



NATIONAL SUICIDE PREVENTION LIFELINE Policy for Helping Callers at Imminent Risk of Suicide

December 2010

Developed by the staff from the National Suicide Prevention Lifeline (Lifeline) at Link2Health Solutions, Inc. in collaboration with the Lifeline Steering Committee, Standards, Training and Practices Subcommittee, and the Consumer Survivor Subcommittee (see <http://www.suicidepreventionlifeline.org/About/ExpertLeadership.aspx> for more information) under grant No. 5 U79 SM056176-06 from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Any opinion, findings, conclusions, and recommendations expressed herein are those of the authors and do not necessarily reflect the views of the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

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EXECUTIVE SUMMARY

In January 2008, the National Suicide Prevention Lifeline (Lifeline) Standards, Trainings and Practices Subcommittee (STPS) and Steering Committee approved Lifeline's *Policy for Helping Callers at Imminent Risk of Suicide*. This background paper details the underlying process, research and rationale that led to its development. Two independent federally funded evaluations of network crisis centers present findings that indicate a need for consistent center practices for assisting callers at imminent risk of suicide. This paper describes current gaps in crisis center accreditation requirements, where guidelines for helping callers at imminent risk of suicide are nonexistent or insufficient to address the needs noted in the evaluation findings.

The *Policy for Helping Callers at Imminent Risk of Suicide* emanates from an underlying set of values that are represented in this document. These core values of Lifeline's work with callers at imminent risk of suicide emphasize: 1) the need to take all actions necessary to prevent a caller from dying by suicide, 2) active collaboration with the caller to act to secure his/her own safety and 3) collaboration with other community crisis and emergency services that are likely to aid the crisis center towards ensuring the safe, continuous care of the caller at imminent risk. This paper provides a definition for what constitutes a caller at imminent risk of suicide, a definition that is informed by Lifeline's Suicide Risk Assessment Standards. In addition, it describes the process used to determine the core values, definitions and components of the Policy for Helping Callers at Imminent Risk of Suicide.

The *Policy for Helping Callers at Imminent Risk of Suicide* can be understood in terms of the two central concepts of active engagement and active rescue. New to the field of suicide prevention, but familiar to crisis hotlines, these concepts are an integral part of any call center policy that effectively addresses caller safety. The complete policy elements can be summarized as follows:

- **Active engagement:** This central component refers to the ability of the crisis center staff to not only adopt an active listening approach but actively engage the individual at risk in a discussion of his/her thoughts of suicide; supporting the individual's experience, exploring strengths and resources, building hope for recovery and empowering the callers to work towards securing their own safety. While crisis call centers typically seek to engage all callers, active engagement is distinctive in actively seeking collaboration with a caller at *imminent risk of suicide* to prevent his/her suicide. This distinction is necessary, as evaluation findings provided in this section indicate that such active engagement with callers at imminent risk of suicide needs to be practiced with greater consistency. This paper provides additional research and rationale for the support of active engagement.
- **Least invasive intervention:** Building on the use of active engagement, this component promotes the use of approaches that emphasize cooperation over coercion with callers at imminent risk to secure their safety, with the use of involuntary methods as a last resort. Through actively engaging the caller, the goal is to include the person's own wishes in any plan to reduce risk. This section of the paper reviews legal precedents, supportive research and specific less invasive interventions.
- **Active rescue:** This component refers to the need for call center staff to initiate rescue with or without the caller's consent during circumstances in which, *despite all efforts at engagement*, the call center staff believe that the individual is at imminent risk and unable to participate in securing his/her own safety. Active rescue is distinguished from voluntary

rescue in a strict sense; voluntary rescue is predicated on crisis center helper-caller agreement. This component is specific to the helper needing to actively initiate rescue services because the caller is unwilling or unable to do so for him or herself, and, without rescue services, the helper believes that the caller is likely to die by suicide. This paper addresses common concerns and beliefs that may prevent helpers from actively rescuing unwilling/unable callers at imminent risk of suicide. The corresponding section of this paper cites legal precedents, research and common field practices to support the inclusion of this life-saving guideline.

- **Initiation of life-saving services for attempts in progress:** An obvious component of active rescue, this guideline focuses on the need for all centers to *specifically address* the need to immediately initiate rescue when the caller has already taken action with the intent and potential to cause lethal self-harm. Findings from SAMHSA hotline evaluation studies summarized here underscore the need for Lifeline centers to pay particular attention to callers in the act of killing themselves, and further compel the inclusion of a specific element that requires immediate efforts to initiate emergency rescue services in such cases. This section of the paper provides a definition for a caller's attempt in progress.
- **Third-party callers:** This guideline requires that crisis center staff actively engage the third party in determining the degree of risk and work collaboratively on how best to establish a direct connection with the person at risk. While it is recognized that a determination of imminent risk based on third-party reports alone can be difficult, this paper provides guidance on assessment of the reliability of the third-party caller as well as the issue of anonymity that may arise. In addition, this section presents recommendations on how to effectively collaborate with third-party callers on pursuing the least invasive intervention.
- **Supervisory consultation:** This refers to the support necessary to effectively determine the need for, and initiate, an active rescue procedure. Call center staff must have *timely access* to supervisory guidance during all hours of crisis center operations. This section clarifies what constitutes a supervisor at a network center, and also offers recommendations on supervisory review of incidences of active rescue.
- **Caller ID:** A second support element, this requires that call center staff have access to some method of identifying the caller's phone number during the call. This issue is of primary importance when a caller at imminent risk is unwilling or unable to ensure his/her own safety. For centers unable to maintain caller ID, the Lifeline Real Time Call Trace system is available and must be written into the policy/guidelines for staff to follow.
- **Confirmation of emergency services contact:** This refers to the need for network centers that initiate active rescue to confirm that the caller did in fact receive the emergency help needed. Sample data from a New York-based crisis center are used to illustrate the need for this guideline, noting that nearly one-third of callers were not seen or transported after the center initiated rescue services. In cases where rescue was initiated without the caller's consent, the confirmation of contact may not always be straightforward. This paper discusses potential challenges to this guideline and suggests approaches for successfully addressing them.

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- **Procedures for follow-up when emergency services contact is unsuccessful:** If center staff members learn that emergency rescue services did not make contact with the caller at imminent risk, what should they do next? When centers obtain information that efforts to link the caller with emergency services were unsuccessful, this guideline requires that centers develop a formal plan around following up with these callers. This section of the paper suggests potential follow-up actions, which may include reconnecting with the caller or third party, dispatching a crisis team or informing the local police to continue conducting wellness checks. As this policy element is interdependent with the previous one of confirming emergency service contact, this section discusses similar challenges and possible approaches towards assuring center adherence.
- **Establishing and maintaining collaborative relationships with local crisis and emergency services:** Following the Lifeline value of a shared responsibility for the safety of suicidal callers, this policy element requires that centers develop both formal and informal relationships with community services that can assist in the use of less invasive interventions and/or better ensure optimal continuity of care for callers at imminent risk of suicide. This paper suggests potential areas for relationship building and presents existing crisis center models of collaboration.

Finally, this paper discusses the issue of *confidentiality* that arises within any information-sharing situation. Confidentiality issues have been cited as a perceived barrier to active crisis center collaboration with other community crisis or emergency care services. Lifeline provides here a review of Health Portability and Accountability Act (HIPAA) regulations and legal precedents to assist crisis centers in reassessing assumptions that may be currently inhibiting their collaborative efforts.

With the release of the Lifeline Policy for Helping Callers at Imminent Risk of Suicide, Lifeline hopes to provide a unified protocol for emergency intervention culled directly from the collective values and practices of participating centers. Just as the risk assessment guidelines encouraged a greater focus on the identification of those at risk, the implementation of this policy will, it is hoped, encourage better engagement, assessment and intervention practices that will work towards the common goal of ensuring caller safety. The effect of this policy on crisis center practice will be independently evaluated, which may lead to further related amendments or recommendations designed to improve network crisis center help for callers at imminent risk of suicide.

POLICY STATEMENT

Values Underlying the Lifeline Policy for Helping Callers at Imminent Risk of Suicide

The National Suicide Prevention Lifeline (Lifeline) seeks to instill hope, sustain living and promote the health, safety and well-being of callers and community members it serves. Whereas the primary mission of the Lifeline is to prevent the suicide of callers to its service, all crisis center staff must undertake necessary actions intended to secure the safety of callers determined to be attempting suicide or at imminent risk of suicide.

The Lifeline promotes the most collaborative, least invasive course(s) of action to secure the health, safety and well-being of the individuals it serves. Obtaining the at-risk individual's cooperation is the most certain approach to ensure his/her continuing care and safety.

The Lifeline recognizes that ensuring the health, safety and well-being of individuals it serves is a shared responsibility between the Lifeline's network of member crisis centers and its local crisis and emergency response systems. In order to enhance the continuous, safe and effective care of individuals it serves who are attempting suicide or at imminent risk of suicide, Lifeline promotes collaboration between its member centers and the essential local crisis and/or emergency services in the communities.

The values noted here serve as founding principles of the Lifeline network, which underlie Lifeline's Policy for Helping Callers at Imminent Risk of Suicide. Lifeline network centers are not required to state that they share these values to retain their membership to the network; however, centers are required to adhere to Lifeline policy to retain their network membership.

The Lifeline policy set forth in this document is based on available evidence and clinical consensus to help center staff in securing the safety of the callers, and is, therefore, required of all network member centers. However, this policy is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of individual fact patterns and all information reasonably available for an individual caller, and are subject to change as scientific knowledge and technology advance and caller assistance patterns evolve.

Policy for Helping Callers at Imminent Risk of Suicide

The following is excerpted directly from Attachment I of the Network Agreement, which outlines the network policies and procedures (with numbering intact). Part IV of Attachment I of the Network Agreement is entitled Suicide Risk Assessment and Imminent Risk. Section A refers to Suicide Risk Assessment while Section B (which follows) refers to the newly added Policy for Helping Callers at Imminent Risk of Suicide. All capitalized terms appearing below, and not otherwise defined here or in the appendices, have the assigned definition contained in the Network Agreement.

From Attachment I, Part IV of the Network Agreement

B. Imminent Risk

As of January 31, 2012, the following requirements shall apply to the Center:

1. Center Guidelines shall direct Center Staff to actively engage Callers and initiate any and all measures necessary—including Active Rescue (as defined in Appendix 3, annexed hereto and hereby made a part hereof)—to secure the safety of Callers determined to be attempting suicide or at Imminent Risk of suicide. Specifically, Center Guidelines shall direct Center Staff to:
 - a) Practice Active Engagement (as defined in Appendix 3) with Callers determined to be attempting suicide or at Imminent Risk of suicide (as defined in Appendix 3) and make efforts to establish sufficient rapport so as to promote the Caller's collaboration in securing his/her own safety, whenever possible.
 - b) Use the least invasive intervention and consider involuntary emergency interventions as a last resort, except for in circumstances as described in c) below. As such, Center Staff shall:
 - i. Seek to collaborate with individuals at Imminent Risk (as recommended in Appendix 4, annexed hereto and hereby made a part hereof); and
 - ii. Include the individual's wishes, plans, needs, and capacities towards acting on his/her own behalf to reduce his/her risk of suicide, wherever possible.
 - c) Initiate life-saving services for attempts in progress. As such, to the degree it is evident to Center Staff that a suicide attempt is in progress, whether the information is gathered directly from the person at risk or someone calling on his/her behalf, Center Guidelines shall direct Center Staff to undertake procedures to ensure that the individual at risk receives emergency medical care as soon as possible. While Center Staff should make reasonable efforts to obtain the at-risk individual's consent to receive such services wherever possible, Center Guidelines shall not require that the individual's willingness or ability to provide consent be necessary for Center Staff to initiate medically necessary rescue services.
 - d) Initiate Active Rescue (as defined in Appendix 3) to secure the immediate safety of the individual at risk, up to and including calling an emergency service provider, if, in spite of the Center Staff's best efforts to engage the at-risk individual's cooperation, he or she:
 - i. Remains unwilling and/or unable to take such actions likely to prevent his/her suicide; and
 - ii. Remains at Imminent Risk.
 - e) Practice Active Engagement with persons calling on behalf of someone else ("Third-party Callers") towards determining the least invasive, most collaborative actions to best ensure the safety of the person believed to be in the process of a suicide attempt or at Imminent Risk of suicide (up to and including Active Rescue, as a last resort). Appendix 5, annexed hereto and hereby made a part hereof, sets forth recommended procedures for Third-

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party Callers reporting Imminent Risk and Appendix 6, annexed hereto and hereby made a part hereof, provides recommendations for working with Third-party Callers who wish to remain anonymous.

- f) Center Guidelines shall direct Supervisory Staff (as defined in Appendix 3) to be available to Center Staff during all hours of the Center's operations for timely consultation from Center Staff needing assistance in determining the most appropriate intervention(s), including Active Rescue, for any individual who may be at Imminent Risk of suicide. Center Guidelines shall describe the circumstances under which supervisory consultation shall be sought as well as the process by which Center Staff shall contact Supervisory Staff.
 - g) In order to enable its Active Rescue efforts, the Center shall maintain Caller ID or some other method of identifying the Caller's location that is readily accessible to Center Staff in real time (i.e., during the call). The Real Time Caller ID tool on the Administrator's Members-Only site may be used in order to fulfill this requirement.
 - h) In cases in which the Center initiates Active Rescue, and in which local emergency service providers are willing and able to provide such confirmation, Center Guidelines shall direct Center Staff to confirm (as per the recommendations set forth in Appendix 7, annexed hereto and hereby made a part hereof) that such emergency services have successfully made contact with the at-risk individual. If the Center reports that local emergency service providers are unwilling or unable to offer confirming information to the Center, the Center shall provide documentation (as described in Appendix 8, annexed hereto and hereby made a part hereof) to the Administrator demonstrating its efforts to collaborate with local emergency service providers.
 - i) To the degree that Center Staff have confirmed that emergency response services initiated by the Center were unsuccessful in making contact with the individual at Imminent Risk, Center Guidelines shall direct Center Staff to take additional steps (as per the recommendations set forth in Appendix 7) to address the safety needs of the at-risk individual.
2. The Center shall establish collaborative relationships with one or more emergency service providers in its community (as described in Appendix 9, annexed hereto and hereby made a part hereof) and submit proof of said relationships (as described in Appendix 9) to the Administrator upon its application to the Network or upon request by the Administrator.

APPENDIX 1*

Asking Lifeline Callers about Suicidality

See appendices to Attachment 1 of the Network Agreement.

APPENDIX 2

Suicide Risk Assessment Standards

See appendices to Attachment 1 of the Network Agreement.

APPENDIX 3

Definitions of Key Terms

Imminent Risk: A Caller is determined to be at imminent risk of suicide (“Imminent Risk”) if the Center Staff responding to the call believe, based on information gathered during the exchange from the person at risk or someone calling on his/her behalf, that there is a close temporal connection between the person’s current risk status and actions that could lead to his/her suicide. The risk must be present in the sense that it creates an obligation and immediate pressure on Center Staff to take urgent actions to reduce the Caller’s risk; that is, if no actions are taken, the Center Staff believe that the Caller is likely to seriously harm or kill him/herself. Imminent Risk may be determined if an individual states (or is reported to have stated by a person believed to be a reliable informant) both a desire and intent to die and has the capability of carrying through his/her intent (see National Suicide Prevention Lifeline Suicide Risk Assessment Standards Packet for further clarification).

Active Engagement: Intentional behaviors undertaken by Center Staff to effectively build an alliance with Callers at Imminent Risk towards mutual understanding and agreement on actions necessary to successfully reduce Imminent Risk or accept medical interventions when the person is in the process of a suicide attempt. “Active” refers to intentional behaviors of the Center Staff to positively affect the Caller’s mood, thoughts and/or behavior towards reducing Imminent Risk, as opposed to “passive” behaviors designed to let Callers at Imminent Risk lead themselves to their own conclusions about what to do or not do. “Engagement” refers to effectively building an alliance with the Caller at Imminent Risk, often evidenced by: the degree to which a Caller expresses feeling understood by the responder; and/or a mutual agreement towards actions necessary to reduce the individual’s Imminent Risk, such as the Caller accepting help if he/she is in the process of a suicide attempt. According to this definition, Active Engagement is staff behavior that seeks to collaborate with and empower the Caller towards securing his/her own safety, or the safety of the person he/she is calling about. Active engagement is typically necessary for both a comprehensive, accurate assessment of a Caller’s suicide risk as well as for collaborating on a plan to maintain the Caller’s safety.

*The following appendices are excerpted directly from Attachment 1 of the Network Agreement. Appendices 1 and 2 (not included here) refer to guidelines specific to the Lifeline Suicide Risk Assessment Standards. Appendices 3–8 refer to the newly added Policy for Helping Callers at Imminent Risk of Suicide.

Active Rescue: Actions undertaken by Center Staff that are intended to ensure the safety of individuals at Imminent Risk or in the process of a suicide attempt. “Active” refers to the Center Staff’s initiative to act on behalf of individuals who are in the process of an attempt or who are determined to be at Imminent Risk, but who, in spite of the helper’s attempts to actively engage them, are unwilling or unable to initiate actions to secure their own safety. “Rescue” refers to the need to provide potentially life-saving services. Center Staff should only undertake such initiative without the at-risk individual’s expressed desire to cooperate if they believe that—without this intervention—the individual is likely to sustain a life-threatening injury.

Supervisory Staff: Center Staff who regularly act in a managerial and/or training capacity and who have knowledge of the Center’s most current policies and procedures related to helping Callers at Imminent Risk of suicide. Such personnel might include center directors, training coordinators/supervisors, shift supervisors, or other staff position(s) consistent with the spirit of this definition. Peers (colleagues with no other official designation or routine role as staff supervisor or trainer) acting as consultants are not alone sufficient to meet this requirement.

