotline” program.

SAMHSA funded the first national crisis line in 2001 with the mission of reaching and serving all persons at risk of suicide in the U.S. through a network of certified crisis call centers. In 2005, SAMHSA awarded a contract to the Mental Health Association of New York City to manage and strengthen delivery of telephone crisis services through the launching of the NSPL, or Lifeline—a 24-hour crisis hotline (1-800-273-TALK [8255])—which now serves as a central switchboard, seamlessly connecting callers from anywhere in the U.S. to the closest of its 165 crisis centers within the network. The Lifeline has emerged as a key component of a range of suicide prevention programs. Since its inception, the role of the Lifeline has expanded from handling incoming calls to offering clinical follow-up services to callers, and from there to offering clinical follow-up services to suicidal individuals who have received care from emergency departments (EDs) and inpatient psychiatric hospitalizations.

In 2008, SAMHSA launched the NSPL Follow-up program and began awarding cooperative agreements to crisis centers in the Lifeline network to reconnect with suicidal callers to offer emotional support and ensure they followed up with referrals to treatment. In 2013, the program was expanded to include follow-up with any suicidal individuals discharged from a partnering ED or inpatient hospital. In total, five cohorts of crisis centers have received funding through the program. Most recently, SAMHSA funded Cohort V, awarding cooperative agreements to six crisis centers in FY 2016. These centers will participate in this revision of the Monitoring of the NSPL.

Approval is requested for the continued use and renaming of five activities previously approved by OMB for the Monitoring of the NSPL—one telephone interview, one questionnaire, and three consents. This data collection involves the monitoring of follow-up activities at six NSPL crisis centers funded in FY 2016. Due to the fulfillment of data collection requirements, approval to remove one questionnaire – Counselor Attitudes Questionnaire also is requested. (See Section A.2.b for a full description of each activity.)

1. Circumstances of Information Collection

a. Background

Suicide continues to be a major public health problem in the United States (U.S.). From 1999 to 2013, the age-adjusted suicide rate for all ages in the U.S. increased from 10.5% to 13.5%, with much of the increase driven by suicides in mid-life (Centers for Disease Control and Prevention [CDC] National Center for Injury Prevention and Control [NCIPC], 2015). In 2013, suicide was the 10th leading cause of mortality, claiming the lives of more than 41,000 people, or approximately 1 person every 13 minutes (CDC, 2015). That year, the highest number of suicides of both men and women occurred among those aged 45 to 54 years, with the highest rates (suicides per 100,000) occurring among men aged 75 years and up and women aged 45 to 54 years. Suicide was second leading cause of death for young people aged 15 to 24 years, as well as those aged 25 to 34 years. Suicide rates are higher among some veteran populations compared with the general population (U.S. Department of Health and Human Services [HHS], 2012). Suicide also is a leading cause of death for college students (King, Vidourek, & Strader, 2008), with 11% of screened college students suffering from recent or current suicidal ideation (Garlow et al., 2008).

For every suicide death in the U.S., there are approximately 25 attempted suicides (Crosby et al., 2011). In 2012, 483,596 people were treated in EDs for self-inflicted injuries (CDC NCIPC, 2012). The most critical risk factors for suicide include prior attempts, mood disorders (such as depression), alcohol and drug use, and access to lethal means. Experiencing serious thoughts of suicide increases the risk that a person will make an actual suicide attempt. Suicidal ideation and suicide rates are higher among certain subgroups, particularly young Native Americans and Alaska Natives (CDC, 2012; Goldston et al., 2008); Hispanic females (SAMHSA, 2005); and lesbian, gay, and bisexual youth (Suicide Prevention Resource Center [SPRC], 2008). However, suicide risk is higher among suicide attempt survivors than any other group. For individuals receiving inpatient psychiatric treatment, suicide risk is particularly high the first week after discharge; specifically, the risk is 102 times higher in men and 246 times higher in women compared to the general population (Qin & Nordentoft, 2005). With the closure of more restrictive settings and push for community-based treatment options, EDs have become the “de facto” setting for treating individuals who attempt suicide (Larkin & Beautrais, 2010). As with inpatient settings, the risk for suicide after discharge from the ED remains high. One Korean study found that individuals treated and released from EDs had a suicide mortality rate 54 times higher than the general population (Choi, Park, Yi, & Hong, 2012).