APPENDIX 4

Examples of Recommended Intervention Measures for Callers at Imminent Risk

Examples of recommended approaches for staff in helping callers at Imminent Risk include, but are not limited to:

- Obtaining agreement from the Caller to take actions on his/her own behalf that immediately reduce Imminent Risk (i.e., intent to die in the immediate sense is diminished and replaced by actions and plans intended to enhance the Caller's personal care and safety);
- Obtaining agreement from a significant other as well as from the Caller that said significant other will intervene towards better assuring the safety of the Caller;
- Obtaining agreement from the Caller to participate in a three-way call with a professional currently treating the Caller, thus returning responsibility to the primary professional overseeing the Caller's ongoing care. Such interventions are most effective in ensuring ongoing safety when Center Staff completely explain to the treatment professional why the Caller has been assessed to be at Imminent Risk;
- Obtaining agreement from the Caller to receive an evaluation in his/her home by a mobile crisis/outreach team trained and licensed to conduct such behavioral health examinations;
- Securing transportation for the person at risk to a hospital emergency room to undergo life-saving medical procedures, treatments and/or psychiatric evaluation; and
- Contacting public safety officials (e.g., police, sheriff) to facilitate a home visit to assess the safety of the Caller, when no other less invasive method is available to determine the Caller's safety.

Note: The above list of examples is not all-inclusive and should not to be viewed as examples of "acceptable course of actions" outside the actual context of any specific call. These examples should be understood as common measures often undertaken on hotline calls that are in the general spirit of concordance with National Suicide Prevention Lifeline Guidelines, with the understanding that appropriate interventions can only be determined by the specific safety needs of an individual Call or Caller.

APPENDIX 5

Recommended Procedures for Third-party Callers Reporting Imminent Risk

In circumstances where a Third-party Caller is reporting that another individual is at Imminent Risk of suicide, it is recommended that Center Staff actively engage the Caller to:

Gather all relevant information from the Caller related to the other's reported risk status, to the degree the Caller can provide such information (see Lifeline Suicide Risk Assessment Standards for ascertaining risk);

- Obtain contact information from the Third-party Caller, as well as information about his/her relationship to the person at risk, towards better ensuring informant reliability and the Caller's collaboration in planning interventions to reduce risk; and
- Obtain contact information for the person at risk from the Third-party Caller, to the degree known.

When working with a Third-party Caller and planning interventions/actions, Center Staff should seek the least invasive, most collaborative approach towards ensuring the safety of the individual at risk.

Examples of recommended measures that may be undertaken by Center Staff when working with Third-party Callers include, but are not limited to:

- Facilitating a three-way call with the Third-party Caller and the person reported to be at risk so that Center Staff may assess and intervene with the individual directly, with the support of the Third-party Caller's concerns and information;
- Facilitating a three-way call with the Third-party Caller and the treatment professional to discuss the current situation and potential safety plans, only if the person at risk is in treatment, unwilling or unable to inform his/her caregiver of his risk, and the Third-party Caller has access to the caregiver's contact information and agrees to a three-way call;
- Confirming that the Third-party Caller is willing and able to take reasonable actions to reduce risk to the person, such as:
 - Removing access to lethal means,
 - Maintaining close watch on the person at risk during a manageable time interval between the Call and the scheduled time when the person is seen by a treatment professional, or
 - Escorting the person at risk to a treatment professional or to a local urgent care facility (e.g., hospital emergency room)
- Obtaining agreement from the Third-party Caller to collaborate with a mobile crisis/outreach service facilitated by Center Staff to evaluate the person at risk within a time frame that—in the best judgment of Center Staff—is reasonable in that it accounts for current level of risk;
- Using information obtained from the Third-party Caller to contact another third party or the individual at risk directly, in cases where the Third-party Caller is either unwilling or unable to help directly with the intervention.

APPENDIX 6

Recommendations for Working with Third-party Callers Wishing to Remain Anonymous

There are occasions when Third-party Callers wish to remain anonymous. This may pose concerns to a Center in that it may undermine assurances of both the Caller's reliability as an informant and his/her willingness to collaborate on behalf of the person at risk. Therefore, Center Guidelines on Third-party Caller should promote greater informant reliability and collaboration with persons reporting others at Imminent Risk.

Recommended exceptions for preserving Third-party Caller anonymity include:

- When Center Staff have reason to believe that revealing the identity of the Third-party Caller to the person at risk might aggravate risks to either the Third-party Caller or the person he/she is concerned about (e.g., a victim of domestic violence reports her husband is planning to kill her, his children, then himself); or
- When the Third-party Caller declines to give his/her name and his/her identity is reasonably believed to be less relevant than his/her report of a clear and present risk to the safety of the person he/she is calling about (e.g., a stranger near a bridge reports a person climbing over the rail and standing on the ledge).

APPENDIX 7

Examples of Recommended Procedures to Confirm Emergency Service Contact and to Determine Caller Safety when Emergency Service Contact Did Not Occur

Steps that can be taken to confirm that emergency service contact was made include, but are not limited to:

- Staying on the line with the Caller until the emergency service provider has arrived and his/her presence is apparent to the Center Staff;
- Contacting local Public Safety Answering Points (or 911 call centers) to determine the pick-up/transport status of the individual at risk (e.g., by using reference or tracking numbers);
- Contacting the emergency room or mobile crisis/outreach staff to determine the status of their contact with the individual at risk (including giving mobile crisis/outreach staff all information collected by Center Staff regarding the at-risk individual's status);
- Contacting the professional responsible for the care and treatment of the individual at risk;
- Contacting the individual at risk directly to obtain affirmation that he/she has made contact with the emergency service provider, and/or conducting an assessment of the individual to verify that he/she is no longer at Imminent Risk of suicide; or
- Contacting the significant other who took responsibility for the individual at risk's safety.

Examples of recommended procedures to determine caller safety when emergency service contact did not occur include, but are not limited to:

- Contacting the individual at risk to assess his/her current risk status and continuing need for service linkages;
- Contacting significant others (e.g., friends or family) believed to have potential access to the individual at risk who are willing and able to conduct a safety check;
- Contacting the individual at risk's treatment professional or case worker to conduct further evaluation and a safety check;
- Providing the individual at risk's contact and address information—to the extent known—to the appropriate mobile crisis/outreach team for follow-up, if one is available in the individual's area; or
- Informing local law enforcement authorities or other appropriate first responders of the situation and requesting continued safety checks until the safety status of the individual at risk can be confirmed (e.g., arrangements or procedures are in place that allow Center Staff to be notified of the individual's safety status).

APPENDIX 8

Examples of Documentation to Demonstrate Efforts toward Collaborating with Emergency Service Providers

It is possible that in spite of reasonable, assertive efforts by the Center, emergency service providers may not respond to Center overtures towards collaboration, or may directly refuse to provide such information to the requesting Center. In such cases, the Center must provide documentation to the Administrator demonstrating its reasonable, assertive efforts towards collaborating with local emergency service providers.

Examples of acceptable documentation to demonstrate efforts on the part of the Center to collaborate with emergency service providers:

Letters, e-mail or other written correspondence from a local first responder authority (or authorities) declining to collaborate towards providing contact-confirming information. The correspondence must include:

- Name and title of the declining individual, and
- Agency's name.
- In the absence of the above, a minimum of two separate incidences of written correspondence from the Center to an emergency service provider seeking to enter a relationship (formal or informal) or otherwise collaborate that include:
 - Date(s) of correspondence,
 - Name of agency contacted,
 - Name and title of individual contacted (at agency),
 - Name of the Center initiating correspondence, and
 - Name and title of Center Staff initiating correspondence.

Evidence of unsuccessful attempts in collaborating with emergency service providers does not suggest that no further efforts should be made by the Center to enable this collaboration in the future. Upon receiving this documentation from a Center, the Administrator will, in turn, provide technical assistance to the Center towards establishing a successful collaboration with a local emergency service provider. When the Administrator provides such technical assistance, it is expected that the Center will continue to pursue such collaborations in the spirit of these guidelines.

APPENDIX 9

Examples of Emergency Service Providers and Types of Relationships for Collaboration

Every Center must make efforts to obtain confirmation of emergency service contact for Callers. This may involve making official arrangements with local emergency service providers.

Examples of emergency service providers for collaboration include, but are not limited to:

- Police departments,
- Fire departments,
- County sheriff offices,
- Mobile crisis/psychiatric outreach teams,
- Hospital emergency departments,
- Public Safety Answering Points or 911 centers,
- Emergency medical services (e.g., ambulance/transport services).

Centers are required to establish and maintain formal and/or informal relationships with emergency service providers.

Examples of formal relationships include, but are not limited to:

- Cooperative agreements,
- Memoranda of understanding,
- Relationships officially authorized by a local government entity (e.g., city/county health or mental health department), and
- Intra-agency policies for collaboration between a Center and an emergency service provider housed within the same parent agency.

Examples of informal relationships include, but are not limited to:

- Regular communications to coordinate rescue and care efforts;
- Exchange of outreach and education materials that promotes awareness and use of the Center's services; and
- Training of local staff regarding the Center's services.

BACKGROUND PAPER:
NATIONAL SUICIDE PREVENTION LIFELINE
POLICY FOR HELPING CALLERS AT
IMMINENT RISK OF SUICIDE
RESEARCH AND RATIONALE

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PART I. THE NEED AND PROCESS FOR DEVELOPING THE POLICY

Introduction

Through a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), Lifeline was launched on January 1, 2005. Lifeline is a network of more than 145 independently operated crisis call centers nationwide that are linked to a series of toll-free numbers, the most prominent of which is 800-273-TALK. When callers dial this number at anytime from anywhere in the United States, they are routed to the nearest network center, where helpers are trained to provide emotional support, assessment, crisis intervention and/or linkages to necessary community resources.

The mission of Lifeline is to prevent suicide by reaching and effectively serving all persons at suicidal risk in the United States through a network of crisis hotlines. In order to serve more callers effectively, Lifeline assembled a subcommittee of nationally and internationally recognized experts in suicide prevention and crisis center work in March 2005. The task of this standing subcommittee—now called the Lifeline STPS—was to consult with the network’s administrator and steering committee on developing policies, standards, guidelines and recommended practices for its network of crisis centers. Following SAMHSA-funded evaluations that indicated the need for more consistent, uniform suicide risk assessment practices for crisis call centers, Lifeline’s STPS developed evidence-informed suicide risk assessment standards in 2006 (Joiner et al., 2007). Lifeline adopted these standards as policy, and verified full network membership adherence with these standards in September 2007.

While the risk assessment standards attended to the need to more effectively identify suicidal risk among Lifeline callers, these standards did not provide guidance to crisis centers as to what subsequent actions might best keep suicidal callers safe from self-harm. In order to better ensure the safety of suicidal Lifeline callers across the network, the task of the STPS was to survey research, field practice and legal precedents to develop uniform guidelines that would shape network crisis center intervention policies and procedures across the country.

In January 2008, the STPS and Lifeline Steering Committee approved the Lifeline Policy for Helping Callers at Imminent Risk of Suicide. This paper details the underlying values, process, research and rationale that led to the development of this network’s first uniform policy for helping callers assessed to be at imminent risk of killing themselves.

Need for an Imminent Risk Policy

It may appear obvious that one of the primary goals of suicide prevention helplines is to prevent suicides. However, organizations offering suicide prevention services differ in the nature of their policies and practices in preventing suicide attempts, and in some instances it is not clear what measures should or would be undertaken to save the life of a caller at imminent risk of suicide. As systematically collected, network-wide data are not currently available to Lifeline, so it is difficult to know the types and frequency of actions employed by center staff to assist Lifeline callers assessed to be imminently at risk of attempting suicide. However, in a data sample of 42,242 Lifeline calls in 2007 offered to Lifeline by four network centers, one measure of assistance to callers at imminent risk of suicide—deployment of emergency rescue services—revealed notable differences of practice across these four agencies. While 2.4% of calls in this sample prompted center staff to send emergency rescue services to the caller, the variance between the four centers ranged from 0.5% of calls at one center (44 of 9,707 calls) to 8.5% at another center (280 of 3,283 calls). Although this is a small sample of centers and the relative number

of callers in acute suicidal crisis may vary between the centers, these data suggest that there are substantial differences between centers in their approaches to defining and/or assisting callers at imminent risk.

Some variation is both expected and desirable among an array of centers serving diverse communities across the country, and much of it can be accounted for by differences in available crisis/emergency support services in the area. However, wide variability between agencies and helpers serving callers at imminent risk of suicide without consensus agreement on field-accepted practices can be problematic. A Lifeline caller who is contemplating suicide should expect that he/she will be similarly assessed and offered appropriate assistance—based on his/her needs and the available local resources—whether he/she is calling from Maine or California. That this wide variance represents real differences across the network indicates the need for more uniform definitions and guidelines on emergency assistance practices for Lifeline callers. With use of emergency rescue services making up only one of several potential methods of assisting callers at imminent risk of suicide, the need for more data about other hotline practices with suicidal callers also appears evident.

The Lifeline Policy for Helping Callers at Imminent Risk of Suicide has been adopted to clarify the actions that should be taken in order to achieve the network's mission of preventing suicides. This policy is based upon a clear vision of the network members' roles and objectives, and provides guidance for centers' policies and practices in situations when a caller's life is at risk. The need for a clear and explicit policy for such high-risk callers was highlighted by a series of SAMHSA-funded evaluations of network crisis centers published in 2007 (Gould, Kalafat, Munfakh, & Kleinman, 2007; Mishara et al., 2007a; Mishara et al., 2007b).

The Gould et al. (2007) evaluation highlights differences in crisis center practices in helping callers at imminent risk of suicide. Evaluation findings reported by Gould et al. (2007) noted differences in staff emergency intervention responses for high-risk suicidal callers at eight crisis centers. Of the 1,085 suicidal callers followed up by Gould and her colleagues, 53.9% had a plan to kill themselves and over a third (33.7%) had both a plan and a history of past attempts. Prior to following up with these individuals, the evaluators collected baseline data from the telephone helpers who first worked with the callers. The crisis center staff working with these callers reported that they dispatched emergency rescue services (typically with the caller's consent) at higher rates (19.2%) than suicidal callers who did not have a plan, and also sent rescues for callers reporting both a plan and attempt history (15.2%) more often than for those with suicidal ideation only. While any number of acceptable interventions other than emergency rescue with these suicidal callers could have occurred, Gould et al.'s findings concerning callers with an attempt in progress are perhaps more striking. Of the 88 callers who had taken some action to kill themselves immediately before calling the center, crisis center staff reported that they did not initiate emergency rescue services to assist them in 54 (61.4%) of these cases. Because the lethality of these attempts varied, it is possible that for some of these callers a number of approaches other than sending emergency rescue services may have been reasonable.

The Mishara et al. (2007) silent monitoring findings strongly indicate a need for a network policy for callers at imminent risk. When Mishara and his colleagues (Mishara et al., 2007a; Mishara et al., 2007b) listened to calls to 16 network centers, they determined that intervention practices with callers at imminent risk were inconsistent and sometimes very different from what center directors and accreditation criteria mandated. In conducting their 2003–2004 study where they listened to 2,611 calls from beginning to end, all the centers in the network were accredited by the American Association of Suicidology (AAS) or an equivalent accreditation organization. According to AAS Certification Standards

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that were also adopted by the network of helplines at the time, crisis programs must have an established policy “to intervene in life-threatening crises along with other community resources such as health and safety agencies” (American Association of Suicidology, 2006). Following its accreditation of a center, AAS does not monitor or spot check centers that it has certified. When Mishara and colleagues monitored calls, they described the nature of the situation and determined for each call if rescue procedures were initiated. They observed if the caller was asked their location, if the helper referred the caller to a walk-in service, if an outreach team was sent, if police or an ambulance was sent, if the caller was informed of this and if the caller stayed on the line or hung up before emergency help arrived.

Mishara and his colleagues identified 33 instances where a suicide attempt was obviously in progress—that is, the caller had clearly engaged in actions that could have resulted in death by suicide during the call. In each of those situations, one would expect that the helper would either convince the caller to stop the attempt or send help to save the person’s life. According to AAS standards, rescue services should be sent if the person’s life is judged to be at risk. In six of the 33 instances, emergency services were sent to the suicidal caller. In three of these cases, the caller stayed on the telephone until the emergency services arrived and in the other three cases the caller hung up before help arrived. Eight of the other calls ended with the callers changing their minds about the attempt and either stopping the attempt or not initiating an imminent action (e.g., putting the gun away, flushing the pills down the toilet).

Of these eight “successful” interventions, three of the calls ended with an agreement on a no-harm contract (and in one of these instances the caller also agreed to call back). One caller accepted a follow-up contact from the center. The four other callers agreed to call back the center. In nine calls, the caller refused offers of help. Three also refused to call back, four refused a call back from the center and also to accept any follow-up help, one refused a no-harm contract (did not agree to not proceed with the attempt) and one refused both a no-harm contract and to call back. In these situations, no emergency help appeared to have been sent after the caller refused the communicated offers of help. Although we do not know what happened after the call, in each of these situations there were no indications during the call that the helper had any intention of doing anything other than accepting the caller’s right to refuse help.

In the remaining 10 instances, the helper did not engage in any attempt at emergency rescue nor did the helper attempt to get the caller to stop the attempt or suggest a no-harm agreement or call back. Four of these callers hung up on the helper when still apparently on the verge of a suicide attempt and it is not known what occurred, in three instances the call ended with the caller still in the process of an attempt (poisoning) and in one of these three instances the caller became unconscious during the call without any help being sent. In this instance, a caller said that she had taken 58 pills and wanted to die. Over the course of 1 hour, she became increasingly incoherent and sleepy. The helper did not appear to understand that the person’s life may have been in danger. At one point, the caller said, “Never mind. I’ll probably fall asleep and that will be it.” The helper responded: “Ok, go to sleep, call us back.” It appeared that the caller became unconscious at that point and was unresponsive. The helper then hung up after repeating to the apparently unconscious caller that she should call back later (Mishara et al., 2007a).

Two of these emergency calls involved delusional, possibly psychotic callers whose contact with reality appeared to be compromised; it is unclear whether or not they completed an attempt. One caller talking on his cell phone from a bridge said he would jump and told the name of the bridge. No action appeared to have been taken and we do not know what ensued when the call ended.

The researchers in the study never anticipated that they would listen to calls where a person's life appeared to be in imminent danger and nothing appeared to have been done to save the person's life. The network had an emergency intervention procedure in place with a simple mechanism for identifying the telephone number and location of callers in need of help. After listening to two calls where it appeared that a caller could have died and no efforts appeared to have been initiated to save their lives, the researchers proposed to the project's research ethics committee that they adopt a policy of breaking the confidentiality agreement with the callers and informing local emergency services if they were convinced that a person's life was in imminent danger, the person could be located and no emergency rescue was initiated by the center.

Since the researchers only had information about what they heard on the telephone, they did not know for sure what occurred after callers hung up. The researchers could not validate if callers who said they were in an attempt were actually in danger, no matter how realistic the call sounded to them; however, they used very conservative criteria in identifying these 33 instances of attempts. (They originally classified over 180 calls as attempts, but afterwards found that only 33 could be considered to be truly at risk without some reasonable doubt).

Despite the limitations of this methodology of listening to calls, it appears from the researchers' observations that lives have been saved by emergency interventions from helplines (Mishara et al., 2007a). However, all callers whose lives appeared to be in imminent danger did not receive emergency rescue, despite center policies, the network procedures and AAS standards that require these practices.

Current accreditation standards are insufficient to address the need for more uniform crisis center approaches to helping imminent risk callers. To ensure that all Lifeline centers maintain a stable infrastructure to support hotline work, all centers are required to have accreditation or licensure from an external body with the authority to audit their practices. At this time, the Lifeline network accepts accreditations from the following organizations: Alliance of Information and Referral Systems (AIRS), AAS, Commission on Accreditation of Rehabilitation Facilities (CARF), CONTACT USA (CUSA), Council on Accreditation (CoA), the Joint Commission (JC) and State Licensure (SL). Table 1 illustrates the current breakdown of organizations accrediting Lifeline centers. With the exception of AAS, none of the accrediting organizations reviewing crisis center work currently has specific standards or protocols that guide center practices in working with callers at imminent risk of suicide.

Table 1: Number of Lifeline Network Centers Accredited by Each Lifeline-Accepted Accrediting Body, 147 Centers, as of August 2010

AAS	CUSA	AIRS	JC	SL	CARF	COA
97	15	4	8	16	4	2

Note: some centers are accredited by more than one organization

Beyond the specific area of crisis line accreditation, accrediting bodies such as JC or CoA that establish standards of care for a wide variety of health care organizations do not have specific guidelines for how to intervene with individuals at imminent risk of suicide, regardless of the health care service area. Instead, they defer to the agency's policies, requiring that the agency seeking accreditation have some definitive protocols for immediately addressing the safety needs of at-risk individuals. It is unclear why

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more specific standards or protocols have not been established by accrediting organizations other than AAS and CUSA.

Without specific guidelines indicating what response protocols for suicidal callers should be, accredited organizations may vary widely in identifying appropriate caller safety measures. As noted earlier in this paper, some variation in practices across agencies providing similar services is desirable. It is, to some degree, important to attenuate protocols to cultural needs and availability of local crisis and emergency response services, and make room for innovative approaches. However, for Lifeline's networked crisis centers, all are, by membership agreement, expected to receive Lifeline calls, assess for suicidal risk and respond to the caller's needs appropriately. These functions are similar enough to require more specific guidance from the network's administrators to member centers as to how to appropriately assist Lifeline callers at imminent risk of suicide. Lifeline's Policy for Helping Callers at Imminent Risk of Suicide is designed to provide greater specificity and uniformity of center protocols to better ensure caller safety, without sacrificing local center's needs for innovation and adjustments to cultural factors.

One accrediting agency, AAS, similarly recognized the need to provide greater specificity to crisis centers applying for certification. To achieve AAS certification, centers must practice active intervention, a term similar to active rescue in Lifeline's guidelines (see section II.B. in this paper for additional detail). AAS-certified centers must also establish interagency relationships with other local community resources that assist in life-threatening crises (American Association of Suicidology, 2006). This requirement is similar to Lifeline's guideline on collaborating with other crisis and/or emergency services, also discussed later in this document. AAS-certified centers must also comply with their guidelines on accepting third party calls reporting others at imminent risk. The AAS standard differs significantly from Lifeline's policy in that it requires direct crisis center calls be made to the suicidal person the third party is calling about and accepts the third party's frequently requested need to remain anonymous. Following-up with moderate to high-risk callers is another AAS certification requirement; Lifeline highly recommends follow-up with high-risk callers, but does not require it. Lifeline requires follow-up only in relation to confirming that callers at imminent risk have been engaged by emergency services initiated by Lifeline centers.

AAS' certification standards for callers at imminent risk of suicide moved the crisis center field forward in its attempt to establish uniform guidelines in this area. Although, among accrediting organizations, AAS devotes the most attention to interventions with suicidal callers, Lifeline centers are not required to obtain AAS certification. However, Lifeline's policy for helping callers at imminent risk is intended to provide its centers with more clear and comprehensive guidance, based on the evaluation findings presented earlier involving mostly AAS-certified centers. Lifeline emphasizes collaboration and least invasive interventions with callers at imminent risk, as well as active rescue, when necessary. Other requirements unique to Lifeline's policy for callers at imminent risk include assurances of available supervisory consultation, use of Caller ID or other call trace technologies and confirming emergency service contacts in active rescue situations. To aid crisis center policy and training development, definitions of terms and practice examples are provided.

Process for Developing the Imminent Risk Policy

As this policy is designed explicitly for helping high-risk callers to Lifeline's network of centers, Lifeline crisis center representatives advised on its reasonability and clarity before, during and shortly after it was drafted.

Prior to the formal development of the policy, Lifeline introduced two terms to the crisis centers at an April 2006 AAS Conference workshop in Seattle. The two terms active engagement and active rescue (to be described in detail in later sections of this paper) were to become central to the soon-to-be-developed network policy for helping imminent risk callers. At least one-third of the network center directors attended the workshop and provided consensus that active engagement was vital in helping callers at imminent risk of suicide; however, many of the participants saw the two terms operating on a “risk continuum,” voicing greater differences on the importance of active engagement relative to active rescue as the caller’s degree of suicide risk became elevated. Workshop participants largely agreed that when callers at imminent risk of suicide resisted attempts by the helper to engage and collaborate with them, the helper should be compelled to activate rescue services on his/her behalf.

From October 2006 through August 2007, six network member crisis center directors provided influential feedback through their roles as STPS and Steering Committee members, helping the committees to develop, review and refine the guidelines. In general, the interplay between the Steering Committee and STPS around the development of this policy was notably dynamic, even more than the previous process related to the creation of the network’s suicide risk assessment standards. With the risk assessment standards, research and surveys of field practices were sufficiently clear and less controversial than the topic of what crisis centers should do after they assess a caller to be suicidal. In this situation, not only was research and knowledge of effective field practices essential, but consumer rights and needs were a paramount consideration, as were relationships with emergency responders. Eventually, STPS and the Steering Committee reached consensus on the policy in August 2007. Consequently, Lifeline was able to present the first draft of the document to the entire network at SAMHSA’s first annual Crisis Centers Conference, held in New Orleans in September of 2007.

At the SAMHSA conference, Lifeline hosted a plenary session focused on the draft policy. Crisis center feedback was strongly encouraged in the following three areas: 1) valuable aspects of the policy in relation to the center and the network 2) perceived challenges in implementing the policy at the centers, and 3) suggestions as to how Lifeline and the network of centers may work together to address these challenges. Based on the ensuing discussion with over 120 crisis center directors participating in the plenary, reactions from the group suggested that the policy largely reflected their current practices and/or values. Subsequent individual Lifeline phone dialogues with center directors from all 130 of the network centers between November 2007 and March 2008 showed significant agreement with most of the Lifeline policy prior to its actual implementation, as shown in **Table 2**.

Table 2: Summary of Network Practices Pre-implementation of Policy for Helping Callers at Imminent Risk of Suicide

Policy, Guideline, or Practice Reviewed	% Centers Meeting Criteria
Actively engaging callers	100%
Active engagement policy in writing	75%
Using least invasive intervention	100%
Having least invasive intervention policy in writing	62%
Center performing life-saving services	99%
Center having 24-hour supervisory consultation available to crisis workers/helpers	99%
Active rescue is provided to involuntary callers who are at imminent risk	99%
Having special programs to build collaboration with police	63%
Having and using caller ID	91%
Center determining whether there has been a successful emergency services contact	54%
Center taking responsibility for the person at risk when there has not been a successful emergency services contact	42%
Routine follow-up calls made to callers at risk for suicide to whom emergency services have not been sent	82%
Other follow-up calls routinely made to other callers	43%
Third-party calls that involve imminent risk actively managed by the center	81%
Written memorandum of understanding existing for emergency services used by the center	23%
Informal understandings existing between the center and the emergency services In lieu of written memorandum of understanding	87%
Centers with either written or informal understandings with emergency services	100%
Crisis workers/helpers monitored for quality assurance purposes	36%

It is also important to note the critical voice of consumer-survivors in drafting the policy. One of the co-chairs of the Lifeline Consumer-Survivor Subcommittee and also a Steering Committee member, who is both a nationally-recognized mental health care consumer advocate and attempt survivor, played a prominent role in underscoring the need to emphasize active engagement by adding a least invasive intervention guideline to further support it.

The policy development and review process included substantial legal consultation. STPS held a conference call with a national expert in suicide litigation, Skip Simpson, in November 2006, to review any legal concerns that might emerge from active rescue and exchanges of confidential information for life-saving purposes. Mr. Simpson's reassuring advice and counsel are reflected in the appropriate sections of this paper. Legal counsel from both the Lifeline grantee (Link2Health Solutions) and SAMHSA also reviewed the policy, with no noteworthy concerns emerging.

Values Underlying the Policy

Although there was vigorous discussion among Lifeline's STPS and Steering Committee members around some of the imminent risk policy, there was clear and immediate consensus around the values that served as its foundation. In the end, the values were ordered in this logical sequence: if life-saving is the first order of business for Lifeline, then a collaborative approach that engages the caller in actions that preserve his/her own life is the best way to accomplish this goal, as well as a collaborative approach with outreach services designed to protect her/him from harm. The order of the values, however, is not intended to diminish their respective significance, and each must be understood as a critical complement to the other (see box below).

Exhibit 1: Values Underlying Lifeline Policy for Helping Callers at Imminent Risk of Suicide

The National Suicide Prevention Lifeline (Lifeline) seeks to instill hope, sustain living, and promote the health, safety and well-being of callers and community members it serves. Whereas the primary mission of the Lifeline is to prevent the suicide of callers to its service, all crisis center staff must undertake necessary actions intended to secure the safety of callers determined to be attempting suicide or at imminent risk of suicide.

The Lifeline promotes the most collaborative, least invasive course(s) of action to secure the health, safety and well-being of the individuals it serves. Obtaining the at-risk individual's cooperation is the most certain approach to ensure his/her continuing care and safety.

The Lifeline recognizes that ensuring the health, safety and well-being of individuals it serves is a shared responsibility between the Lifeline's network of member crisis centers and their local crisis and emergency response systems. In order to enhance the continuous, safe and effective care of individuals it serves who are attempting suicide or at imminent risk of suicide, Lifeline promotes collaboration between its member centers and the essential local crisis and/or emergency services in their communities.

The first value identified by the STPS directs Lifeline to "instill hope, sustain living, and promote the health, safety and well-being of the callers and community members it serves." This phrase was influenced by the similar emergency intervention policy rationale for Lifeline Australia, the national member organization for the network of 42 Lifeline centers in Australia that bears no formal relationship to America's Lifeline program (Lifeline Australia, 2007). Lifeline's primary value statement adds, "All crisis center staff must undertake necessary actions intended to secure the safety of callers determined to be attempting suicide or at imminent risk of suicide." The Australian network's policy rationale also echoes this principle, as both programs recognize that their central mission is to prevent the suicide of callers.

The second value underlying Lifeline's Policy for Helping Callers at Imminent Risk of Suicide promotes collaboration with callers to determine the least invasive course of action for securing the caller's safety and well-being. Here again, Lifeline's value aligns with Australia's policy rationale, which also underscores the importance of collaboration in improving "caller safety and increasing chances that the caller will access help" (Lifeline Australia, 2007).

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Lifeline’s third value addresses the need for its network centers to establish collaborative relationships beyond assisting callers by sharing responsibility for caller safety with local crisis and emergency response systems. Implicit in this value is that Lifeline does not believe that it is enough for Lifeline centers to simply initiate referrals to local crisis and emergency services. To reinforce continuity of care of callers at imminent risk of suicide, Lifeline centers must also seek to activate and maintain cooperative communication channels with key staff within local crisis or emergency response systems.

The values noted here serve as founding principles of the Lifeline network that underlie the Lifeline’s Policy for Helping Callers at Imminent Risk of Suicide. Lifeline network centers are not required to state that they share these values to retain their membership to the network; however, centers are required to adhere to the Lifeline policies to retain their network membership.

Defining Imminent Risk

There are a variety of tools that helpers may use to determine the best response to a caller in crisis. These might include symptom severity (acuity) questions, level of care/placement criteria, and lethality assessment instruments. However, the ultimate arbiter of the degree of intervention is the concept of imminent risk. In **Appendix 3** (see page ix) to Attachment 1 of the Network Agreement, the STPS defined imminent risk of suicide in this manner:

A Caller is determined to be at “imminent risk” of suicide if the Center Staff responding to the call believe, based on information gathered during the exchange from the person at risk or someone calling on his/her behalf, that there is a close temporal connection between the person’s current risk status and actions that could lead to his/her suicide. The risk must be present in the sense that it creates an obligation and immediate pressure on Center Staff to take urgent actions to reduce the Caller’s risk; that is, if no actions were taken, the Center Staff believes that the Caller would be likely to seriously harm or kill him/herself. Imminent Risk may be determined if an individual states (or is reported to have stated by a person believed to be a reliable informant) both a desire and intent to die and has the capability of carrying through his/her intent (see Lifeline Suicide Risk Assessment Standards for further clarification).

Imminent risk is a phrase not unique to crisis center work. It is commonly used in behavioral health settings across the country (e.g., emergency rooms, law enforcement, community mental health centers), and is frequently key language in civil commitment statutes and managed care patient placement criteria. The concept is also employed by other industries—including aviation and child welfare—and is commonly used in the media to describe individuals threatened by violence (Australian Government, 2004; Kentucky State Cabinet for Health and Family Services, 2007).

There is an important level of clinical judgment involved in assessing if an individual is at imminent risk of suicide. More specific phrases like imminent death or immediate risk have been proposed, which present fewer challenges for clinical judgment. However, these terms are too limited in scope to embrace the full potential for hotline workers to prevent suicide among high-risk callers. Imminent death might refer to an individual who has already made a lethal overdose attempt but not yet died. However, this phrase “imminent risk” would not be immediately relevant for individuals who demonstrate the desire, capability and intent to attempt suicide. Likewise, the risk might not be immediate but nonetheless imminent. Lifeline’s use of imminent risk is to be distinguished from alternative phrases like imminent death in that the latter suggests that a caller must be in the suicidal act, as opposed to the caller preparing to kill him/herself soon. How soon, though, is imminent?

Rather than specifying an exact number of hours (e.g., within 24 hours this person is likely to kill him/herself) as a measure of imminence, the Lifeline Steering Committee decided it was best to borrow the phrase from the Australian Civil Aviation Safety Authority indicating a “close temporal connection” between the person’s current risk status and actions that could lead to his/her suicide (Australian Government, 2004). Specifying intervals of time, the Steering Committee reasoned, constrained helpers and callers to potentially arbitrary estimations that might often lead to minimizing degrees of risk. For example, a woman who reports she will end her life on her birthday this coming week might not be at immediate risk in the next 24 hours, but nevertheless, she may constitute a high-risk caller who is at imminent risk.

In 2006, two key journal articles criticized the use of the term imminent in relation to suicide risk terminology. Robert I. Simon, M.D., an established expert in psychiatry and law at Georgetown University, made the case that a similar phrase, imminent suicide, was an illusion, writing that “no suicide risk factors exist for the short-term prediction of suicide” (Simon, 2006). Later that year, Silverman (2006) called into question the validity of many industry-accepted terms used on the subject of suicide by crisis centers and researchers. However, Silverman and colleagues followed up in 2007 calling for a “revised nomenclature,” stating that a “total revision of the initial effort” was needed based upon the dialogue that ensued following the original article (Silverman, Berman, Sanddal, O’Carroll, & Joiner, 2007). We believe this important process will ultimately lead to new concepts and language that will benefit both research and practice, but the Lifeline Steering Committee agreed that it is a work in progress that does not currently offer an alternative, research-based term to imminent risk.

Because imminent risk is a term that is embedded in the current system of behavioral health care outside the narrow field of suicide research, its use by crisis centers in practice helps to improve continuity of care through sharing a common language with health and behavioral health providers. Law enforcement, emergency department (ED) staff, outpatient clinicians, psychiatric inpatient workers and managed care agents use the term regularly, which facilitates better communication about the individual’s safety needs.

Importantly, the Lifeline definition for imminent risk is novel in that it includes the core concepts of the network’s suicide risk assessment standards of suicidal desire, suicidal capability and suicidal intent (Joiner et al., 2007). These concepts do not substitute for the judgment of the helper; rather, they interact with the helper’s knowledge of the caller’s individual circumstances (including chronic callers) and inform the helper’s determination of the caller’s level of risk. The inclusion of these concepts in this definition for imminent risk invites research opportunities for distinguishing if the presence/absence of these factors more accurately affects predictions of short-term suicide risk.

PART II. RESEARCH AND RATIONALE FOR THE POLICY

As noted previously, Lifeline’s values underlie the proceeding policy for helping callers at imminent risk of suicide. In accordance with these values are the Lifeline policies, which require center adherence in order to maintain network membership.

The policy outlined here is intended to influence Lifeline crisis center policies and protocols related to helper practices with callers at imminent risk, with specified guidelines describing necessary components of center policies and protocols for the helpers. In addition, this policy focuses on improving continuity of care for Lifeline callers, requiring that all centers establish and maintain collaborative relationships with local crisis and emergency services in their respective communities. The proceeding policy is based on available evidence and clinical consensus to help center staff in securing the safety of the callers. However, this policy is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of individual fact patterns and all information reasonably available for an individual caller and are subject to change as scientific knowledge and technology advance and caller assistance patterns evolve.

The Lifeline policy states that “Center Policies and/or Protocols shall direct Center staff to actively engage Callers and initiate any and all measures necessary—including active rescue—to secure the safety of Callers determined to be attempting suicide or at Imminent Risk of suicide.” There are key terms that the STPS identified and defined as essential in framing this policy, some of which are new to the field. Two terms that have not been previously employed in suicide prevention are active engagement and active rescue. Although the terms may not be familiar, their meaning and implied actions in working with suicidal callers are quite common in crisis hotline work. Other terms that shaped policy development here are better known among suicide prevention call services, such as attempts in progress, third-party caller and imminent risk. Other than the previously defined imminent risk, each of these terms and how they relate to the policy will be further described in this section.