Since its inception, the Lifeline has helped more than 6 million people. In FY 2015, the Lifeline answered approximately 120,000 calls a month, averaging 4,000 calls a day. Further, more than 1,200 veterans, service members, and their families call the Lifeline each day, press “1”, and are connected to professional VA counselors in Canandaigua, NY. While previous evaluations demonstrated that suicidal callers experienced a reduction in hopelessness and suicidal intent after contacting Lifeline, 43% of suicidal callers participating in follow-up assessments reported some recurrence of suicidality (ideation, plan, or attempt) since their crisis call (Gould et al., 2007). Even so, only a minority of suicidal callers set up an appointment. Upon follow-up 2 to 3 weeks after the crisis call, just 22.5% of callers had been seen by the behavioral health care system to which they were referred, and 12.6% had an appointment scheduled but had yet to be seen (Gould et al., 2007; Kalafat et al., 2007). Similarly, while several randomized, controlled

trials have demonstrated that following up by telephone or letter with patients discharged from inpatient or ED settings can reduce rates of repeat suicide attempts (Vaiva et al., 2006) and completions (Fleischman et al., 2008; Motto & Bostrom, 2001), suicidal individuals discharged from EDs rarely link to ongoing care. As many as 70% of suicide attempters either never attend their first appointment or drop out of treatment after a few sessions (Knesper et al., 2010). Thus, it is imperative that EDs link these individuals to follow-up care.

These findings underscore the need for crisis center follow-up and ongoing behavioral health care treatment for suicidal individuals after discharge from EDs and inpatient hospitalizations. SAMHSA is addressing this need through the NSPL Follow-Up program; the Monitoring of the NSPL will continue to assess whether the NSPL Follow-Up program achieves its intended goals.

b. The Need for Evaluation

The Monitoring of the NSPL has been ongoing since 2006. During that time, the evaluation has become a gold standard in data-driven decision-making. Researchers have called for improved crisis center support through formalized standards and guidelines, enhanced training, silent monitoring, and enhanced procedures for follow-up (Kalafat et al., 2007; Mishara et al., 2007). The Lifeline also has disseminated guidelines and policies for helping callers at imminent risk of suicide (Draper, Murphy, Vega, Covington, & McKeon, 2014), a crucial area for which little empirically-based guidance previously has existed. Meanwhile, evidence to support the effectiveness of crisis lines for suicide prevention has steadily grown (e.g., Gould et al., 2007, 2012, 2013; Gould & Kalafat, 2009; King et al., 2003; Knox et al., 2012) and such findings have been directly applied to help improve the quality of crisis line services. In light of its innovative and evaluation-supported programs, the Lifeline has been recognized as a model program and key national resource (e.g., NSSP, 2012), helping to advance knowledge and move the field forward.

Systematic monitoring of suicidal persons who call the Lifeline, and other suicidal individuals served by Lifeline crisis centers, is necessary to understand client outcomes and to identify and refine best practices for linking suicidal individuals to ongoing behavioral health care. Through continued monitoring of suicidal callers, crisis center follow-up clients, 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 individuals in crisis.

Data from earlier NSPL evaluations demonstrated the need for follow-up with suicidal individuals and contributed to SAMHSA's decision to implement the follow-up initiative. In addition, initial findings from the ongoing evaluation have been critical to understanding caller outcomes, identifying areas for improving caller outcomes, and enhancing and refining follow-up protocols. For example, when the majority of callers reported the follow-up stopped them from killing themselves and kept them safe, SAMHSA expanded the NSPL Follow-up program to fund an additional 30 centers beyond the initial six, as well as promote crisis center follow-up with clients referred from partnering hospital EDs and inpatient units. Thus, continuing to gather data on the process and impacts of the NSPL Follow-Up program will enable SAMHSA to determine whether to continue to advocate for and promote crisis center follow-up of suicidal

individuals in its current form, as well as provide the basis for shaping future follow-up programs so as to optimize their effectiveness.

This effort contributes to two SAMHSA/CMHS national outcome measures (NOMs), “perception of care” and “access to care.” The former is addressed through questions to participants about the outcomes of the help they received during follow-up calls, including their suicide risk before, during, and after the call, as well as their perceptions of the extent to which the intervention reduced that risk. The latter is addressed by determining whether the client followed up with referrals provided.

c. Previously-Approved Clearance

Currently, data collection for the Monitoring of the NSPL is operating under OMB approval (No. (OMB No. 0930-0274), valid through July 31, 2016). The previously-approved OMB request involved a process and impact evaluation of crisis center follow-up with callers to the Lifeline, as well as an assessment of the impact of a motivational interviewing and safety planning (MI/SP) training on counselor behavior and caller outcomes.

d. Clearance Request

SAMHSA is requesting approval for revisions to the previously-approved Monitoring of the National Suicide Prevention Lifeline (OMB No. 0930-0274; Expiration, July 31, 2016). OMB approval is requested for three years of data collection for two instruments and three consents. The evaluation represents SAMHSA’s desire to expand this process and impacts assessment to include follow-up with clients referred to the Lifeline from partnering hospitals and EDs, as well as to continue to improve the methods and standards of service delivery to suicidal individuals receiving crisis center services. The evaluation will build on information collected through previous and ongoing evaluations of the Lifeline; expand our understanding of the outcomes associated with the NSPL Follow-Up program, particularly among clients referred to crisis centers for follow-up services; and continue to contribute to the evidence base.

2. Purpose and Use of Information Collected

a. Purpose

Previous evaluations of the NSPL have shown the follow-up intervention to be invaluable in the eyes of its recipients, the vast majority of whom indicated that the follow-up calls helped to keep them safe and to prevent their suicide. This revision of the Monitoring of NSPL represents a continuing effort by SAMHSA to (1) improve the methods and standards of service delivery to suicidal clients by informing the development of staff training in networked crisis centers, and (2) collect data on follow-up assessments of clients referred to crisis centers in the Lifeline network. The evaluation design is informed by earlier evaluations of the NSPL Follow-Up program, the ongoing evaluation of currently-funded crisis centers engaged in follow-up with suicidal callers to Lifeline, and experiences working with EDs participating in the Hospital Data Abstraction Form Evaluation of Emergency Department Crisis Center Follow-Up (OMB No. 0930-0337; Expiration, 12/31/2018). 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.

Data gathered through this revision, in combination with data from other evaluations of the Lifeline, will help to answer SAMHSA’s overarching questions related to the NSPL Follow-Up program:

- Do Lifeline Crisis Center Follow-Up programs achieve the intended goal of reducing the number of nonfatal suicide attempts and mortality due to suicide?
- Can changes in outcomes related to suicide be explained by the Lifeline Crisis Center Follow-Up programs, or are they the result of other factors occurring simultaneously?
- Do program impacts vary across different groups of intended beneficiaries (males, females, indigenous people, military families/veterans, etc.), regions, and over time?
- How effective are the programs in comparison with alternative interventions?

b. Data Collection Activities and Methods

This effort involves data collection with clients referred to Lifeline crisis centers for follow-up, as well as crisis counselors. All instruments, consents, and procedures have been approved previously by OMB and are described in Exhibit 1. No revisions to content have been made; only instrument titles have changed.

Exhibit 1. Instrument and Consent Descriptions

Revision	Description
Client Follow-up Interview <i>(Attachment A)</i>	The Client Follow-up Interview (formerly the MI/SP Caller Follow-up Interview) assesses whether crisis hotlines provide effective services to the clients with whom they follow-up. The interview gathers: (1) demographic data; (2) client feedback on the initial visit to the ED or hospital; (3) client feedback on follow-up call(s) received; (4) client suicide risk status at the time of the initial crisis call/hospitalization, as well as during the course of follow-up; (5) depressive symptomology at the time of the interview; (6) client follow-through with the safety plan and referrals made by the crisis counselor; and (7) barriers to clients use of services. The interview will be conducted by a trained crisis counselor via computer assisted telephone interviewing (CATI) technology between six weeks and six months after the initial visit to the ED or hospital. Interviewers are required to have previous experience in telephone crisis counseling and will be trained on the interview via role-play. Any follow-up clients meeting criteria for continuing suicide risk at the time of the interview will be conferenced back to the center from which they received follow-up. The interview takes approximately 40 minutes to complete.
Client Initial Script <i>(Attachment B)</i>	At the end of the first or second follow-up call, crisis counselors will read the Client Initial Script (formerly the MI/SP Client Initial Script). The initial script requests permission for the evaluation team to recontact the client six weeks after referral to the Lifeline about a study being conducted with individuals who receive follow-up from a crisis center. The script collects name, telephone number(s), best dates/times to call, and instructions for leaving messages. The initial script takes approximately 5 minutes.