Active Engagement

A high priority in Lifeline telephone crisis work must be “efforts to establish sufficient rapport so as to promote the Caller’s collaboration in securing his/her own safety, wherever possible” (see box below).

Exhibit 2: Active Engagement and Least Invasive Intervention

1. Center Guidelines shall direct Center Staff to actively engage Callers and initiate any and all measures necessary—including Active Rescue (as defined in Appendix 3, annexed hereto and hereby made a part hereof)—to secure the safety of Callers determined to be attempting suicide or at Imminent Risk of suicide. Specifically, Center Guidelines shall direct Center Staff to:
 - a) Practice Active Engagement (as defined in Appendix 3) with Callers determined to be attempting suicide or at Imminent Risk of suicide (as defined in Appendix 3) and make efforts to establish sufficient rapport so as to promote the Caller’s collaboration in securing his/her own safety, whenever possible.
 - b) Use the least invasive intervention and consider involuntary emergency interventions as a last resort, except for in circumstances as described in 1.c. below. As such, Center Staff shall:
 - i. Seek to collaborate with individuals at Imminent Risk (as recommended in Appendix 4, annexed hereto and hereby made a part hereof).
 - ii. Include the individual’s wishes, plans, needs, and capacities towards acting on his/her own behalf to reduce his/her risk of suicide, wherever possible.

The active engagement approach, by supporting individuals' experience and resources, builds hope for recovery and an empowering model for resolving crises as well as long-term problems. The following written testimony of an Lifeline caller—an M.D. who had an active plan for suicide and who had multiple experiences with mental health care—speaks eloquently to how powerful such an approach can be on a crisis line:

...she took a genuine interest in me, in my feelings, and in why I came to feel this way about myself and about life. She asked all the appropriate questions to assess the situation she was dealing with and the likelihood/probability of self-injurious behavior or a suicide attempt occurring. During this time she never came close to making me feel defensive, and she never asked her questions in a way that made me feel like I was being challenged to defend feeling the way I felt at that time. She got me to describe my feelings and what led me to them, without a hint of confrontation. I did not ever feel that she felt that I, my thoughts or my feelings were messed up, misguided, or “nuts.” I was able to vent all the terribly negative feelings and thoughts I had been having about myself, and that alone was quite a release. From the very beginning I felt like she was an ally interested in getting to know me better. It felt safe to really, really open up to her because [the helper] accepted me as I was, where I was. There was just no lack of acceptance.... I think this is one of things that made [the helper] such a special operator, and made our talk so helpful to me. She listened to me and she heard me....I felt like she was a partner, working with me—and it felt safe...

Active engagement proceeds from the understanding that the most effective course for interacting with anyone seeking help or comfort is to support his/her personal needs, wishes and values, as they relate to the individual's best self-interests. To do this effectively with suicidal callers, a crisis hotline worker must suspend his/her commonly experienced anxieties, enough to be fully present with the caller, communicate authentic empathy and attempt to empower the caller's capacity to make decisions that will keep him/her safe. As detailed in the guidelines' definitions (**Appendix 3**, page ix), active engagement is typically necessary for both a comprehensive, accurate assessment of a caller's suicide risk as well as for collaborating on plans that both agree are most certain to ensure the caller's safety. Crisis hotline workers who are actively engaging suicidal callers seek to facilitate a dynamic, interactive dialogue towards agreeing upon actions necessary to reduce imminent risk or accept medical interventions if the person is in the process of a suicide attempt.

In a genuinely collaborative approach, the helper establishes and maintains a positive alliance with the caller by communicating respect, compassion, concern and a desire to help. This optimal approach requires that hotline workers engage callers in ways that avoid the pitfalls of extreme communication styles that may be construed as authoritarian or passive. On the one hand, authoritarian helper communications with a caller (e.g., more speaking than listening, telling the caller what he/she must do without regard for the caller's wishes) may lead to caller hang-ups, rejection of help or resistance to emergency services when these are sent. On the other hand, helpers employing passive communication styles (e.g., listening only, failing to provide suggestions for help, not showing clear interest in keeping the caller safe) may leave callers feeling stranded, short of resources and even more desperate than before, or lead to an inaccurate or incomplete understanding as to the severity of risk.

Examples of appropriate, “just right” behaviors signaling active engagement with callers can be present in a number of ways. Effective reflections and affirmations that flow both ways between callers and helpers can show that both parties understand one another and are moving towards some agreement. Mirroring and summarizing statements that are free from judgment, as well as clarifying questions that reveal the helper's genuine intention to understand, are indicators of helpers actively engaging callers.

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Active engagement is evident when helpers promote exchanges with suicidal callers where reasons for both dying and living are thoroughly heard, leading to a joint evaluation of the pros and cons of different approaches to planning for safety and care. Characteristic outcomes of effective engagement with callers include a sense of being understood and valued (“I am not alone,” “I am not stupid or crazy” and “I am worthwhile”), and an increased feeling of empowerment (“I can do something to reduce my pain other than kill myself”). Effective engagement with callers is also more likely to ensure better follow-through and compliance than less deliberative service referrals unilaterally offered by the helper. Callers who agree to engage resources in the course of a personal crisis may also be more likely to develop personal resilience and skills to employ in the future.

Other sources have provided suggestions for how to effectively engage individuals at imminent risk of suicide. An Australian panel of 22 expert behavioral health professionals and 10 consumers (with histories of feeling suicidal) were convened to determine agreement towards developing “mental health first aid guidelines for suicidal ideation and behavior” (Kelly, Jorm, Kitchner, & Langlands, 2008). Among the statements endorsed by the group include the following:

- “The first aider should tell the suicidal person that they care and want to help.”
 - “The first aider needs to allow the suicidal person to talk about their reasons for wanting to die.”
 - “The first aider should remind the suicidal person that these thoughts need not be acted on.”
 - “Suicidal thoughts are often a plea for help and a desperate attempt to escape from problems and distressing feelings. The first aider should therefore allow the suicidal person to talk about those feelings.”
 - “By discussing specific problems, the first aider can help the person work out ways of dealing with the difficulties that seem insurmountable.”
 - “The first aider needs to find out what has supported the suicidal person in the past, and whether these supports are still available.”
 - “The first aider should encourage the suicidal person to do most of the talking.”
 - “The first aider should express empathy for the suicidal person.”
- (Kelly et al., 2008, pp.10–11)

Although research related to the effect of active engagement with callers in suicidal crisis is sparse, what little exists is strongly persuasive. Research with suicidal callers showed that a supportive approach and good contact, and to a lesser degree, collaborative problem-solving, were most related to positive outcomes on calls (Mishara et al., 2007b). Helper qualities such as expression of empathy and respect for callers and behaviors such as offers to call back, reframing, appropriate self-disclosures and empowering the caller towards resources and developing action plans had the greatest impact on reducing feelings of sadness, helplessness and hopelessness. Further, these qualities led to fewer hang-ups and higher levels of helper-caller agreement (Mishara et al., 2007b).

How does a helper actively engage with a suicidal caller by showing empathy and respect for one’s suicidal wishes—and promote choice—without encouraging the very act the helper wishes to prevent? Beginning with the assumption that some degree of ambivalence exists with all suicidal persons—that is, there is both a wish to live and a wish to die—it is critical that helpers both tolerate and invite the caller’s expression of reasons for dying (Ramsay, 2004). As artfully demonstrated in Living Works’ Applied Suicide Intervention Skills Training (ASIST), listening to and understanding a person’s reasons for dying naturally evoke the suicidal individual’s counter impulse to express reasons for living. However, the tendency of helpers to focus primarily or exclusively on an individual’s reasons for living can lead the

suicidal individual to hide, protect or even actively assert his/her suicidal desires. By helping a suicidal individual to fully express both sides of his/her ambivalence about living, trainings such as ASIST believe that a helper can more effectively engage him/her in realistic safety planning activities (Ramsay, 2004).

Other non-hotline related research pertinent to collaborative therapeutic approaches has shown great promise in reducing suicidal thoughts and behaviors. The Collaborative Assessment and Management of Suicidality (CAMS) is a suicide problem-focused approach that hinges on a strong therapist-client treatment alliance and de-emphasizes the role of therapist as expert (Jobes, Moore, & O'Connor, 2007). Using a rigorously interactive assessment and treatment planning framework, the CAMS model helps the client and therapist identify and understand the functional role of suicidal thoughts and behaviors for the individual and explores other coping strategies and behaviors that might serve similar functions that maintain the client's safety (Jobes & Drozd, 2004). The therapist's nonjudgmental, empathic attitude in relation to the client's suicidal experience is central to the success of the treatment alliance. Preliminary research on CAMS has shown reductions in both suicidal thoughts and non-mental health medical visits for clients engaged in this model (Jobes, Kahn-Greene, & Goeke-Morey, 2007; Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005). Though the authors of the CAMS model do not explicitly mention its potential use for hotline work, they note its flexibility and potential application in a wide variety of settings (Jobes, Moore et al., 2007).

Another study investigated optimal crisis intervention models used by professional therapists with suicidal clients. Although the preferred method of therapists involved a more authoritarian approach (where the therapist assumes control over determining what is best for his/her patient), the therapeutic response style that clients reported to be most desirable and helpful was the one that treated the client as an active participant, if not the expert, in his/her care (Thomas & Leitner, 2005). Consumer participants in the Australian panel cited previously universally endorsed a consumer as primary decision-maker model, and further noted that professional clinical care should be among a series of options available to suicidal persons, as opposed to the only option (Kelly et al., 2008).

Prior to implementing this policy, every center in the Lifeline network affirmed that it trains its staff in a manner consistent with the principle of active engagement (Table 2). While this underscores that the practice of actively engaging and collaborating with callers in crisis is a universally appreciated value across the network, it does not mean that all Lifeline centers have a stated policy related to this principle.

In spite of the network-wide support for this policy, Mishara et al.'s (2007a) analysis of 18 network member centers found that, in 15.6% of the calls they monitored in 2003–2004, at least one helper rating related to supportive approach and good contact was unacceptable (e.g., low empathy, low respect). Among the 33 calls monitored where a suicide attempt was in progress, Mishara and his colleagues also found that 10 of the helpers did not try to engage the caller in stopping the attempt, encourage him/her to take measures to reduce imminent risk or discuss the need for emergency rescue services. It is hoped that this policy, once implemented, will further reinforce the need for training, monitoring and supervision of center staff to better ensure active engagement with callers in crisis.

Least Invasive Intervention

The guideline for least invasive intervention with callers in emergency situations relates directly to active engagement. As noted in **Exhibit 2**, to “seek collaboration with individuals at Imminent Risk” and, to the degree possible, “include the person's wishes, plans, needs, and capacities towards acting on his/her own behalf to reduce his/her risk of suicide,” depends on the helper's capacity to actively engage the

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crisis caller successfully. The policy clearly states that involuntary interventions should be a last resort for callers at imminent risk of suicide.

The least invasive approach echoes throughout American legal systems and state laws requiring the least restrictive alternative for treatment of persons with mental illness, as is most appropriate for their clinical needs (Siegel & Tuckel, 1987; Simon, 2004). Outside of the United States, the Scottish government's Mental Health Care and Treatment Act 2003 specifies that, "wherever possible, care, treatment and support should be provided to people with a mental disorder without the use of compulsory powers." Specifically, in relation to suicidal individuals, the Scottish government urges that, "Firstly, [suicide] intervention and prevention should begin with the least 'invasive' and most readily reversible options available to the practitioner" (Leitner, Barr, & Hobby, 2008). These laws do not rule out involuntary approaches, nor are they inconsistent with them; they merely discourage coerced care unless it cannot be avoided for persons who could be a danger to self or others. To this extent, Lifeline's guideline for least invasive intervention is consistent with the spirit of these directives.

It is vital that helpers should directly discuss the issue of suicide with Lifeline callers in a collaborative mode that conveys compassion and calm. Survivors of suicide attempts and people who have been chronically suicidal have typically affirmed the value of being able to speak openly and honestly with someone who is not afraid of the subject. As one participant in a focus group of attempt survivors convened by Lifeline noted:

It's not a problem for me [to talk about suicide]. I've thought about it every day for years. But people are afraid of the subject or they want to call the police right away. That's just not helpful. (Macro International Inc., 2007)

As indicated in this cogent reflection of an attempt survivor, fear of potential police intervention can prevent individuals from feeling safe in discussing their suicidal thoughts with others, including crisis line helpers. Involving the police in jurisdictions where they have not developed specialized services for persons with mental illness can have more invasive, nontherapeutic results than jurisdictions that do have such services. A review of research on models of police procedures with persons with mental illness shows that police departments with services such as Memphis' Crisis Intervention Training model reported fewer uses of deadly force, fewer arrests, and fewer incarcerated persons with mental illness than departments without such specialized services (Compton, Bahora, Watson, & Oliva, 2008; New York Civil Liberties Union Report, 2005). In addition, such services were more likely to result in more voluntary (and fewer involuntary) transports to psychiatric emergency services (Compton et al., 2008). These data further support the need for Lifeline crisis centers to collaborate with local first responder agencies, as discussed in detail later in this paper.

In **Appendix 4** (see page xi), a number of less invasive approaches are suggested for callers assessed to be at imminent risk of suicide. Such approaches can include obtaining agreement from the suicidal individual and/or an involved third party to reduce the individual's access to lethal means and seek care that is appropriate to reduce the individual's imminent risk (e.g., go to ED voluntarily, contact his/her therapist and engage in a reasonable safety plan). If moderate-to-high-risk individuals have sufficient family and treatment supports and are willing to engage them to reduce imminent risk, this can be a preferred strategy to hospitalization (Forster & Wu, 2002; Simon, 2004).

To the degree that mobile outreach services are available in a center's community, they can also provide a critical, less invasive approach other than rescue services for assisting at risk callers who cannot or will

not seek services on their own. While there is a dearth of randomized controlled studies on mobile outreach services, research has suggested that these services can reduce psychiatric symptoms of persons who may be otherwise unwilling or unable to seek outpatient care, thereby reducing the number and costs of psychiatric hospitalizations (Bengelsdorf, Church, Kaye, Orlowski, & Alden, 1993; Guo, Biegel, Johnson, & Dyches, 2001; Morris & Warnock, 2001; Reding & Raphelson, 1995). Mobile outreach services vary considerably in their availability in communities around the country, with differences in hours of operation (some 24/7, others not), capacity to respond urgently (within an hour in some regions), and staff make-up. Mobile outreach (or mobile crisis) services also vary in the degree to which they routinely interface with local law enforcement personnel, a factor to be considered in determining their potential in providing a less invasive approach to local callers. Typically consisting of a small team of mental health workers, mobile outreach services appear to be particularly effective in reducing hospitalizations when they include a staff psychiatrist, who can dispense medications to stabilize psychiatrically ill individuals at home (Reding & Raphelson, 1995). However, in all cases, mobile outreach services provide a critical supplement to community crisis lines, behavioral health professionals and law enforcement officials by providing—at relatively short notice—the capacity for comprehensive face-to-face assessments of reportedly at-risk individuals in their homes.

The experience of two Lifeline network crisis centers with direct mobile outreach capacity is instructive of their potential as a less invasive course of action for attending to crisis callers indicating some level of risk. One Lifeline center, Behavioral Health Link's (BHL) statewide crisis line in Georgia, reported data of over 500,000 calls from 2006–2008 that clearly illustrate how the presence and use of mobile outreach services can avoid the use of more invasive, costly services for at-risk individuals. Although BHL initiated rescue services in less than 1% of these cases, they found that when they did send rescue, a caller at imminent risk was five times more likely to have law enforcement dispatched to them in areas of the state that do not possess home-based mobile crisis outreach services. Further, they reported that individuals in crisis are four times more likely to be referred to an emergency room when this service is unavailable (D. Covington, personal communication, May 21, 2008). Another network center with similarly connected mobile outreach capacity—Behavioral Health Response (BHR) in Missouri—reported that their mobile outreach services reduced ED visits at a local state psychiatric hospital by 7% in 2007–2008 (L. Levin, personal communication, November 19, 2008). Interestingly, neither of these crisis line-connected mobile outreach services typically includes a psychiatrist on staff. It is conceivable that even more impressive reductions in use of law enforcement and hospital resources could occur with greater in-home capacity to dispense and monitor psychotropic medications. Again, it is important for a referring crisis center to have information about a local mobile team's services, client eligibility criteria, hours of operation and staffing and interface with law enforcement to determine the degree of assessment, clinical care and other less invasive services they can potentially provide to callers.

Aside from avoiding interventions that could be unnecessarily stigmatizing and invasive, there are other practical reasons for promoting less invasive interventions for callers at imminent risk of suicide. Primarily, reliance on 911-call interventions has important technological limitations, most of which are known to Lifeline's network centers. Initially, 911 emergency number services are not available everywhere. According to the National Emergency Number Association (NENA), a trade organization whose membership consists of every Public Safety Answering Point (PSAPs, also known as 911 call centers) in the country, 4% of the U.S. counties and parishes are not covered by 911 services, although 911 services are accessible to 99% of the population (National Emergency Number Association, 2008). Further, the use of cell phones and voice-over-internet phone (VoIP) systems often prevent obtaining the caller's location, without getting that information directly from the caller. At this time, NENA and the Federal Communications Commission are working together to address these serious, growing concerns.

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However, the current state of telephony technology requires that crisis centers make every effort to collaborate with callers in need of emergency services to agree to accept such interventions, or, preferably, work with the caller to secure his/her own safety to reduce the need for emergency rescues altogether.

As shown in **Table 2**, 62% of Lifeline center policies explicitly address least invasive interventions for callers at imminent risk, although all report practicing this philosophy. A greater emphasis on active engagement and least invasive interventions may help some crisis centers broaden their views of what rescue means when referring to assisting callers they have assessed to be at imminent risk of suicide. Initially, empowering an individual who felt hopeless and helpless before a call to take action during the call to help him/her feel more safe and hopeful can, in some cases, be experienced as life-saving. When researchers followed up with suicidal callers to eight Lifeline centers in 2003–2004, nearly 12% of the callers spontaneously reported that the call prevented them from killing or harming themselves (Gould et al., 2007). Of the 44 persons reporting that the line had a life-saving effect, only two received emergency rescue services (M. Gould, personal communication, 2008). When Lifeline assembled a focus group of survivors of suicide attempts in January 2007, one participant, perhaps, best reframed rescue in this way: “I am less likely to feel that a call to 911 saved my life as much as, say, just being listened to.”

Active Rescue

Regarding Lifeline’s primary life-saving value, it was essential that the Lifeline’s STPS establish a definitive term that described the value’s phrase of undertaking necessary actions intended to prevent a caller’s imminent suicide. In most cases, callers to suicide prevention hotlines are purposefully seeking help for their psychological pain and in search of hope and reasons to remain alive; most suicidal callers are, therefore, willing to collaborate with helpers towards ensuring their safety. In these more typical situations, actively engaged callers first assessed to be at imminent risk often make statements and plans that indicate that they—by the end of the call—are no longer at imminent risk, or that they are willing to take immediate actions to reduce their imminent risk. On the other hand, there are relatively infrequent but highly dangerous circumstances where suicidal callers are unwilling or unable to work with the helper to take actions to secure their own safety. Some suicidal callers are simply too intoxicated or psychotic to collaborate with helpers in any meaningful, reliable manner, while others may overtly refuse assistance in spite of the helper’s best efforts to engage them. In such extraordinary circumstances, it is critical that Lifeline provide guidance to its network centers on how to respond to these unable or unwilling callers who remain in imminent danger. The term active rescue, which appears in **Appendix 3** (see page ix) to Attachment 1 of the Network Agreement, is defined by the STPS as follows:

Active rescue involves actions undertaken by Center staff that are intended to secure the safety of individuals at imminent risk or in the process of a suicide attempt. “Active” refers to the Center staff’s initiative to act on behalf of individuals who are in the process of an attempt or who are determined to be at imminent risk, but who, in spite of the helper’s attempts to actively engage him/her, the individual at risk is unwilling or unable to initiate actions to secure his/her own safety. “Rescue” refers to the need to provide potentially life-saving services. This imperative underscores that Center staff should only undertake such initiative without the at-risk individual’s expressed desire to cooperate if he/she believes that—without this intervention—the individual is likely to sustain a life-threatening injury.

The active rescue element of the Imminent Risk Policy is detailed in the box below.

Exhibit 3: Active Rescue

Specifically, Center Guidelines shall direct Center Staff to:

- c) Initiate life-saving services for attempts in progress. As such, to the degree it is evident to Center Staff that a suicide attempt is in progress, whether the information is gathered directly from the person at risk or someone calling on his/her behalf, Center Guidelines shall direct Center Staff to undertake procedures to ensure that the individual at risk receives emergency medical care as soon as possible. While Center Staff should make reasonable efforts to obtain the at-risk individual's consent to receive such services wherever possible, Center Guidelines shall not require that the individual's willingness or ability to provide consent be necessary for Center Staff to initiate medically necessary rescue services.
- d) Initiate Active Rescue (as defined in Appendix 3) to secure the immediate safety of the individual at risk, up to and including calling an emergency service provider, if, in spite of the Center Staff's best efforts to engage the at-risk individual's cooperation, he or she:
 - i. Remains unwilling and/or unable to take such actions likely to prevent his/her suicide.
 - ii. Remains at Imminent Risk.

Both the definition and the Lifeline guideline for active rescue refer to active engagement as a consistent course of action, throughout the duration of the call, wherever possible. Callers at imminent risk can and should be repeatedly invited by helpers to collaborate with actions intended to secure their safety.

While active rescue is not a previously familiar term in the crisis call center field, it has considerable precedent in crisis center practices. In the 2004 edition of AAS accreditation standards, AAS introduced the phrase active intervention, a forbear of active rescue, which was described in this manner:

One of the core values of AAS is that every citizen has the basic right to necessary assistance in life-threatening or other crises. This value reflects the basic philosophy that an active intervention must be done in life threatening situations. Being mindful of the caller/client's confidentiality and, in some case, anonymity, the intervention would ideally be done with the client's consent and only after all other options have been exhausted. When that is not possible, the intervention will occur without the client's consent or knowledge. The basic tenet of active intervention is that anyone who is suicidal deserves aggressive intervention to keep him/her alive. Individuals in a suicidal crisis do not think rationally; nor do they make reasoned judgments. Thus, crisis intervention demands active intervention; that is, crisis counselors must act to protect life. An agency that is accredited by AAS must accept this tenet (American Association of Suicidology, 2006).

Approximately 66% of Lifeline network centers are accredited by AAS, and a preliminary check of 133 Lifeline member centers (undertaken in 2008) showed that 99% were practicing a form of active intervention (or active rescue as defined by Lifeline; see **Table 2**). Nevertheless, as previously reported in this paper, active rescue is inconsistently practiced.

Lifeline's STPS identified a need to distinguish active rescue from the active intervention, as the AAS phrase lacked clarity in some critical respects. A major area of controversy surrounding AAS' active intervention term, as understood by both AAS accreditors and the crisis centers, was that it was operationally defined exclusively as initiating emergency rescue services on behalf of the suicidal individual (active rescue, as defined in Lifeline terms). However, some crisis center directors believed that interpreting an active intervention as emergency rescue was too narrow to reflect their actual

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practices. For example, some directors noted that when a helper actively collaborates with a person in suicidal crisis to develop a safety plan (or actively engaging them, as Lifeline guidelines would suggest), this is not only an active intervention as they would define it but a vital practice that should be equally valued in accreditation standards. As a result, Lifeline's STPS sought to resolve this confusion in the development of this policy, to more directly reflect the values and practices of its network centers. The STPS agreed that deliberate collaboration with callers and initiating rescue on their behalf were both critical forms of actively intervening with callers at imminent risk. Subsequently, the STPS dispensed with the more ambiguous active intervention term, distinguished active engagement from active rescue, defined the terms separately and made both terms the prominent centerpieces of Lifeline's policy.

Given the clear importance of actively engaging callers to collaborate on measures to secure their own safety, there has been small but significant disagreement in the crisis center community as to whether actions to save a caller's life without his/her consent (active rescue) should be required at all. In October 2006, the STPS undertook a discussion of this issue as a priority consideration in the early stages of developing the imminent risk policy for the network. While consistently reaffirming the primary role of active engagement, the STPS cited several reasons for instituting a network guideline for active rescue.

First, when suicidal individuals themselves choose to call a service whose clear mission is suicide prevention (in this case, Lifeline), the STPS believed that there is, at least, some implicit understanding between the caller and the helper that this service has a responsibility to secure the caller's safety. Once the caller has engaged this suicide prevention service, the responsibility for what course of action to take to address the caller's suicidality is, at least, a shared responsibility.

Second, a considerable body of research challenges the degree to which a helper can accept a caller's choice to die as a rational, responsible decision. Studies have indicated that persons who are suicidal are often cognitively constricted, or constrained by tunnel vision, whereby options for addressing their psychological pain become narrow and dichotomous ("If I live, I will be in pain, if I die, I will no longer suffer") (Schneidman, 1996). This phenomenon of cognitive constriction in suicidal thinking can be successfully addressed in clinical settings, suggesting that treatment is often one among several rational choices other than suicide (Brown, Jeglic, Henriques, & Beck, 2006). In addition, there is evidence among survivors of suicide attempts that some degree of ambivalence towards dying exists among many suicidal individuals until the very instant of their attempt, which is often, tragically, most apparent to them only in the moments after they have taken action to kill themselves (Joiner, 2005; Siegel & Tuckel, 1987). The number of suicide attempts and attempters to actual suicides—estimated at 28 attempts for every completed suicide in the U.S. annually—further suggests that ambivalence is prevalent among persons with suicidal intent (Borges et al., 2006; Siegel & Tuckel, 1987). As one of the remarkably few survivors of a jump from the Golden Gate Bridge, Kevin Hines noted in a later interview:

I didn't want anybody to talk me out of it. I just wanted to die. So I hurtled over the railing with my hands...and the second my hands left the bar of the railing, I said, "I don't wanna die; what am I gonna do?" (From the documentary *The Bridge*, 2006)

This ambivalence towards dying can be understood as implicit in the action of persons who call a suicide prevention hotline to state that they are intending to kill themselves.

Finally, the STPS noted that respecting the choice of callers who wish to kill themselves does not account for significant others in the person's life who are not included in this choice, individuals who are often harmed by the devastating consequences of a loved one's suicide. It is estimated that at least six and as many as hundreds of people are emotionally affected by every suicide (Crosby & Sacks, 2002; Provini, Everett, & Pfeffer, 2000). Family members of a suicide loss have been found to have a suicide risk that is twice as high as the general population (Runeson & Asberg, 2003), and complications from the grief related to a peer's suicide are associated with a five-times higher rate of suicidal ideation among adolescents and young adults (Melhem et al., 2004). Although it is frequently the perception of the suicidal individual that his/her choice to die may make life better for others (Joiner, 2005), or that others simply would not notice or care about his/her suicide, evidence suggests that these perceptions are more often the likely product of depression and its related cognitive constriction phenomena rather than an accurate description of the true social impact of an individual's suicide.

Involuntary Interventions

Some staff at Lifeline centers have stated reluctance to activate rescue services for persons at imminent risk of suicide for fear that such actions could be nontherapeutic or, even worse, harmful to the person at risk. As noted in the Active Engagement section of this paper, there are good reasons to maintain such concerns, insofar as these concerns motivate the helper to consider other reasonable options for intervention before resorting to sending rescue services without the caller's consent. However, *such concerns should not preclude helpers from taking necessary actions without the caller's consent that, if they did not occur, could allow a person to kill him/herself.*

While American legal systems and state laws observe and value the use of least restrictive alternatives for treatment, they are unanimously balanced by a recognition of the state's rights to authorize intervention to prevent a suicide, to the extent that involuntary interventions are seen as the last resort (Siegel & Tuckel, 1987). As some scholars on suicide and civil commitment procedures reasoned:

Dangerousness to self is, in our opinion, the most justifiable basis for involuntary commitment. Involuntary hospitalization represents such a serious deprivation of fundamental liberties that the only morally defensible basis for invoking it is to preserve something more valued than curtailment of freedom—life itself. Some would argue that life without personal freedom is not worth living; but realistically, it must be acknowledged that most involuntary commitments to prevent suicide are of relatively short duration. (Siegel & Tuckel, 1987, pp.351-352)

In a review of the research on the short- and long-term impact of involuntary hospitalizations on individuals, Siegel and Tuckel (1987) noted that the data are largely mixed. They noted that some individuals who have been involuntarily hospitalized report that such an event can be experienced as punitive and potentially damaging to their self-esteem and social reputation. On the other hand, other studies showed that most involuntarily committed patients described their hospital stay positively a year after discharge, reporting that their relationships with spouses and others had improved significantly (Gove & Fain, 1977). In an Lifeline focus group of suicide attempt survivors, one participant offered that most persons who have received rescue services—whether they want them or not—report “feeling grateful later that those services were there for them” (Macro International, 2007).

With or without these uncertain findings, a crisis center staff member's decision to initiate active rescue for unwilling callers at imminent risk should be made without concerning oneself with the potential effects of involuntary hospitalizations. First, as will be explained later in this paper, it is neither certain that

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initiating active rescue for a suicidal caller will either lead to his/her admission to a hospital or even his/her being transported to a hospital. Second, when individuals are involuntarily transported to a hospital, it is not uncommon for them to consent to voluntarily admit themselves. Above all, the primary concern of crisis center workers in such imminent risk situations is to keep the callers from acting on their clear, unrelenting intent to kill themselves *in that moment*, despite the workers' best efforts to persuade them to secure their own safety.

Aside from concerns related to the potential effect of involuntary hospitalizations on suicidal callers, some crisis center staff members report reluctance to call 911 for fear of local law enforcement officials resorting to inappropriate force, arrest or causing other undesirable outcomes for the caller in need of care. While such incidences are tragic when they do occur, and may occur more frequently in jurisdictions where specialized police services for mentally ill persons are unavailable, fears of how the police may respond should not be a determinant in decision-making related to active rescue. First, crisis center staff should only initiate active rescue when non-consenting callers are at imminent risk of suicide and less invasive interventions have failed to secure their safety. In these circumstances, the helper can more directly and accurately assess the potential suicide risk for the caller than he/she can reasonably assess the probability of police causing greater harm to the individual. Second, concerns about police response are less of an argument for avoiding activating rescues than they are a reason for a crisis center to seek collaboration in local police training, education and awareness. Opportunities and benefits of crisis centers collaborating with local law enforcement agencies are discussed at length later in this paper.

Like active engagement, active rescue is a term that reverberates through several of Lifeline's guidelines to help callers at imminent risk. A center's ability to initiate active rescue relates directly to other Lifeline guidelines presented here, such as attempts in progress, availability of supervisory consultation, caller ID and procedures designed to better ensure that emergency service contact occurs with imminently suicidal callers. Each of these guidelines and how they relate to the principles of active rescue and active engagement will be examined in this section.

Attempts in Progress

Prior to the policy's implementation, a preliminary check with the network revealed that 99% of centers initiate life-saving services for individuals attempting to kill themselves during the call (**Table 2**); however, it was not clear how many of these centers reinforced such practices with their own policy and/or procedural directives specific to attempts in progress. Given the data previously cited from the Mishara et al. (2007a) and Gould et al. (2007) evaluations of crisis lines showing inconsistent helper responses for attempts in progress, the STPS determined that there should be a specific guideline addressing this issue. This guideline appears in **Exhibit 3**.

In most circumstances, an attempt in progress is readily apparent and typically less complex than determining imminent risk for persons not in the act. Nevertheless, the determination of an attempt in progress is less clear through telephonic communications than witnessing an attempt in person, so some judgment on the part of the hotline worker is still necessary in concluding that an individual's actions described on a call are, in fact, indicating his/her need for immediate medical attention.

There are two key factors that can inform a hotline worker's judgment about attempts in progress. A suicide attempt in progress can be determined by information evident to the helper that the caller has

taken action—or is currently initiating action—that has either 1) the intent to kill oneself or 2) the *potential effect* of causing lethal self-harm.

In many cases, intent to die and/or lethality of method are clearly indicated by the caller (“I have a gun and I am going to kill myself”). However, there are other cases where either the intent or imminent lethality are unclear, but may still be considered an attempt in progress. It is possible, for example, that a caller may be intoxicated or psychotic, and engaged in a potentially lethal activity not expressly intended to cause self-harm (“I just took 100 aspirin to get these voices to stop hurting my brain”). In this situation, the caller does not convey suicidal intent, but the helper may reasonably believe that the caller is out of touch with reality and has ingested enough medication to require immediate medical attention (potential effect of causing lethal self-harm). Conversely, a caller may have stated that she is sitting on the ledge of her building, intending to kill herself by jumping from a height no more than two stories high. In this circumstance, the caller fully intends to kill herself, but the consequence of her action is more likely to lead to injury than death. It is possible that she may in fact incur a lethal or medically severe injury (falling on her head), or she may subsequently survive to immediately pursue a more certain, lethal course of action. In the latter case, it is the intent of her action that is the critical indicator of an attempt in progress.

As noted earlier, in all circumstances of imminent risk, helpers should seek to actively engage the caller’s cooperation in reducing the risk. This is no less true for cases where lethal means for suicide are immediately accessible (the caller is holding a gun) or even when an attempt is in progress (pills are about to be ingested) and rescue services are determined by the worker to be necessary. For example, the worker should continue to try engaging the caller to take actions on his/her own behalf, such as surrendering the gun to a significant other, flushing the pills down the toilet, obtaining his/her agreement to cooperate with rescue personnel when they arrive. These are actions that can make the difference in saving his/her life before rescue services appear.

This first phase of the policy also includes reports of attempts in progress by individuals calling on behalf of the person at risk (third-party callers). The relevance of this inclusion is addressed in greater detail in the next section.

Collaborating With Third-party Callers

Individuals calling on behalf of someone they are concerned about (third-party callers) make up a significant number of calls to crisis hotlines. Although the precise number of third-party callers to the Lifeline network is not currently known, data offered to Lifeline from four network centers indicates that 8.3% of a total sample of 42,242 Lifeline calls are from third parties (between center variance ranging from 6.3%–14.7%). These data further report that 3.4% of these third-party calls led to activating emergency rescue, with even greater extremes in the variance (from no cases at one center to 20.1% of third-party callers at another center). This relatively small sample from four centers appears to suggest a need for more uniform guidance on third-party Lifeline suicide calls. As noted in **Table 2**, 81% of the network’s crisis centers currently have a policy instructing staff to actively respond to third-party calls that report an individual to be at imminent risk of suicide.

The need for the Lifeline to devise a policy that addresses third party-related active rescue situations is also supported in the AAS Accreditation Application. In explaining its third-party caller accreditation standard, AAS reasoned that, “In general, people who are suicidal but don’t call the hotline are likely to be at even higher risk than someone who calls. In many cases, at-risk individuals come to our attention because someone who cares about them calls” (American Association of Suicidology, 2006).

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Exhibit 4: Third-party Callers

Specifically, Center Guidelines shall direct Center Staff to:

- e) Practice Active Engagement with persons calling on behalf of someone else (“Third-party Callers”) towards determining the least invasive, most collaborative actions to best ensure the safety of the person believed to be in the process of a suicide attempt or at Imminent Risk of suicide (up to and including Active Rescue, as a last resort). Appendix 5, annexed hereto and hereby made a part hereof, sets forth recommended procedures for Third-party Callers reporting Imminent Risk and Appendix 6, annexed hereto and hereby made a part hereof, provides recommendations for working with Third-party Callers who wish to remain anonymous.

Lifeline and its committee advisors recognize that assessing an individual’s imminent risk of suicide based on third-party reports alone can be potentially precarious. The phrase in the box above—“to the degree that Center Staff have a reasonable belief that this Third-party Caller is reliably informed”—is intended to underscore the need for the call center’s helpers to be sensitive to the veracity of the reporter’s information. If the caller seems well-informed, it may still benefit center staff to have clearer guidance as to what type of information should be gathered that would enhance their risk assessment.

Appendix 5 (see page xii) provides a series of such recommendations:

- Gather all relevant information from the caller related to the other’s reported risk status, to the degree the caller can provide such information (see Lifeline Suicide Risk Assessment Standards for ascertaining risk);
- Obtain contact information from the third-party caller, as well as information about his/her relationship to the person at risk, towards better ensuring informant reliability and the caller’s collaboration in planning interventions to reduce risk; and
- Obtain contact information for the person at risk from the third-party caller, to the degree known.

The recommendations listed in **Appendix 5** serve the purposes of learning what the caller’s relationship is to the person presumed to be at risk, what he/she knows about the individual’s current risk status, and how both the caller and individual at risk might be contacted to collaborate for further evaluation and/or intervention.

Related to the informant reliability issue is the concern of how to manage suicide crisis calls from third parties who insist on maintaining anonymity. In some cases, third-party callers will wish to remain anonymous, for a wide variety of reasons. Fears related to negatively affecting their relationship with the at-risk person (“I promised her I wouldn’t tell anyone or try to stop her”) and fears of subsequent violence or threats in retaliation (“He said he would kill me if I ever called the cops on him, so if you bring the cops, don’t tell him it was me that called you”) are among the more common concerns leading callers to request anonymity. However, it is important to distinguish the need to maintain anonymity between the caller and helper from the need for the caller to remain anonymous to the person that he/she is concerned about. Regardless of whether or not the caller’s identity is known to the person at reported risk, it is typically beneficial to the center to have enough information about the caller and his/her relationship with the identified individual to better discern the veracity of the reported concerns. The helper may also need to have the caller’s contact information for further follow-up and intervention planning purposes.

In most cases, it will be important to educate the third-party caller as to the problems associated with him/her remaining anonymous, particularly if he/she has details about the person's suicidality that few (if any) others have. Helpers wishing to contact and assess reported persons at risk cannot generally afford to leave out critical information gained from the third party in their assessment. Perhaps the most important reason for resisting requests for anonymity here is that the anonymous caller often fails to recognize the value of the at-risk person hearing a message such as: "Billy called us because he cares about you, and wants us to help you get through this terrible pain so the two of you can continue to be close friends for years to come."

Within the Lifeline imminent risk policy is a requirement for center policies and/or protocols to "address the issue of anonymity of Third-party Callers in order to promote greater informant reliability and collaboration with Callers." While the Lifeline policy does not provide explicit requirements as to what the center policies and/or protocols should contain, **Appendix 6** (see page xiii) provides some clear recommendations. This appendix suggests that center policies and/or protocols should make exceptions to preserve third-party anonymity only in the following circumstances:

- Center staff have reason to believe that revealing the identity of the third party to the person at risk might aggravate risks to either the third party or the person he/she is concerned about (e.g., a victim of domestic violence reports her husband is planning to kill her, his children, then himself); or
- The third party's identity is reasonably believed to be less relevant than his/her report of a clear and present risk to the safety of the person he/she is calling about (e.g., a stranger near a bridge reports a person climbing over the rail and standing on the ledge).

As stated in **Exhibit 4**, center policies and/or protocols should direct staff to actively engage the third-party caller towards determining the least invasive, most collaborative actions to best ensure the safety of the person believed to be at risk. This guideline echoes many facets of the AAS Accreditation requirement on third-party callers, which also notes: "Many times, the third-party caller can be made an ally and use their contact with the person at-risk to help keep them safe. The caller can be educated about suicidal intervention and risk assessment." AAS further offers the caveat that "It is unfair, however, to give third-party callers the responsibility for actually providing the suicide intervention. They are personally and psychologically too close to the person at risk to be objective and effective as interventionists" (American Association of Suicidology, 2006). Consequently, AAS explicitly requires that the crisis center worker make every effort to speak directly with the person at risk.

Lifeline's third-party recommendation in **Appendix 5** (see page xii) largely concurs with AAS requirements, with some noteworthy exceptions. Lifeline recognizes that it is most important that an assessment of the individual occur, and in a manner that is thorough without being inappropriately invasive. The policy (and recommendation) does not specify that, in all cases, a direct call to the individual is the best way to accomplish this objective; in some cases, facilitating a visit from a mobile outreach team may be more effective than a direct call, particularly if the third-party believes that a direct call would aggravate the individual and undermine a thorough evaluation. In addition, Lifeline's recommendations in **Appendix 5** suggest a number of possibilities where the third party could be engaged in some form of intervention, depending on his/her relationship with the person at risk (e.g., the third party could be his/her therapist). Other examples from **Appendix 5** are listed below:

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- Facilitating a three-way call with the third party and the person reported to be at risk so that center staff may assess and intervene with the individual directly, with the support of the third party's concerns and information;
- Facilitating a three-way conversation with the caller and the treatment professional to discuss the current situation and potential safety plans, only if the person at risk is in treatment, unwilling or unable to inform his/her caregiver of his risk, and the third-party caller has access to the caregiver's contact information and agrees to a three-way call;
- Confirming that the third party is willing and able to take reasonable actions to reduce risk to the person, such as:
 - Removing access to lethal means,
 - Maintaining close watch on the person at risk during a manageable time interval between the call and the scheduled time when the person is seen by a treatment professional, or
 - Escorting the person at risk to a treatment professional or to a local urgent care facility (e.g., hospital emergency room).
- Using information obtained from the third party to contact another third party (e.g., mobile outreach team) or the individual at risk directly, in cases where the third party is either unwilling or unable to help directly with the intervention.

In the last example where an intervention is indicated without the third party's involvement, it is important for the worker to collect information from that individual that clearly suggests that he/she is a credible reporter of the at-risk person's status. Careful attention to this credibility issue will avoid inappropriate, false positive interventions with persons who are not, in fact, at risk. These issues were discussed in greater detail in the previous section relating to third-party caller anonymity and reliability.

Additional Guidelines

Additional guidelines were developed by the STPS to ensure that supervisory and technological supports are in place to aid hotline workers in efficiently and appropriately initiating active rescue. Where active rescues have been initiated by crisis center helpers, further guidelines were identified that are intended to provide assurances that callers at imminent risk of suicide have successfully connected with emergency/crisis services for further evaluation and/or care. These guidelines appear in the following box and are described in greater detail below.

Exhibit 5: Imminent Risk Policy

- f) Center Guidelines shall direct Supervisory Staff (as defined in Appendix 3) to be available to Center Staff during all hours of the Center's operations for timely consultation from Center Staff needing assistance in determining the most appropriate intervention(s), including Active Rescue, for any individual who may be at Imminent Risk of suicide. Center Guidelines shall describe the circumstances under which supervisory consultation shall be sought as well as the process by which Center Staff shall contact Supervisory Staff.
- g) In order to enable its Active Rescue efforts, the Center shall maintain Caller ID or some other method of identifying the Caller's location that is readily accessible to Center Staff in real time (i.e., during the call). The Real Time Caller ID tool on the Administrator's Members-Only site may be used in order to fulfill this requirement.

Supervisory Consultation

Crisis center workers are often faced with circumstances presented by callers that are complex and provocative, which, at times, do not readily reveal a clear course of action for the helper. No matter how clear a crisis center's assessment and intervention guidelines are—and no matter how experienced or well-trained a hotline worker is—no worker can possibly be prepared to know what to do in every situation. While such limitations can also be said of the most expert clinician, the sheer number and variety of calls handled by any regular hotline worker on any shift present a largely unique level of exposure to cross-sectional community issues, often presented by individuals who would never access a traditional behavioral health service. Consequently, when faced with questions about how to help a person who could be at imminent risk of suicide, the Lifeline policy (in **Exhibit 5**) requires member centers to ensure that its Lifeline-responding workers have timely access to supervisory guidance during all hours of crisis center operations.

Appendix 3 (see page ix) to Attachment 1 of the Network Agreement defines supervisory staff as:

Center Staff that regularly act in a managerial or training capacity, who have knowledge of the Center's most current policies and procedures related to helping Callers at Imminent Risk of suicide. Such personnel might include Center Directors, Training Coordinators/Supervisors, Shift Supervisors, or some other title consistent with the spirit of this definition. Peers (colleagues with no other official designation or routine role as staff supervisor or trainer) acting as consultants are not alone sufficient to meet this requirement.

Although the availability of peer consultation alone is not sufficient to meet this element of the policy, center directors or other administrative staff can designate experienced staff/volunteers on a particular shift as shift supervisors, for example. It is also not required that center supervisors be onsite during all hours of center operations; ready availability may simply mean that an offsite supervisor can be contacted by cell phone, as another example.

Lifeline's Steering Committee considered supervisory appraisal of active rescue calls to be particularly critical. To better ensure that active rescues occur only when necessary and appropriate, **Appendix 4** (see page xi) (relating to least invasive interventions) recommends that:

...supervisory consultation and/or review [should] occur before, during and/or after instances where active rescue has been initiated for Callers by Center Staff. It is further recommended that Supervisory Staff review these instances and use lessons learned to inform subsequent Center Staff training and supervisory practices, as well as inform cooperative communications with relevant crisis or emergency response service providers in order to better ensure optimal care of Callers at Imminent Risk.

The above recommendation underscores that instances of active rescue should not be treated at a Lifeline center like any other call. Due to the special concerns these occurrences raise (as noted in the Active Engagement section of this paper), they should be discussed during a call or deconstructed after the fact by center supervisory personnel. Although it was suggested at the Steering Committee that a supervisor, prior to these instances, approve all active rescues, the majority of the committee members agreed that such a requirement could unnecessarily prolong decision-making in time-sensitive, life-saving circumstances. However, it was agreed that supervisors not consulted during an active rescue

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call should at least be made aware of the event soon thereafter so he/she may review it for ongoing training and procedure development purposes. In reviewing active rescue events, supervisors should evaluate both the process (how was the decision made) and documentation related to the call. Documentation should minimally include risk assessment information (noting the presence of imminent risk) and indicate that less invasive courses of action were either inappropriate for the situation or declined by the caller.

Prior to the policy implementation, 99% of 130 crisis call centers in the network reported having supervisory consultation available during their hours of operation (**Table 2**).

Access to Caller ID

If a Lifeline caller is imminently suicidal but unable or unwilling to provide identifying information or collaborate with the worker to secure his/her own safety, a center worker must still have the ability to facilitate life-saving services on his/her behalf. Skip Simpson, a leading U.S. attorney in suicide litigation, noted in a conference call with Lifeline STPS members that “The center needs to be able to have all the tools to rescue the caller and needs to have a working, rehearsed process for getting emergency rescue to the caller” (STPS conference call communication, October 31, 2006).

In order to ensure compliance with the active rescue element of the imminent risk policy, all member centers must maintain caller ID or some other method of identifying the caller’s phone number that is readily accessible to center staff during the call. For centers that have caller ID, all caller phone numbers are revealed on the display when calling Lifeline’s toll-free lines. For centers that do not have caller ID service, Lifeline provides a secure online, password-protected real time call trace system that enables centers to look up the at-risk caller’s number. Further, the Lifeline Real Time Call Trace site also provides member-only access to listings of all PSAPs in the country. This latter resource enables centers to locate the appropriate PSAP for imminently suicidal callers residing in areas outside of their local 911 coverage area.

There is considerable precedent for use of caller ID in hotline services. AAS’s current application for accreditation indicates that “If a crisis worker cannot de-escalate a suicidal caller, the crisis worker must use whatever means he/she can to intervene when the caller is judged to be intent on suicide. One strategy would be to use caller ID to locate the caller even when the caller does not want to be located.” Prior to the policy’s implementation, 91% of member centers reported that they provide ready access to caller ID as a tool to rescue for their hotline workers (**Table 2**). In their 2003–2004 evaluation of eight centers, Gould and her colleagues (2007) found that crisis center staff were unable to initiate emergency rescue for 8 of the 54 callers, who were in the act of harming themselves because they had no caller ID or other means of locating the caller.

With the growing use of cell phones and Internet-based telephone technologies, the ability of a phone number to pinpoint the caller’s exact location is becoming increasingly limited. This complication is vexing to all crisis and emergency call centers, including 911 networked agencies. Lifeline is seeking to ensure that all developing technologies capable of overcoming these challenges are made available to its network by working with organizations such as the National Emergency Number Association and vendors of VoIP services to identify efficient solutions.

Confirmation of Emergency Services Contact

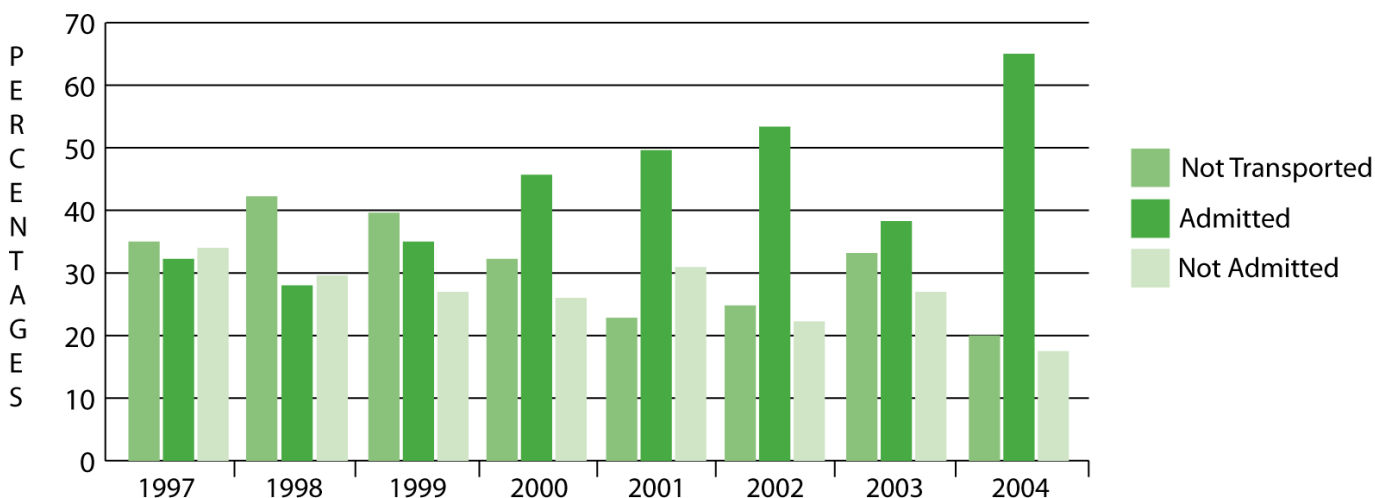
If and when callers can be actively engaged to collaborate towards measures to secure their own safety, confirmation of emergency service contact with the caller is relatively uncomplicated. Most Lifeline crisis call centers encourage and train their staff to collaborate with the caller to receive emergency services. In such cases, hotline workers are often trained to stay with the caller until emergency services appear on the scene, at which time the helper may speak with the rescue worker and confirm contact. Similarly, if a crisis center worker is collaborating with a third party to activate rescue services (the individual's treatment provider or other concerned person), the worker may determine that rescue occurred through subsequent contacts with the third party (see **Appendix 7** on page xiv for more examples).

However, situations where no third party is involved and the uncooperative, non-consenting caller is in need of active rescue present special challenges for confirming his/her contact with rescue services. When crisis call centers initiate active rescue, it is not certain that the rescue service will either find the caller or, if they do, that they will transport the individual to an ED for evaluation. Local responders to psychiatric emergencies vary widely by training and county. In more urban areas, police and emergency medical technicians are often sent while, in many rural areas, law enforcement officials (e.g., sheriff, marshal) are not uncommonly the designated first responders. Typically, law enforcement officials at the scene are the decision-makers as to whether or not a person should be transported to a psychiatric or medical setting for further evaluation. Many law enforcement personnel lack formal training in assessment and intervention with persons in crisis, leading to uncertainties as to how they will respond to non-consenting individuals at imminent risk (Lamb, Weinberger, & DeCuir, 2002; Matheson et al., 2005). Aside from the training of the responder, the willingness of the caller to engage emergency services is a significant factor. If imminently suicidal callers have refused emergency assistance and are informed or suspect that the crisis center has nevertheless activated rescue services without their consent, some will leave their location to avoid contact with first responders. Others may simply deny to the first responders that they are a danger to themselves or others.

At this time, Lifeline does not have data that indicates how many callers actually received contact with the emergency services that its centers have initiated. Prior to the implementation of these guidelines, just over half (54%) of Lifeline centers knew whether the callers they initiated rescue services for were actually seen by first responders (**Table 2**). LifeNet, a Lifeline member center in New York City, is one service that does confirm the status of its calls to local emergency services. LifeNet confirms contacts by first obtaining a reference number for the call from the 911 operator, and then calling a special number (ambulance call report service) at the PSAP that informs the LifeNet worker as to whether or not the caller was transported, and to which hospital he/she was transported to. Data collected by LifeNet from 1997–2004 shows that nearly a third (31.6%) of active rescue calls do not result in transport of the at-risk individual to a hospital for further evaluation (**Figure 1**, below). LifeNet uses this information to initiate follow-up checks with the non-transported at-risk callers, often by arranging visits to their homes by local mobile outreach services for further evaluation.

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Figure 1: LifeNet NYC Transports and Hospital Admission Rates for Callers Needing Emergency Rescue, 1997–2004



Interviews with network centers that have been able to confirm local emergency service contacts with callers reveal a variety of successful approaches. The Crisis Support Service of Alameda County in Oakland follows up with local law enforcement authorities by obtaining the badge number of the responding officer and calling back for confirmation of contact. Other centers, such as A Better Way in Muncie, Indiana, maintain such positive relationships with the local police through their joint efforts to prevent domestic violence that “the police call us back to confirm emergency rescues without us even asking,” according to the center director, Teresa Clemmons.

When interviewed about this issue, Lifeline crisis centers not currently confirming such contacts reported a number of perceived barriers in obtaining this information from local PSAPs and/or local law enforcement agencies. For example, some center directors note that multiple police authorities oversee several jurisdictions in their area, challenging their capacity to establish positive relationships with all of them. As for 911 call centers, some state a similar concern, noting that several PSAPs serve their area of coverage. Other centers report that they have approached local PSAPs, who have been resistant to offer such information due to concerns related to privacy protections. Others report that local PSAP officials have declined offers to meet with them. Some centers convey that they simply do not know whom to contact locally, how to subsequently approach them with requests for this information, and, if they did approach first responder administrators, some centers further presume that the agency could not offer this information due to privacy issues. A few center directors have noted that they did not previously consider the caller their responsibility after the 911 call was completed; the caller’s care had been turned over to local public safety officials.

To further investigate the concerns presented by many of the Lifeline centers on this issue, the Lifeline reached out to officials from the National Emergency Number Association (NENA). On a call in March 2008, NENA confirmed that, in fact, many PSAPs do not routinely provide such contact confirmations and, in order to implement a practice similar to what LifeNet and NYC’s PSAPs have established, collaborative relationships would have to be formed between local PSAPs and Lifeline centers. To enable such collaborations, NENA suggested that a national standard operating procedure (SOP) for PSAPs could be created that encourages them to provide such information to centers to better ensure the continuity of care for at-risk individuals. Lifeline proposed that the SOP encourage PSAPs to follow

the LifeNet/NYC PSAP model, insofar as they provide contact confirmation status and the destination of the receiving emergency facility. On the call, one NENA workgroup member further noted that perceptions related to HIPAA privacy regulations might prevent some PSAPs from providing this information. However, the NENA Operations Committee chair then affirmed that HIPAA does not preclude transfer of information in emergency situations where such information is needed to support the individual's care. Lifeline began work with NENA in the development of a SOP that could facilitate local partnerships between the network centers and nearby PSAPs to enable information exchanges about transport status of Lifeline callers at imminent risk of suicide. In July 2010, NENA established formal workgroups (incorporating members of both the Lifeline and 911 training communities), which were tasked with finalizing the SOP and developing training recommendations and materials for 911 operators responding to suicidal callers.

It is important to note the distinction between confirming caller contact with emergency rescue services and confirming that the caller believed to be at imminent risk was actually assessed by emergency response officials. If a caller is clearly in the act of killing him/herself, the capacity to accurately assess suicidality by emergency responders is less likely to be a factor. However, if a caller is not in the act of attempting suicide but is assessed by the telephone helper to be at imminent risk of suicide, a helper's call to emergency services should ideally lead to a face-to-face evaluation of the caller by a behavioral health worker trained in suicide risk assessment.

In areas of the country where existing mobile outreach teams and police crisis intervention teams can be activated by the helper to respond with relative immediacy, there is some assurance of a qualified assessment to accompany contact with the caller. In areas where, for example, law enforcement officials who are less trained in suicide risk assessment are the only available first responders to be called to assist persons who could be at risk of suicide, contact does not necessarily equate with assessment. In such cases, a truly at-risk individual who is resisting help may be able to present superficially as neither dangerous nor mentally ill to officers. He/she may immediately deny a need for assistance and easily persuade officers that a mistake has been made, leading them to leave the scene without the person ever receiving any substantive assessment of risk. If a center follows up with the emergency service to confirm contact, the service might report that contact did occur, but note that the center's description of this individual as suicidal was unfounded. While this in fact may be the case, it is less trustworthy than a similar finding from a person trained in risk assessment. If a face-to-face assessment by a qualified individual is what is most desired and cannot be readily assumed in areas without emergent mobile psychiatric capacity, how can a helper confirm if an assessment has occurred? If an emergency service reports that the individual was in fact transported to the hospital, this provides confirmation of contact by the service as well as the greater promise of more qualified assessment to follow.

The imminent risk policy requires only that emergency service contact (not assessment) be confirmed—to the extent it can be—primarily because PSAPs and police will not likely be able to offer information beyond whether or not the caller was seen and/or transported by the first responders. Nevertheless, center staff should make efforts to enhance informed assessments by any officials who are likely to respond to and/or encounter their callers at imminent risk. Some recommended practices for crisis centers in this regard include (but are not limited to) the following:

- Establish relationships with local police departments and/or other relevant first responders to enhance information exchanges, such as risk assessment protocols, for callers at risk.

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- When contacting emergency services, the helper should provide 911 or first responder service with his/her direct contact data (e.g., direct phone line) to encourage exchange of information between the helper and first responder before, during and after the visit. Information should include all data collected by the helper related to the caller's risk, and the caller may also request that the first responder confirm contact with caller and outcome of that contact.
- If the caller is cooperative and remains on the phone when the emergency service arrives, the helper should ask to speak directly with the first responders arriving to exchange vital information that could influence assessment.
- Be familiar with local mental hygiene law and what information about the caller is pertinent to authorize the first responder to remove the at-risk individual involuntarily, as a last resort. For example, if the state mental hygiene law requires an appearance of mental illness and behaviors that indicate a potential risk to self or other, the helper might describe any statements made by the caller that are relevant to these specific factors (online searches and/or inquiries with local public mental health authorities can provide you with your jurisdiction's mental hygiene law).

In addition, the Lifeline requirement for contact confirmation has been amended to recognize that network centers, despite their best efforts, may be unable to establish relationships with local first responder agencies to facilitate vital information exchanges (see **Exhibit 6**, below). The policy now requires that centers make reasonable, assertive efforts to establish such relationships, and, if unsuccessful, must provide Lifeline with documentation demonstrating their efforts (see **Appendix 7** on page xiv for examples of acceptable documentation). However, upon providing Lifeline with this documentation, Lifeline will subsequently offer the center technical assistance towards alternative, strategic approaches, which may have more successful results (e.g., providing them with the proposed NENA SOP). Upon receiving this assistance, the center is expected to resume its pursuit of collaboration with a local PSAP or other first responding agency.

Exhibit 6: Emergency Services Contact

- h) In cases in which the Center initiates Active Rescue, and in which local emergency service providers are willing and able to provide such confirmation, Center Guidelines shall direct Center Staff to confirm (as per the recommendations set forth in Appendix 7, annexed hereto and hereby made a part hereof) that such emergency services have successfully made contact with the at-risk individual. If the Center reports that local emergency service providers are unwilling or unable to offer confirming information to the Center, the Center shall provide documentation (as described in Appendix 8, annexed hereto and hereby made a part hereof) to the Administrator demonstrating its efforts to collaborate with local emergency service providers.
- i) To the degree that Center Staff have confirmed that emergency response services initiated by the Center were unsuccessful in making contact with the individual at Imminent Risk, Center Guidelines shall direct Center Staff to take additional steps (as per the recommendations set forth in Appendix 7, annexed hereto and hereby made a part hereof) to address the safety needs of the at-risk individual.

To the degree that network centers are able to determine that rescue service contact has not occurred for callers, this element requires center policies and/or protocols to direct their staff to continue actions to assure that the caller is safe. This element of the imminent risk policy may be minimally interpreted by the center as "we have learned that the caller was not seen by emergency service (he/she left the scene, etc.), so we will follow up to see if he/she is safe." However, as noted above, assessment by a behavioral health official is most desirable. Optimally, the center may establish additional procedures for following up with callers whom they believe were at imminent risk of suicide, who were in fact seen by non-CIT

police officers or other non-behavioral health officials (contact was made), yet determined by these officials to not be at risk. This is a commendable approach to interpreting this guideline, but it is not required by the Lifeline.

As indicated in **Appendix 7** (see page xiv), such follow-up actions might include calling the at-risk individual back, contacting third parties known to have access to the individual, making a referral to a mobile outreach team to conduct a visit or informing a local law enforcement agency of the situation so that they may continue to conduct a safety check. Although offering suggestions in **Appendix 7**, the guidelines do not prescribe any course of follow-up action for centers; only that their center policies contain protocols that they determine are sufficient for assuring caller safety.

While over half of the network centers confirm rescue service contact, fewer still (42%) have guidelines for following up with at-risk callers who have not been found or transported by an activated emergency services (**Table 2**). Interestingly, **Table 2** also shows that most (82%) network centers report that they routinely follow up with at-risk callers whom the center did not dispatch rescue services for. This suggests that Lifeline centers typically seek to actively engage at-risk callers, collaborate with callers to identify ways to keep them safe without calling rescue services, and try to obtain consent to follow up with them. Center staff are willing to check on suicidal callers who are willing to receive their call. However, for callers that are unable or unwilling to cooperate and active rescue was sent, following up creates more challenges. First, if the individual was not cooperative before, some center directors reason that the caller would be even less interested in being contacted after the center “sent the cops out.” Second, if caller ID were their only identifying information to facilitate the active rescue, centers may not have an address or name to refer the caller to mobile outreach services. Nevertheless, it is important that centers develop protocols to address these challenges on behalf of callers who, in many respects, may be at the highest risk of suicide (“I’m intending to die and I’m not going to let you find me”). If less invasive alternatives are not feasible (e.g., direct calls, third-party intermediary contacts, mobile outreach teams), this dangerous situation may need to be reported to law enforcement officials who can continue to check on the individual.

The policy elements (d) and (e) referred to earlier are interdependent; a center must be able to obtain information about emergency services contact to know whether or not they need to follow up with a non-transported caller. If a center offers sufficient documentation to the Lifeline showing that it is unable to confirm emergency service contact, how can the center meet this related follow-up guideline since it relies on knowing that the individual was not seen or transported by rescue services? While it may appear that waiving this follow-up guideline for centers in such cases would be reasonable, there are compelling reasons to maintain some form of the guideline for all network members. Any attempt by a center to partner with the appropriate agency to confirm emergency service contacts should be preceded by a plan made by the crisis center that explains what it would do with this information (e.g., “If we knew the caller wasn’t picked up by the police, we would send out a mobile crisis team to check on him/her”). However, for centers that have been frustrated in their attempts to get more caller status information from first responders, they may not have fully considered what they might do for suicidal callers who were not picked up by emergency services. To the extent center directors have a more developed vision of what they might do with contact confirmation information if they are able to get it, they can more clearly convey to first responder agencies how this exchange of data would benefit their mutual interests towards improving caller care and safety. In order to both demonstrate a commitment to their intention to seek further collaboration with first responder agencies, as well as enhance their thinking around how they might constructively use this information to address caller safety concerns, the Lifeline will require that

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centers submit a proposed policy to be enacted if/when it is successful in obtaining contact confirmation information from first responder agencies.

Collaborative Relationships

The final component of the policy for helping callers at imminent risk of suicide underscores the importance of working with services that are most likely to be involved with a center's suicidal callers.

Exhibit 7: Establishing and Maintaining Collaborative Relationships with Local Crisis and Emergency Services

2. The Center shall establish collaborative relationships with one or more emergency service providers in its community (as described in Appendix 9, annexed hereto and hereby made a part hereof) and submit proof of said relationships (as described in Appendix 9) to the Administrator upon its application to the Network or upon request by the Administrator.

The requirement to establish and maintain formal and/or informal relationships, relates directly to Lifeline's third imminent risk value of a shared responsibility for the continuous, safe care of suicidal callers with local crisis and emergency systems. As listed in **Appendix 8** (see page xv), potential collaborators for centers could include local law enforcement and/or fire departments, PSAPs, ambulance/transport services, mobile crisis/psychiatric outreach teams and hospital EDs. Formal relationships between crisis centers and these entities consist of cooperative agreements, memoranda of understanding (MOUs), interagency policies directing mutual collaboration, and/or authorized relationships through a local government entity (county health, mental health and/or police departments). Examples of informal relationships listed in **Appendix 8** are documentation showing regular communications with local crisis or emergency providers to confirm coordination of rescue and care efforts, documents demonstrating some exchange of outreach and educational materials that promote awareness and use of the center's services and/or documents displaying that the center conducts trainings to crisis or emergency services providers about the center's services.

The prior section introduced the importance of centers building collaborative relationships with local law enforcement and/or PSAPs. However, a cooperative relationship with such agencies can have the potential for both confirming rescue contact and coordinating care with local EDs receiving suicidal callers. If a local PSAP, for example, can provide information to the center about the transport destination of the suicidal caller, the center can then contact the receiving facility and inform them as to its assessment of the caller's risk. The effect of this collaborative information exchange between the PSAP, the crisis center and the ED can be remarkable, as suggested by data provided to the Lifeline by NYC's LifeNet.

LifeNet NYC Model

As mentioned earlier, LifeNet obtains from 911 both rescue contact status and the ED destination whereby the caller will receive further evaluation. As a service funded primarily by New York City's Department of Health (NYCDOH), NYCDOH was instrumental in establishing this model in two ways. First, NYCDOH established an agreement with the local 911 center to provide LifeNet with this information. Second, the NYCDOH medical director in 1997 created a MOU between LifeNet and the City's 25 local hospital EDs that authorized LifeNet to obtain the subsequent admission status of callers transported to their facilities.

Very few callers to the Mental Health Association of New York City's LifeNet are assessed to need emergency rescue services (between 0.4%–0.08% of callers, for up to 100,000 callers per year). For the 639 complete records for LifeNet at-risk callers from 1997–2004, the previously displayed **Figure 1** illustrates noteworthy trends in subsequent hospital admission rates. In 1997 and 1998, roughly half of the suicidal callers sent by LifeNet to EDs were subsequently admitted. Given the apparent discrepancy between LifeNet and the ED's evaluation of caller risk, LifeNet's director sought to improve rescued caller communications between both parties in 1999. LifeNet implemented an internal procedure in mid-1999 that required staff to fax written information indicating related risk factors of rescued callers to the receiving ED. Staff would then contact the ED to confirm that the fax was received, and would offer to speak with the evaluating physician, if needed. In the first full year of LifeNet practicing this procedure (2000), ED's reported a 52% increase in admission rates of suicidal callers over the rates reported pre-procedure in 1998. The trend either remained higher or continued upward in proceeding years, peaking in 2004 with a 116% increase over 1998's admission rates. Given that Lifeline centers seek least invasive interventions, rescues must occur only when they are determined to have potential life-saving capacity. In this regard, LifeNet's model appears to have significant value for better assuring the continuous, safe care of at-risk callers with receiving EDs.

Another interesting trend related to caller transports suggested in **Figure 1** relates to the potential positive effects of a crisis center's collaboration with local law enforcement officials. The New York City Police Department (NYPD) joins emergency medical services in responding to all psychiatric emergencies called into 911 (emotionally disturbed person, or EDP calls). Of those two entities, only NYPD is authorized to make the decision to involuntarily transport an EDP to a hospital ED. In 1999, LifeNet proposed a partnership with NYPD towards training their members of service to divert more EDPs to mental health assistance via LifeNet referrals, thereby reducing repeat encounters between untreated EDPs and NYPD, as well as reducing opportunities for the NYPD to criminalize persons with mental illness. NYPD agreed to collaborate with LifeNet in 2000, disseminating LifeNet wallet cards to all field officers to provide to persons "who need attention, not detention." The LifeNet director conducted trainings at several precincts across the city, and a "LifeNet video" was produced to support the initiative's description to all police academy trainees. In 2001, the LifeNet wallet card procedure became an official part of every officer's patrol guide.

The broader scope of police awareness of LifeNet beginning in 2000 may have contributed to its greater likelihood of deciding to transport its callers. **Figure 1** indicates that callers assessed by LifeNet to be at imminent risk of danger to self/other were, on average, transported at a 50% higher rate in the years after the NYPD initiative (2000–2004). The possible relationship between the LifeNet/NYPD initiative and rescue transport rates is further supported by the fact that transport rates in 2003 were lowest during this period (35% lower than 2002 and 66% lower than 2004). Interestingly, the LifeNet/NYPD initiative began to wane in 2002 and was completely inactive in 2003 due to a lack of resources (no precinct trainings or wallet card disseminations occurred). However, by the beginning of 2004, the year in which rescue transports were the highest (98% higher than the average transport rates in the pre-initiative years), NYCDOH began funding a full-time LifeNet-NYPD trainer to reinvigorate the project, leading to ongoing, widespread officer trainings and wallet card dissemination among field officers.

Although police interventions with imminently suicidal individuals may be considered to be the most invasive of options, it is important to note here that the LifeNet/NYPD partnership encourages more appropriate—and often the least invasive—interventions for officers when they encounter persons with mental health needs. The primary goal of the initiative is to help officers to recognize and divert persons with mental health needs to LifeNet and the behavioral health system. The project appears to be

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achieving this goal to some degree, as LifeNet reports that in 2007, 271 callers had been referred by police, a conservative figure in that many callers do not identify what prompted their call. For such a partnership to work, the NYPD must believe that LifeNet is a trustworthy, reliable service. It is perhaps a byproduct of their appreciation of LifeNet's credibility that officers are more frequently transporting LifeNet's high-risk callers to EDs for necessary evaluation. The accompanying trend in higher subsequent hospital admission rates for these callers over this period further suggests that ED evaluators have mostly agreed with both LifeNet and NYPD's determinations that these individuals, in fact, are at high risk and in need of inpatient care.

Other Crisis Center Models

Table 2 shows that, prior to implementation of the policy, all of the network's crisis centers have some type of relationship with local crisis and/or emergency response services. While a minority (23%) report more formal relationships (e.g., MOUs), most have at least an informal relationship with local crisis and emergency providers, independent or instead of other formalized agreements.

As stated by researchers on the subject of police and mental health, "Collaboration between the law enforcement and mental health systems is crucial, and the very different areas of expertise of each should be recognized and not be confused" (Lamb et al., 2002). Most of Lifeline's crisis centers and their local police departments have found that their mutual needs can result in natural partnerships, as 63% of centers report such collaborations at this time (**Table 2**). While there are a wide variety of police/crisis center partnership models in the network, the most common appears to be crisis center participation in training local officers in the Crisis Intervention Training (CIT) model.

It is estimated that more than 400 CIT programs are operational across the country (Compton et al., 2008). The CIT model, pioneered by the Memphis Tennessee Police Department, consists of a special training to a designated group of officers to respond to "mental health-related crisis calls." These officers are trained to offer a "more humane and calm approach" to "resolve each situation in a manner that shows concern for the citizen's well-being." The CIT model invites partnerships with local mental health providers and consumers, "enjoining both the police and community together for common goals of safety, understanding, and service to the mentally ill and their families" (Memphis Police Department, 2004). As noted previously in the Least Invasive Intervention section of this paper, CIT models promote voluntary transports of persons at imminent risk and reduce the incidence of punitive, coercive tactics in police encounters with persons with a mental illness (Compton et al., 2008; New York Civil Liberties Union Report, 2005). Based on interviews, 21 network centers were actively providing some facet of the CIT training to local officers, with centers such as Alachua County's Crisis Center providing up to 60% of the CIT training for Gainesville Florida's Police Department.

In other approaches, eight centers reported providing training to hostage negotiators for police departments, with half of these centers stating that the negotiators, in turn, volunteer on their crisis lines. Some centers provide specific suicide prevention trainings to police officers, employing the Question, Persuade and Refer or Applied Suicide Intervention Skills Training (ASIST) models. Other centers report that their staff members conduct regular crisis intervention trainings at the police academy, with two centers employing full-time liaisons with the local police department. Baton Rouge Crisis Intervention Center established a program where staff and trained family members who have lost a loved one to suicide join the police in outreach to families following the report of a completed suicide (Local Outreach to Suicide Survivors, or LOSS teams). A handful of other network crisis centers have subsequently

deployed the LOSS model with police in their communities. In addition, a number of centers include local police chiefs and sheriffs on their boards.

Crisis center collaborations with law enforcement—particularly trainings consistent with the CIT model—can have a significant impact on least invasive, more efficient and effective care for individuals in crisis. Research demonstrates that training police to work more effectively with persons who may have a mental illness can reduce unnecessary hospitalizations and jailing of such individuals, while reducing burdens on the police and the criminal justice system (Borum, Deane, Steadman, & Morrissey, 1998; Compton et al., 2008; Lamb, Shaner, Elliott, DeCuir, & Foltz, 1995).

Some Lifeline crisis centers also report collaborations with local PSAPs. Seven centers—including Neighborhood Services Organization in Detroit and CONTACT Beaver Valley in Pennsylvania—train 911 dispatchers in using their local crisis line to assist callers with non-emergent mental health needs.

In addition, many of Lifeline’s crisis centers maintain relationships with local mobile outreach services. Some of the mobile outreach teams operate out of the same agency, as is the case with Augusta Maine’s Crisis Counseling Center, Behavioral Health Response (Missouri) and Behavioral Health Link mentioned earlier. With these agencies, their mobile outreach capacity is nearly immediate and they can often provide a less invasive alternative to sending law enforcement. Many other Lifeline centers can readily dispatch local mobile outreach teams through formal or informal agreements.

There appears to be a relationship between crisis center collaborations with local community crisis/emergency services and the ability to confirm contact with emergency rescue services. Of the 72 centers that report having collaborative relationships with community crisis response and rescue services, 50 (or nearly 70%) are also able to confirm emergency services contact. The types of crisis center collaborations that appear to have the highest correlations with rescue confirmations are centers that assist in providing CIT trainings (85.7%, or 18 of 21 centers) and centers that train 911 dispatchers (85.7%, or 6 of 7 centers). These data suggest, not surprisingly, that centers that have gained enough credibility with law enforcement and PSAP agencies to provide trainings to their staff can effectively leverage that relationship to exchange information about the safety status of the callers they refer to them.

Confidentiality Issues

A major barrier to preventing critical information exchanges about suicidal individuals between crisis centers, external crisis and emergency services and other third parties has been concerns related to privacy. As is true of all health and behavioral health services, protecting information and preserving confidentiality for the persons they help is integral to maintaining the integrity of crisis center service to the community. As previously mentioned, most crisis call center policies nevertheless compel staff to breach confidentiality of callers only if they assess the individual to present an imminent threat to the safety of self or others. In spite of this common practice to enable emergency rescue, many centers are uncertain as to how far this exception to confidentiality extends. Can they, for example, contact a receiving hospital to provide them with information about the caller? Can they contact a family member or significant other to support efforts to help callers at imminent risk of suicide?

In addition, external crisis or emergency services may also be reluctant to exchange vital information about suicidal callers with crisis centers for fear of violating the individual’s privacy. Lifeline centers have reported that they have encountered resistance related to privacy concerns from PSAPs and EDs when

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they requested to exchange information about suicidal callers. In particular, conversations about whether or not to exchange information often come to an end when one or the other party raises questions or concerns related HIPAA.

In reviewing the regulations and related legal interpretations, HIPAA appears in no way to be an impediment to exchanging information that could, in effect, better ensure an individual's personal safety. HIPAA Standard 164.512(j) states that:

A covered entity may, consistent with applicable law and ethical codes of conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure: (i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (B) Is to a person or persons reasonably able to prevent or lessen the threat; or (ii) Is necessary for law enforcement authorities to identify or apprehend an individual.... (OCR/HIPAA Privacy/Security Enforcement Regulation Text, 45 CFR 164.512(j))

When the individual or patient is not present or it is impractical due to emergency circumstances, HIPAA does not prevent disclosures of information to persons responsible for the individual's care, family members or others, if it is believed that, in exercising professional judgment, such disclosure is in the best interest of the individual or patient (see 45 CFR 164.510(b)). Simon (2004) noted that it is standard practice for psychiatrists seeking to protect their patients from self-harm to take such measures as to notify and/or counsel the individual's family or caretakers, inform them of suicide risks and possible methods and mobilize them to remove access to lethal means or other actions to better ensure the individual's safety. Dr. Simon cites *Gross v. Allen*, a 1994 California appellate court decision, which ruled that caretakers of patients with a history of self-harm are legally responsible for informing the individual's new caretakers. This decision did not properly establish a "Tarasoff-like duty to warn" others about an individual's suicidality, but reinforced common-sense standards of practice (Packman, O'Connor Pennuto, Bongar, & Orthwien, 2004; Simon, 2004).

The *Gross v. Allen* and other case rulings have some implications for clinicians—in hospital EDs or other clinical settings—to invite crisis call center staff to inform them of any information they have about at-risk callers. When crisis centers initiate active rescue for callers at risk, it is in the best interests of the caller's subsequent care that ED physicians evaluating the individual have information collected by the center pertinent to his/her risk status. To the degree that a center has knowledge of the emergency facility receiving the caller and seeks to provide this information to that facility, legal scholars are in agreement that a physician should accept or gather information that could affect their evaluation of the individual's risk (Packman et al., 2004; Simon, 2004). In addition, the HIPAA regulations and case law do not appear to prevent PSAPs or law enforcement officials from disclosing to center staff the transport status or destination of callers for whom the center has initiated active rescue, insofar as such information exchanges can aid in the center's capacity to continue to act in the best interests of the individual's safe care and evaluation.

Collaborations between crisis centers and EDs that encourage appropriate information exchanges should include mutual agreement on an efficient, confidential mechanism for routine communications. Protocols and procedures for secure transmission of protected information (e.g., secure fax lines, dedicated phone lines) between the facilities should be established. Constructing MOUs between the center and the ED is also good practice to ensure clear agreement on communications protocols. Negotiating these procedures with ED administrators can often serve as the leading edge towards

creating other clinical protocols between the center and the ED (e.g., assessment trainings, crisis center follow-up with discharged patients from the ED).

In considering HIPAA regulations, a few caveats are in order. HIPAA does not require nonconsensual disclosures of individual health information in emergency situations; it simply does not preclude it. Nonconsensual disclosures of individual health information should only be provided on a need-to-know basis (what information is important to provide the most appropriate care to keep the individual safe). Throughout the document, HIPAA regulations consistently reinforce the need to provide individuals with the opportunity to agree or object to disclosures of their information, wherever possible or reasonable, given the clinical circumstances. Second, state laws, if they are more stringent in their privacy protections of health information, supersede HIPAA's regulations. It is, therefore, important that crisis centers be aware of their state's laws related to confidentiality restrictions and limitations. Often, statutes are readily available via online searches, and seeking the guidance of legal counsel expert in the area is always a prudent exercise. Online searches about a state's relevant rules can often be found by typing phrases such as "[name of state] health information privacy" into the search field of the browser.

In discussing legal considerations related to Lifeline's Policy for Helping Callers at Imminent Risk of Suicide, the Lifeline's STPS consulted directly with Skip Simpson, a leading U.S. Attorney in suicide litigation. During this lengthy discussion, Mr. Simpson advised:

I would suggest getting away from a concern about liability. If a person is at risk for dying soon, then everything that can be done to save that life must be done. There are no legal consequences to that action. When you are talking about saving someone's life you forget about confidentiality. As long as you are focused on the mission [of preventing suicide] there should not be any liability. Be more concerned about doing your job right based on the clinically reasonable standards of the field. (STPS conference call communication, October 31, 2006).

PART III. DISCUSSION AND IMPLICATIONS FOR FURTHER WORK

Implementation Process

Once the Lifeline’s Policy for Helping Callers at Imminent Risk of Suicide is released for network implementation in January 2011, network centers will have 1 year in which to ensure their adherence. Along with the policy, all centers will receive this document, which provides the supporting research and rationale for them, and will be encouraged to share it with their staff. This process will mirror the approaches that were successful in enabling full network adherence to the Lifeline Suicide Risk Assessment Standards in 2007. The Lifeline Standards, Training and Practices Division staff will follow up with each center director, provide technical assistance—including giving them research, tools and model policies and procedures submitted by other centers (with their permission)—and make sure that each center provides all the required documentation that demonstrates its adherence to Lifeline’s policy. Network conference calls and Lifeline crisis center blog articles will regularly provide network adherence updates and allow center directors to share strategies for successfully meeting challenges towards becoming fully compliant.

Implications for Network Practice

Crisis hotlines have been performing emergency interventions for suicidal callers since the Los Angeles Suicide Prevention Center established the nation’s first suicide hotline 50 years ago. For the now more than 145 crisis centers in the Lifeline network, this policy for helping callers at imminent risk does not—in and of itself—suggest a major paradigm shift affecting the practices in that center in Los Angeles or most other network crisis centers. Rather, the milestone of this policy is that, for the first time, independently operating centers across the country have a unifying document that mirrors their collective values and practices in suicide prevention. To that extent, this policy is not so much a construct of the Lifeline or its committee advisors, but a compendium of what most American crisis centers have believed in—and what they have been mostly doing—in their efforts to save lives for decades.

The two centerpieces of Lifeline’s policy, active engagement and active rescue, are understood here as new terms for familiar crisis center practices. The Lifeline first introduced these terms to approximately 50 network centers during a workshop at the American Association of Suicidology conference in 2006. At that time, there was consensus opinion among workshop participants that crisis centers should and do practice active engagement in emergency situations, up to and until the caller refuses to cooperate with the helper seeking to secure his/her safety. At that point, most centers agreed that active rescue was necessary. In later interviews summarized in **Table 2**, all of the centers reported practicing active engagement in helping callers at imminent risk of suicide, and nearly all used active rescue when necessary. However, as previously noted, silent monitoring and follow-up evaluations of a sample of these centers showed that neither active engagement nor active rescue is consistently practiced by center staff members on calls (Gould et al., 2007; Mishara et al., 2007a). In addition, Mishara et al.’s research demonstrated that what crisis center directors say that their staff do is not significantly related with their staff’s actual practices. If centers have always been doing active engagement and rescue, what effect can this policy possibly have on an actual call at any of the Lifeline network centers?

Crisis Center Evaluations

While the policy alone is not likely to have a substantial effect on crisis center staff practices, its implementation is not occurring in a vacuum. Rather, it is emerging as part of an ongoing network evaluation feedback loop, necessarily involving a continuing dialogue between the Lifeline and its centers about quality improvement practices. This policy is the offspring of research on crisis centers that is now intrinsic to the field's practice environment, signaling a paradigm shift for crisis center work. The references to the crisis center evaluation work of Mishara and his colleagues, as well as Gould, Kalafat and their staff, arose from SAMHSA-funded evaluations that were (and are) a requirement of the federal grant that supports this network. Ongoing evaluation and related reports of crisis center activities must occur to ensure quality improvements to network callers.

When Mishara, Gould and Kalafat first presented their 2003–2004 evaluation findings to network centers at an April 2005 AAS conference, the event was truly groundbreaking. Never before in the field's history have America's crisis centers had a mirror held up to them and cast such an indisputably clear reflection of their work. Their assumptions about their practices, approaches and outcomes were fully tested and challenged by the subsequent findings. The investigators—Mishara, Gould and Kalafat—were enlisted by Lifeline to provide several opportunities for dialoguing with center directors at a series of conference workshops and through network conference calls. The investigators also provided summaries of their evaluation findings to the Lifeline for distribution to all of the centers and their staff in 2005, long before these findings were eventually published in June 2007. Following the systematic exposure of network centers to these findings and recommendations, Lifeline and the STPS developed and implemented national standards for suicide risk assessment. Undoubtedly, full network adherence to those standards by September 2007 would have been unlikely without the evaluations that clearly showed a need for more consistent, rigorous suicide risk assessment practices. The effect on a significant sample of network center staff of the risk assessment standards, exposure to research, trainings and other technical assistance was also evaluated by Gould and Kalafat, and will be made available to the network in 2011. Here too, a research team headed by Gould will independently evaluate the effect of the implementation of this policy for helping callers at imminent risk of suicide.

Although more concrete data will be available soon that indicates the effect of Lifeline policy implementation on network practices, there are some early indicators of change occurring among centers. When Lifeline's Standards, Trainings and Practices coordinator interviewed centers about emergency intervention practices (detailed in **Table 2**), he also inquired about whether or not a center practiced silent quality assurance monitoring of calls. Although few if any of these centers reported practicing silent monitoring in 2004, 36% affirmed to the STP coordinator that they were now doing so as a result of Mishara's findings. In addition, the project's independent evaluators have received enthusiastic interest from network centers wishing to participate in the ongoing evaluation, so they may learn more about internal quality assurance practices as well as contribute to scientific inquiries that are offering valuable information to the field.

It should be stated that the Lifeline network of crisis centers deserves special notice for their openness to such extensive, broad-scale independent evaluations. Their readiness to both participate in the evaluations and respond to the subsequent findings (e.g., adherence to standards, acceptance of training and resources) is extraordinary in the field of behavioral health.

Skills-Based Trainings

How will this policy actually filter down to crisis center staff? Policies provide direction for procedures and certainly have implications for staff training. However, they alone do not teach or make for more skilled staff to intervene in emergencies. Lifeline initially recognized the need to provide additional skill-building tools for center staff prior to the implementation of the network's suicide risk assessment standards. An STPS workgroup was convened by Lifeline in the summer of 2006 to review several prominent suicide prevention-training models to ascertain which most directly addressed Lifeline's suicide risk assessment standards and other key recommendations in the Mishara, Gould and Kalafat evaluations. Of the models reviewed, the workgroup unanimously selected the Living Works ASIST program for Lifeline to adapt for its centers. Importantly, the ASIST trainings are notably consistent with the Lifeline values and policy for helping callers at imminent risk of suicide as well as the standards for risk assessment. Subsequently, Lifeline contracted with Living Works to reframe its training for trainers (T4T) model for crisis center applications, and Lifeline piloted the model to 12 centers in January 2007. These trainers were then required to transfer the ASIST model to their center staff. The effect of this training on these center staff's assessment and intervention practices—in addition to the risk assessment standards, technical assistance and exposure to research findings—has also been evaluated by the SAMHSA-funded evaluation team and will be among the evaluation results reported in 2011. Lifeline is making the ASIST crisis center T4T program available to all of its network centers free of charge through 2012, so that crisis center skills can better match the required and recommended practices indicated in Lifeline's guidelines. Each iteration of the evolving T4T model will be evaluated by a federally funded research team. SAMHSA and Lifeline are also exploring the development of computer-simulation trainings for crisis center staff to enable continuing practice and development of vital skills to reinforce ASIST or other trainings.

Emergency Rescues

Will this policy create more or less network-generated calls to 911? As noted previously, the Mishara, Gould and Kalafat evaluations suggested that there were a significant number of incidences where emergency services were not sent when center protocols recommended that they be sent, and the investigators did not evaluate the occurrence of false positives (e.g., sending rescue services out when it did not appear necessary). This may seem to incorrectly suggest that better training to follow policies and protocols might lead to a greater use of emergency services by Lifeline centers. However, since these evaluation findings spawned the Lifeline network-wide quality improvement efforts (including the risk assessment standards and now imminent risk policy), it is hoped that better engagement, assessment and more improved intervention practices will lead to more appropriate use of emergency rescue services, and less inappropriate use of such services.

In a 2005–2006 study of adolescents at a Philadelphia Children's Hospital, Wintersteen and colleagues found that training physicians to better engage, assess and refer children presenting with some suicidal thoughts reduced the number of children sent to the ED for further evaluation by 82%. Prior to the physician engagement and assessment training, adolescents with suicidal thoughts who were sent to the ED were only admitted to inpatient units 51% of the time; although fewer adolescents were sent to the ED after the training, all (100%) of the adolescents were subsequently admitted (Wintersteen et al., 2007, April). Ultimately, the intention of Lifeline's policy and related skills trainings is to have a similar impact as this training had at a Philadelphia hospital. Through providing a shared policy and appropriate skills-based trainings, the Lifeline centers may better ensure that only the people who are truly at

imminent risk of suicide will be seen in an emergency room, to the extent that they are willing to seek less invasive and more appropriate, available community supports that will keep them safe.

Next Steps

It is critical to take a broader view of this policy and appreciate it as more valuable in the context of community emergency response and treatment systems. Without collaborative commitments with local EDs, PSAPs and/or law enforcement personnel, such quality improvement efforts with callers are limited in their ultimate impact on continuity of care. Lifeline will continue to build on its partnerships with influential national trade organizations such as the American Association of Emergency Psychiatry, the American College of Emergency Physicians and the National Emergency Number Association, with the goal of developing standard operating procedures or other recommended practices to encourage local alliances that will enhance public safety. In addition, Lifeline plans to continue to work with its centers to identify recommended models for routinely following up with at-risk callers to further improve their continuous, safe care. (In fact, to date up to 20 Lifeline centers have received SAMHSA funds to focus specifically on the development of follow-up practices with callers at risk of suicide.)

The Lifeline STPS is now exploring standards and/or recommended practices for center quality assurance monitoring of its staff. Once such requirements and/or recommendations for silent monitoring are established, Lifeline and its centers will be more capable of ensuring that their staff members follow standard practices and protocols.

It is possible that this version of the Lifeline policy for helping callers at imminent risk may evolve over time. Gould's evaluation team will be, for the first time, following up with the same callers that they are silently monitoring in their 2008–2009 evaluation. This data will help Lifeline to directly associate behaviors concordant (or not) with its policy and recommended practices and how such behaviors affect callers. Such unprecedented empirical findings may suggest that these guidelines be revised or refined to underscore the anticipated lessons learned from this prospective research. However, at this time, this policy represents the current state of the field's knowledge of appropriate practices for helping persons at imminent risk of suicide in a crisis center setting.

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