Revision	Description
Client Follow-up Consent Script (Attachment C)	The Client Follow-up Consent Script (formerly MI/SP Caller Follow-up Consent Script) requests verbal consent from clients to participate in The Client Follow-up Interview telephone assessment to determine whether crisis centers provide effective services to clients. The consent script describes the purpose of the research, duration, and procedures; risks/discomfort; benefits; voluntary nature of participation; measures to protect privacy; and contact information for the principal investigator. A trained counselor will read the verbal consent script at the time of recontact and record the client's response when asked to agree to participate. The follow-up consent script takes approximately 10 minutes.
Counselor Follow-up Questionnaire (Attachment D)	As in previous and ongoing evaluations, crisis counselors at each of the participating centers will complete a questionnaire on each client referred for follow-up. The Counselor Follow-up Questionnaire (formerly MI/SP Counselor Follow-up Questionnaire) examines the process of follow-up. The survey gathers: (1) information about the counselor employment, education, and training status; (2) counselor assessment of client suicide risk status during follow-up, independent of client self-report; (3) counselor assessment of client suicide risk status at the last follow-up call, independent of the client self-report; (4) a description of clinical activities during follow-up; (5) counselor understanding of whether the client followed through with referrals or resources provided during the initial call or during follow-up; and (6) obstacles to follow-up and any changes needed to the implementation of the follow-up protocol. Counselors complete one survey for each client with whom they follow-up/attempt to contact. The survey takes approximately 10 minutes to complete per client. Each counselor is expected to complete 15 questionnaires each.
Counselor Consent (Attachment E)	The Counselor Consent (formerly MI/SP Counselor Consent) requests written consent from crisis counselors prior to completing the Counselor Follow-up Questionnaire. This form explains the purpose of the research, privacy, risks and benefits, what the study entails, and participant rights. The written consent takes approximately 10 minutes to read and complete. Prior to engaging in data collection, each of the 125 crisis counselors will complete one written consent for the three-year data collection period.

c. Revisions

Revisions to the previously-approved evaluation and the rationale behind the changes are described in Exhibit 2.

Exhibit 2. Revisions to the Monitoring of the NSPL

Revision	Description
Burden	Respondent burden for this revision request is calculated for the next 3 years of data collection, from July 2016 to July 2019.
Crisis	The number of crisis centers for which burden is calculated is 6,

Revision	Description
Centers	representing a decrease from the previous package.
Respondent Type	<ul style="list-style-type: none"> ▪ Follow-up interviews will be conducted with clients referred to Lifeline crisis centers after discharge from EDs and inpatient hospitalizations; suicidal callers to Lifeline will no longer participate. ▪ Counselors will complete questionnaires for clients referred to Lifeline crisis centers after discharge from EDs and inpatient hospitalizations, rather than for suicidal callers.
Instrument Titles	<ul style="list-style-type: none"> ▪ Due to the completion of the MI/SP training, MI/SP will be removed from the titles of all instruments and consents. ▪ The term “caller” will be replaced with “client” on relevant instruments to reflect the change in respondent type.
Instrument Continuati ons	<p>Two instruments and three consents will continue without changes to content.</p> <ul style="list-style-type: none"> ▪ Client Follow-up Interview ▪ Client Initial Script ▪ Client Follow-up Consent Script ▪ Counselor Follow-up Questionnaire ▪ Counselor Consent
Instrument Removal	Due to the completion of MI/SP training, the MI/SP Counselor Attitudes Questionnaire will be removed from the evaluation.

d. Uses of Information Collected

In *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018* (Leading Change 2.0), SAMHSA identifies six strategic initiatives (SIs) that provide a framework for its vision and mission. The Monitoring of the NSPL is in line with SI-1:

SI-1: Prevention of Substance Abuse and Mental Illness

- Goal 1.3. Prevent and reduce attempted suicides and deaths among populations at high risk.
 - *Objective 1.3.3. Promote rapid, continued, and skilled follow-up with individuals who have attempted suicide or experienced a suicidal crisis.*

The evaluation also addresses the strategic directions (SDs) outlined in the NSSP, which was updated in 2012 to “reflect advances in suicide prevention knowledge, research, and practice, as well as broader changes in society and health care delivery that have created new opportunities for suicide prevention.” In particular, the evaluation addresses the following:

SD-1: Healthy and Empowered Individuals, Families, and Communities

- Goal 3. Increase knowledge of the factors that offer protection from suicide behaviors and that promote wellness and recovery.

SD-2: Clinical and Community Preventive Services

- Goal 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

SD-3: Treatment and Support Services

- Goal 8. Promote suicide prevention as a core component of health care services.
- Goal 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

SD-4: Surveillance, Research, and Evaluation

- Goal 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Further, the continued monitoring of crisis center follow-up, as well as counselors and practices, will help to identify additional areas for improvement in crisis intervention. 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. Findings can be used by crisis centers to improve their services, processes, and functions. Centers also can use the information 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 clients referred to Lifeline crisis centers for follow-up allows researchers to examine and understand who is being served with crisis center services and the outcomes of receiving these services. Finally, the analysis of monitoring data aids in formulating new questions about the NSPL network and helps improve the delivery of crisis hotline services.

Finally, information and findings from the 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.

3. Use of Improved Information Technology

Every effort had been made to limit burden on individual respondents who participate in the Monitoring of the NSPL through the use of technology. The Client Follow-Up Interview will be administered 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 crisis worker will administer the interview via telephone using CATI technology to collect and record the data.

Crisis centers are given the choice of completing the Counselor Follow-up Questionnaire in hardcopy or electronically, using an interactive Microsoft Word document. Hardcopy forms are submitted to the evaluation team by facsimile for data entry. Electronic forms are submitted via email and imported into project databases through an automated program.

4. Efforts to Identify Duplication

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

5. Impact on Small Businesses or Other Small Entities

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

6. Consequences if Information 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.

7. Consistency with the Guidelines of 5 CFR 1320.5(d)(2)

The data collection fully complies with the requirements of 5 CFR 1320.5(d) (2).

8. Consultation Outside the Agency

a. Federal Register Notice

SAMHSA published a notice in the *Federal Register* on April 18, 2016 (81 FR 22622), soliciting public comment on this study. No comments were received.

b. Consultation Outside the Agency

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.

9. Payment to Respondents

Based on experience with previous NSPL evaluations, and consistent with previous OMB approval, follow-up clients will receive \$50 for participating in the Client Follow-up Interview. Remuneration is suggested for respondents not directly affiliated with suicide prevention programs at the time of their participation in surveys and interviews as compensation for the additional burden, potential inconvenience of participation, and any related costs (e.g., transportation costs, mobile phone minutes or data, compensation for time). Previous evaluations have shown that, due to the length of the assessment, lesser compensation would result in low response rates and a biased sample that is unrepresentative of suicidal individuals receiving crisis center services. The evaluator's Institutional Review Board (IRB) considers the \$50 amount of payment to be consistent with that given in other studies using interviews of similar length. No remuneration is planned for the Counselor Follow-up Questionnaire as respondents are crisis center staff.

10. Assurances of Confidentiality

To ensure the confidentiality of data compiled and the protection of human subjects, the data collection protocol and instruments will be reviewed through the IRB of the New York State Psychiatric Institute and the Columbia University Department of Psychiatry IRB prior to the collection of covered or protected data. All reports and publications from these efforts will

include only group-level analyses that fully protect the privacy of individual participants. No data have been or will be stored with identifying respondent information. Strict measures to ensure privacy will be followed. These are described below.

Temporary Use of Personal Identifiers

Client, counselor, and center names will be recorded temporarily on the Counselor Follow-Up Questionnaire. Specifically, only client first names and/or initials will be recorded on the questionnaire, and only first names and/or initials of counselors are to be used on any form that is submitted via email. Upon receiving the questionnaires, the evaluation team will remove the client, counselor, and center names and replace with ID numbers.

Secure Procedures for Transferring and Storing Identifying Information

Secure procedures will be maintained for transferring and storing personal identifiers and other contact information provided by potential participants. Crisis centers will transfer this information to the evaluation PD by telephone directly or by secure facsimile. 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 identifying information on clients (i.e., name, address, telephone number, and signed informed consent forms) will be stored by the Research Foundation for Mental Hygiene principal investigator (PI) in locked files at the study headquarters at the New York State Psychiatric Institute, or in administrative files maintained on the Child Psychiatry server that is protected by a firewall. The Access database will be password protected; only individuals requiring access to the information will have the password—the PI, project director (PD), database administrator/data analyst, and research assistant. All project staff will sign a privacy agreement saying that they will keep the participants' answers private. This administrative database is the only linkage between specific individuals and the data to be collected through the battery of assessment instruments follow-up interview and questionnaire. The battery of instruments completed for each participant will be assigned a unique case number. Once all instruments from the entire battery of all instruments have been completed, they will be stored in separate locked files at the study headquarters at the New York State Psychiatric Institute.

Respecting Participant Preferences

The Client Initial Script protects the privacy of clients by asking how and when they want to be contacted, as well as what type of message (if any) the team member can leave on an answering machine or with the person answering 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 office phone numbers for PD and/or interviewer, for which they alone have access.

Obtaining Informed Consent

The Client Follow-up Consent Script, which is used by the evaluation team for the follow-up interview, states the following: the information collection is sponsored by an agency of the Federal Government, the purpose of the information collection and the uses which will be made

of the results, the voluntary nature of participation, and the extent to which responses will be kept private.

11. Questions of a Sensitive Nature

Because this project concerns suicide prevention, it is necessary to ask clients 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 client as a function of the crisis intervention; however, they will not be asking sensitive questions as a function of the monitoring.

Additionally, the purpose of the monitoring of suicidal individuals receiving crisis center services is to collect follow-up information on participants’ mental health status six weeks after their initial crisis contact. This information is sensitive, but important to expanding the evidence base for suicide prevention hotlines.

The crisis counselors at participating centers will ask clients’ permission to be re-contacted by evaluation staff, using the Client Initial Script. Counselors will use this script during a follow-up call. They will only make this request if, at the end of the telephone crisis counseling intervention they believe that the client 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 client 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 client be approached for a follow-up contact. (Note that clients 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 client’s initial crisis contact, they will talk to an evaluation interviewer who is a trained crisis counselor, who will use the Client 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 Client Follow-up Interview, as well as permission for the evaluation staff to obtain baseline information on referral recommendations at the time of their initial crisis contact. The client’s consent will be audio taped. At that point, ten percent of the clients will also be asked whether they would agree to the audio taping of their actual Client 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 client’s response to this request will also be audio taped.

12. Estimates of Annualized Burden Hours and Costs

Approval is being requested for three years of data collection for the Monitoring of the NSPL. Data collection for the current cohort (Cohort IV) of 12 crisis centers is operating under the

previous OMB approval (OMB No. 0930-0286; Expiration, January 31, 2016). Data collection requirements for Cohort IV will be fulfilled in July, 2016.

This revision involves the monitoring of follow-up activities with a new cohort (Cohort V) of six crisis centers funded in FY 2016. Exhibit 3 describes the burden and costs associated with data collection for these crisis centers. Estimates of burden for non-respondents to client instruments and consents also have been calculated. Non-response burden is not associated with counselor activities. The cost was calculated based on the hourly wage rates for appropriate wage rate categories using data collected as part of the National Compensation Survey (BLS, 2014) and the U.S. Department of Labor Federal Minimum Wage Standards.

Exhibit 3. Estimated Annualized Burden Hours and Costs

Type of Respondent	Instrument	Number of Respondents	Responses/ Respondent	Total Number of Responses	Burden/Response (hours)	Annual Burden (hours) ¹	Hourly Wage Rate (\$)	Total Cost (\$) ¹
Client	Client Initial Script	217	1	217	.08	17	\$7.25 ²	\$123
Client	Client Initial Script Refusal ³	53	1	53	.02	1	\$7.25	\$7
Client	Client Follow-up Consent Script	161	1	161	.17	27	\$7.25	\$196
Client	Client Follow-up Consent Script Refusal ⁴	10	1	10	.03	1	\$7.25	\$7
Client	Client Follow-up Interview	160	1	160	.67	107	\$7.25	\$776
Client	Client Follow-up Interview Refusal ⁵	1	1	1	.25	1	\$7.25	\$7
Counselor	Counselor Consent	42	1	42	.08	3	\$20.81 ⁶	\$62
Counselor	Counselor Follow-up Questionnaire	42	15	630	.17	107	\$20.81	\$2,227

¹ Rounded to the nearest whole number; if the nearest whole number is 0, rounded up to 1.

² Assumes Federal minimum wage

³ Client Initial Script Refusal represents the nonresponse burden for individuals who hear a portion of the script and do not consent to be contacted or provide their contact information.

⁴ Client Follow-up Consent Script Refusal represents the nonresponse burden for individuals who hear a portion of the script and do not consent to participate in the follow-up interview.

⁵ Client 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.

⁶ Assuming mean hourly wage of all occupations taken from Bureau of Labor Statistics, *May 2014 National Occupational Employment and Wage Estimates*. http://www.bls.gov/oes/current/oes_nat.htm

Type of Respondent	Instrument	Number of Respondents	Responses/ Respondent	Total Number of Responses	Burden/ Response (hours)	Annual Burden (hours) ¹	Hourly Wage Rate (\$)	Total Cost (\$)
Total		685		1,274		264		\$3,406

13. Estimates of Annualized Cost Burden to Respondents or Record Keepers

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

14. Estimates of Annualized Cost 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 \$280,694 that include the evaluation costs and the cost of Federal staff. These costs are described below.

An average of approximately \$278,294 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 will be made to cover the continuation of any annualized costs. An estimated 72 hours per year of a senior GS-14 Federal staff member will be required for oversight to the data collection efforts, for an annualized cost of \$2,400.

15. Changes in Burden

Currently there are 649 total burden hours in the OMB inventory. SAMHSA is requesting 264 hours for this revision, representing a decrease of 403 annual burden hours. This change in burden is the result of a program change where the number of participating crisis centers has decreased and the one data collection form has been eliminated.

16. Time Schedule, Publication, and Analysis Plans

a. Time Schedule

The time schedule for implementing the cross-site evaluation is summarized in Exhibit 4. A three-year approval period is requested for this project.

Exhibit 4. Time Schedule

Activity	Timeframe
OMB approval received	August 2016
Data collection	August 2016-July, 2019
Ongoing analysis	August 2016-July 2019

Activity	Timeframe
Final Report	No more than one annual report

b. Publication Plans

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. It is also anticipated that results from this data collection will be published and disseminated in peer-reviewed publications similar to the published articles from prior phases of the NSPL evaluation efforts, such as *Suicide and Life Threatening Behavior*, (i.e., Kalafat et al., 2007; Gould et al., 2007; and Gould et al., 2012).

c. Data Analysis Plan

All of the data collection and analytic strategies detailed in this package are linked to the main questions of interest, which include determining the efficacy of follow-up and what factors might modify its efficacy (Exhibit 5).

Exhibit 5. Indicators and Their Purpose

Indicator	Purpose
Client Follow-up Interview	
Client demographic data	Potential modifier of the efficacy of the follow-up
Client feedback on the initial visit to the hospital/ED	Potential modifier of the efficacy of the follow-up
Client feedback on the follow-up call(s) received	Outcome measure of the efficacy of the follow-up
Suicide risk status of the client at the time of the initial crisis contact and during the course of follow-up	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	Outcome measure of the efficacy of follow-up
Depressive symptomology at the time of the interview	Outcome measure of the efficacy of follow-up
Client follow through with the safety plan and referrals made by the crisis counselor	Outcome measure of the efficacy of follow-up
Barriers to client service use	Future program development to enhance client use of services
Counselor Follow-up Questionnaire	
Information about the counselor employment, education and training status	Potential modifier of the efficacy of follow-up
counselor's assessment of client's suicide risk status during follow-up, independent of client's self-reports	Predictor and potential modifier of the efficacy of the follow-up
Counselor assessment of client suicide risk status at the last follow-up call,	Outcome measure of the efficacy of follow-up

Indicator	Purpose
independent of client self-reports	
Description of clinical activities during follow-up	To describe the clinical course of follow-up and predict its efficacy
Counselor understanding of whether the client followed through with referrals or resources provided during follow-up	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

The statistical analyses will take into account the hierarchical structure of our sampling design. Mixed effects linear models will be estimated. This analysis has the benefit of accounting for clustering of clients or counselors nested within center, and clients nested within counselors. Before any modeling, we will examine the distribution of continuous outcomes for outliers, and inconsistent values for ordinal and nominal outcomes. Analyses will be performed using SAS version 9.4 copyright 2002-2012, SAS Institute Inc., Cary, NC, USA. SAS can fit models with continuous, count, ordinal, nominal, and survival outcome variables with nested data. 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 that might arise with complete case analysis that excludes cases with missing data by default.

17. Display of Expiration Date

All data collection instruments will display the expiration date of OMB approval.

18. Exceptions to the Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions.