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Crisis Center Guidance: Follow-up with Callers and Those Discharged from Emergency Department and Inpatient Settings

July 2012

[Rev. 12/14]

NATIONAL SUICIDE PREVENTION LIFELINE

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About

The National Suicide Prevention Lifeline (Lifeline) is a toll-free suicide prevention hotline network comprised of over 160 local crisis centers that launched in 2005. The Lifeline is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by Link2Health Solutions, a wholly owned subsidiary of the Mental Health Association of New York City (MHA-NYC). The Lifeline provides free and confidential crisis counseling to anyone in need 24/7 and answers over a million calls per year.

This paper contains information gathered by Manisha Vaze from research, interviews, and previously published Lifeline materials. All of the recommendations come from information gathered about Lifeline network crisis centers through interviews and meetings that have provided follow-up at their agencies, and from a follow up paper developed by L. Judy in 2010.

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*All sample materials are meant to serve as a guide, and are not necessarily endorsed or standard practices of the Lifeline network. We thank all the centers who contributed to this document.

Introduction

For over 50 years crisis centers have provided vital services to callers at risk of suicide. Every month, over 60,000 calls are answered through the National Suicide Prevention Lifeline ("Lifeline"). Crisis centers play an essential role in providing much needed support 24 hours a day, seven days a week to reduce feelings of hopelessness and suicidal intent (Gould, Kalafat, Munfakh, & Kleinman, 2007). Crisis hotlines also provide referrals to mental health and other appropriate services based on an individual's needs. Emergency intervention can be initiated promptly through crisis centers and may result in a psychiatric hospitalization or other acute mental health service provision.

Evidence of suicidal ideation following discharge from an inpatient facility or emergency department demonstrates the need for services that will target this population for prevention (Appleby et al., 1999; Qin & Nordentoft, 2005). As many as 70% of suicide attempters never attend their first appointment or maintain treatment for more than a few sessions (Appleby, et al., 1999; Boyer, McAlpine, Pottick, & Olfson, 2000; Jauregui, Martínez, Rubio, & Santo-Domingo, 1999; Tondo, Albert, & Baldessarini, 2006). Recent research indicates that follow-up with hotline callers and people recently discharged from an emergency department (ED) or inpatient setting has positive results for both consumers and providers of mental health services (Fleischmann, 2008; Vaiva et al., 2006; Zanjani, Miller, Turiano, Ross, & Oslin, 2008). Crisis centers are uniquely positioned to be a crucial resource for people in need of follow up care, as they have the resources, trained staff, and technological capabilities to provide effective services and appropriate referrals.

The following document was produced by the Lifeline to provide crisis centers with evidentiary support for follow-up, and to provide a range of resources that could facilitate the development and maintenance of crisis center follow-up programs. After a brief review of the literature, this report offers recommendations for essential elements of a follow-up program that are based on research and anecdotal evidence from crisis centers that already manage comprehensive programs. It also offers general guidance on building relationships and partnerships with local hospitals, basic tips on program sustainability, information on types of donors, fee for service models, and other resources available to centers that are helpful for program development. Lastly, the appendix, and largest section of this report, includes sample documents, such as memoranda of understanding, one-pagers, and sample follow-up protocols which are all provided for centers to use freely.

The Case for Follow-up Programs

Suicide is the tenth leading cause of death in the United States, with over 35,000 people lost to suicide each year (Centers for Disease Control and Prevention (CDC), 2012). Recent studies show that there is an evident gap in services for suicide attempt survivors after a visit to the emergency department. In 2008, of the 1.1 million adults that attempted suicide, 678,000 reported receiving medical attention for their suicide attempt, and 500,000 stayed overnight or longer in a hospital (Substance Abuse and Mental Health Services Administration, 2009). Research indicates people are at high risk of suicide upon discharge from the hospital and alarmingly, studies in Europe found that suicide risk is greatest within one week after discharge (Appleby, et al., 1999; Qin & Nordentoft, 2005). Furthermore, patients previously admitted to the hospital for a suicide related incident have a higher risk of suicide after discharge than patients admitted to the hospital for other emergencies (Crandall, Fullerton-Gleason, Aguero, & LaValley, 2006). By providing attempt survivors a resource that reduces the gap in services between emergency and inpatient discharge and outpatient appointments, a critical step in preventing suicide and decreasing the number of visits to an emergency department can be taken (Knesper, 2011). Follow-up services offer a powerful level of care that fills this need, is cost-effective, and for which crisis centers are uniquely positioned to administer.

Follow-up after discharge is an effective and important intervention to reduce suicide. A study based in five countries that differ in size and economic development indicated that follow-up after emergency department discharge significantly reduced suicide (Fleischmann, 2008). The follow-up program included 9 contacts by trained professionals at crisis centers over a maximum period of 18 months. In England, a study found that use of 24 hour crisis teams and 7 day follow-up programs showed a significant reduction in suicide within 3 months of a patient's discharge from inpatient services (While et al., 2012). Furthermore, patients who have received telephonic follow-up have a lower suicide rate in five years and a significantly lower suicide rate in the first two years after discharge (Motto & Bostrom, 2001).

Crisis call centers are a crucial resource in linking patients to services and providing emotional support. Crisis centers help reduce emotional distress and suicidal ideation in callers (Gould, et al., 2007). In addition, crisis centers already have the resources, professionally trained staff, and telephone service capabilities to provide services and connect with patients recently discharged. Given that suicide risk is highest one week after discharge from an inpatient setting, the 24/7 availability of crisis centers' services are invaluable. For medium to high risk callers, studies show that centers help to minimize ideation, hopelessness, and psychological pain (Gould, et al., 2007; Kalafat, Gould, Munfakh, & Kleinman, 2007). Further, crisis center follow-up before a service appointment is associated with improved motivation, a reduction in barriers to accessing services, improved adherence to medication, reduced symptoms of depression, and higher attendance rates (Simon, VonKorff, Rutter, & Wagner, 2000; Zanjani, et al., 2008).

Findings from an evaluation of crisis center follow-up to suicidal callers found that 80% of participants perceived the follow-up calls as helping at least a little in stopping them from killing themselves, while more than half of interviewed callers said the follow-up intervention helped a lot in stopping them from killing themselves. Callers who received more follow-up calls perceived the follow-up intervention to be more effective. Callers also perceived the intervention as more effective when counselors engaged in the following activities: discussing social contacts/settings as distractors; discussing social contacts to call when needing help; discussing warning signs; and exploring reasons for dying (Gould et al., 2014).

Follow-up by crisis centers is also cost effective; it reduces utilization of emergency services and offers diversion to more appropriate services for patients who do not require admission to the hospital (Andrews & Sunderland, 2009; Vaiva, et al., 2006). A study in Australia found that proactive telephone

support for individuals with recurrent admissions reduced the number of hospital days per patient by 45% and saved $AU895 per person (Andrews & Sunderland, 2009). In one year, a Lifeline crisis center in St. Louis, Missouri reduced psychiatric hospitalization state-wide by 7% by referring some callers to more appropriate mobile outreach services and outpatient facilities based on the callers' needs (National Suicide Prevention Lifeline, 2011).

More research needs to be done on the efficacy of specific models for follow-up service delivery, cost benefit analyses of follow-up programs, utilization of emergency services after follow-up program enrollment, and its ability to divert over use of EDs and inpatient hospitalizations. Preliminary data from an evaluation of follow-up programs within the Lifeline, undertaken by the Research Foundation for Mental Hygiene in partnership with the Substance Abuse and Mental Health Services Administration and the Lifeline shows positive results. Evaluation findings are expected to be published in the coming year.

Recommendations & Best Practices

The Lifeline views follow-up programs as an integral part of crisis centers' service delivery. While there are a variety of models in operation across the network, a review of center practice has highlighted certain elements as essential to a successful follow-up program. The Lifeline, therefore, recommends the following:

Recommendation 1: Create Clear Program Enrollment Criteria

Clear guidelines for all staff and volunteers to use when speaking with callers are important to assess whether enrollment in the follow-up program would be appropriate. Center practices in this area vary: some centers ask callers with any degree of suicide risk to enroll in their follow-up program while others limit this program to those that present with a medium to high risk of suicide. Other centers only follow up with those recently discharged from an emergency department or inpatient setting. Your center may decide to create several follow-up programs based on a caller's risk level. For example, lower levels of risk may require only one follow-up call within a 24 - 48 hour period, whereas higher risk callers may require a shorter interval.

Sample Follow-Up Criteria:

PROVIDENT, INC., MO

Low Risk: 24 hours

Medium Risk: 12 hours

High Risk: 3 hours

Immediate High Risk: 1 hour

If Admitted to Hospital: Call 7 days later

Whatever criteria you choose in establishing your own center guidelines, it is important to ensure that the enrollment criteria are not based solely on the caller's level of suicidality, but also on your center's resources, staff time and capacity to properly follow up with individuals. Start small, and expand the program once the staff is comfortable with the procedures and enrollment criteria.

When planning your staffing for this program, keep in mind these general guidelines that the evaluation team at Columbia has learned so far from their evaluation of follow-up calls:

- Of those offered clinical follow-up, approximately 67% agreed.
- Of those who agreed, only 61% were reached successfully (after multiple attempts).
- Approximately 41% of callers offered follow-up were actually reached (after multiple attempts).

Recommendation 2: Create Clear Program Protocols

Establish a clear program protocol that can be used by staff doing follow-up. The protocol should include:

1. Review a safety plan that may have been created or started on the initial contact (further described in Recommendation 4 and in the appendix)
2. Minimum number of follow-up contacts made to each participant
3. Maximum number of attempts to reach an individual before it is assumed they have dropped out of the program, typically three to five attempts are made.
4. Maximum duration (in days or weeks) of program involvement
5. General guidelines on content of follow-up calls
6. General goals for the follow-up care

While your center's protocol does not have to be rigid (i.e. individualized call schedules can be developed based on a caller's needs), it does need structure in order to ensure consistent and effective service provision. So while details of a caller's follow-up plan may vary depending on risk level and the goal of follow-up (i.e. follow-up until relinked to treatment – or follow-up until specific stressor has passed) the overall approach should remain the same. In general, follow-up calls should involve a mood check and assess for continuing risk based on the presenting problem. The safety plan should also be reviewed and revised as needed. All calls should contain structure, but allow for variations depending on the needs that arise. Staff should make sure that the caller understands when their participation in the follow-up program will end. Lastly, as in all hotline calls, staff should invite the caller to stay in touch and call the Lifeline whenever they feel the need to talk to someone or if they are in crisis.

Recommendation 3: Openly Describe the Program to Participants and Gain Consent

Ensure that the caller clearly understands how the follow-up program operates – including the service that will be provided and what will NOT be provided. For example, the caller should be made aware that follow-up is designed to be time limited and not designed to replace short-term treatment. The sample consent form provided in the appendix highlights much of the information for review with the caller as you obtain consent to call them back.

> To increase caller consent, hotline staff can say, "Before we end the call, I want you to know that I am concerned about you and that we want to make sure that you are safe. Is it OK if we call you back and see how you are doing?"

It is important to know whether you have permission to leave a message or speak to a 3rd party about the caller. This helps to continue to follow-up when someone's contact information has changed, or the individual is hard to reach.

Recommendation 4: Establish a Safety Plan and Use it to Structure Follow-up Calls

A safety plan is a document that identifies ways in which an individual can keep him/herself safe. The safety plan intervention is a collaborative problem solving approach for suicidal individuals that can be developed during a crisis call once it is established that immediate emergency intervention is not required. The plan is meant to be flexible and can change as an individual's level of distress changes. Structure your follow-up calls around the plan by reviewing and modifying it during the calls. Assess with the caller how useful the safety plan has been. If the caller has not used the plan despite feeling suicidal, the counselor can review barriers to implementation and alternative strategies. A sample safety plan has been provided in the appendix to guide you in this process.

Recommendation 5: Fully Integrate the Follow-up Program into your Center's Objectives

Ensure that the follow-up program is folded into all staff and volunteer trainings to promote full integration of the service and enhance sustainability of the program. In addition, train as many staff and volunteers as possible to be able to provide follow-up. Most centers have dedicated staff provide the majority of the follow-up services. However, typically all counselors will be offering to enroll callers or chat visitors in follow-up and should have a clear understanding of what is being offered.

Consider creating a separate line for follow-up callers to call back. Some crisis centers have noted that when an attempt is made to reach someone by follow-up and a message is left, it is helpful to be able to provide that person with a specific phone number to reach that is separate from the crisis line. A recorded voicemail can indicate the purpose of the line, and the number to call if the caller is in crisis.

Follow-up work has been anecdotally shown by crisis centers to increase morale. Often, the center finds that the crisis from the initial contact has lessened when the individual is reached during a follow-up contact. When this is the case, it gives counselors an opportunity to see the impact of the services they are providing, and they are able to hear about how offering this additional layer of support is helpful. Counselors are also able to provide support and encouragement for the person's next steps, such as asking about attending previously discussed appointments, which has been experienced as rewarding for some counselors.

When following up with those referred from outside organizations (e.g. a local hospital system) focusing on engagement first is important. In these cases, the person has not had previous contact with the crisis center, and the counselor will need to "sell" the service by developing a rapport first, before the assessment. There will be time later in the call to ask about suicidal thinking, it is important to first build that relationship.

Recommendation 6: Consider a Range of Follow-Up Methods

Use of text or email services can help engage more callers in the follow-up program. While there is a scarcity of research on the topic, crisis centers have found that by offering alternative methods of communication they can engage a wider demographic, particularly youth or those without access to a phone. Across the Lifeline network, protocols are currently being developed for using text and email for follow-up. The offer of email to follow-up has been used by some centers when the person's initial contact with the center is via chat. Contact Community Services, for example, created a specific email address so that all follow-up comes from one central email that can be accessed by all chat specialists. They also set up time constraints for answering follow-up emails (only during chat hours) so that visitors know the limits of the service. They do not include any sensitive or specific information from the chat in the follow-up in order to keep the email as confidential as possible. They have also added a disclaimer at the bottom of all chats that indicates the limits of email usage and provides both their Contact Hotline number and crisis chat website, along with the Lifeline number and website.

When using text, staff will schedule a date and time to follow-up with the caller by text, just as they would with a phone call. Based on the needs of the caller and the safety plan, the staff will check-in to ensure safety and risk level. Some centers ask the caller if they can switch to a phone call if the risk level has elevated since the previous chat or text. An example of an online follow-up protocol, developed by the Careline crisis center in Fairbanks, Alaska, is included in the appendix.

Recommendation 7: Track and Evaluate Key Outcomes

A system to track and evaluate your center's follow-up program is essential. Clean data and easy reporting tools allow staff to closely examine program effectiveness and refine approaches to address specific needs. Data can make the difference in whether or not you can apply for funding opportunities. Suggestions for data elements to gather include:

Metrics and indicators help funders, major donors, and government agencies see the impact your programs have on your community. Indicators that show cost savings to an overburdened mental and behavioral health system are of particular importance. Track ED diversion rates or referrals to outpatient services to show these impacts.

- Number of people screened for follow-up
- Number actually enrolled
- Demographic information
- Average number of contacts made per individual
- During the time the individual was a participant in the program (a) were they admitted to the hospital or an inpatient setting, and/or (b) did they attempt suicide?
- Self-reporting on whether the individual accessed referral services or other services
- Satisfaction of the program on a 1-5 scale

Recommendation 8: Establish a Policy to Deal with Frequent Callers and Program Dependency

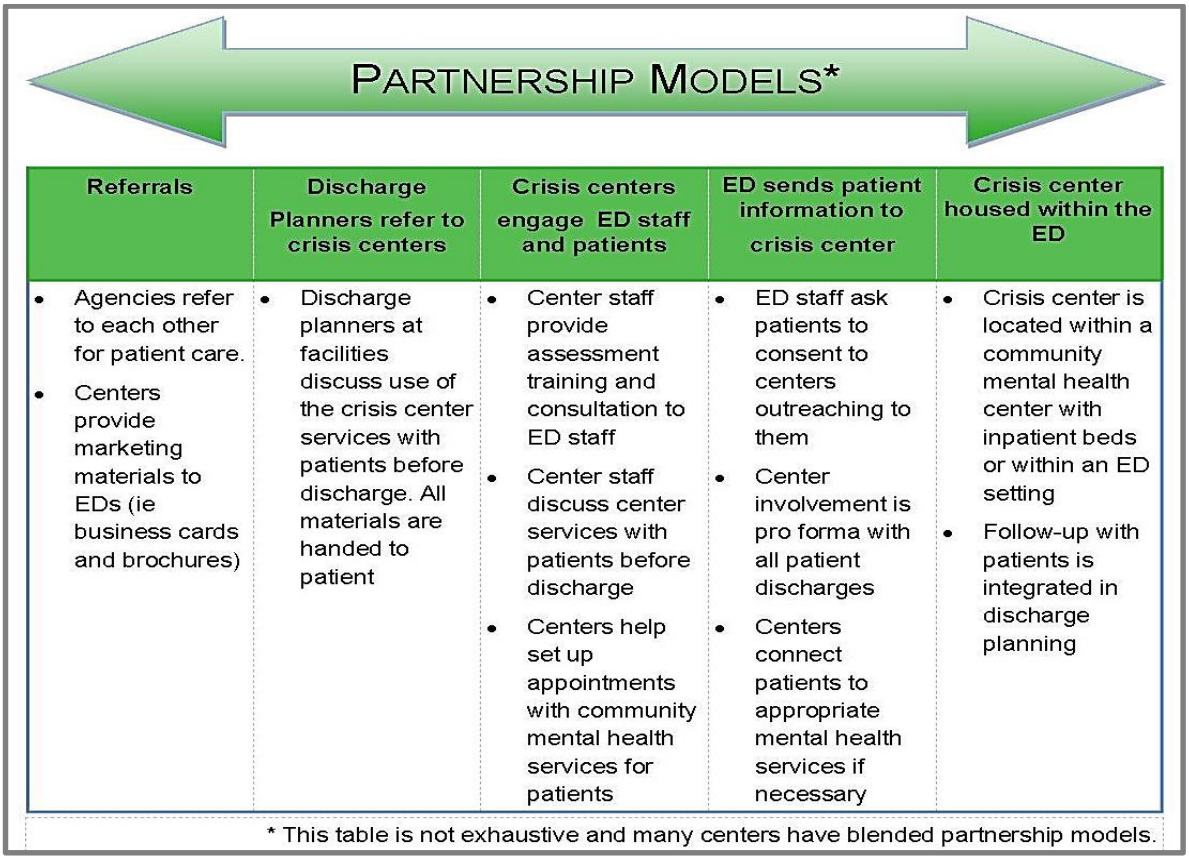
Create a policy to deal with frequent callers and prolonged participation in the follow-up program. Make sure you have a consistent approach on how to deal with a frequent caller and maintain a list or database with the names and description of these callers so all staff can access the information any time. Remember to re-iterate the purpose of the follow-up program, which is to provide short-term, limited check-in calls based on a prepared safety plan. Frequent and abusive callers need to be reminded often of the limits you set with them. Be direct and de-escalate a situation if the caller becomes abusive. You may want to de-brief the call with a supervisor or co-worker to build skills in dealing with frequent callers. A tip sheet for managing frequent and abusive callers is available in the appendix.

Recommendation 9: Establish a Policy to Work with Local Law Enforcement

Having a working relationship with your local police and 911 centers helps promote proper care for follow-up participants at imminent risk. Given that your staff will have more contact with follow-up program participants, it is possible that you will be asked to provide information to local law enforcement or other government agencies about particular participants. To deal with these information requests, your agency should develop an internal policy. Within that policy, the Lifeline recommends that your center ensures that law enforcement obtain a court ordered subpoena before accessing any requested information about specific individuals who use your services.

If your center uses online services such as chat, you will need to develop a policy around finding someone's physical location in the instance of imminent risk. Crisis centers can find someone's physical location using their IP address and time stamp, which often are automatically tracked by your center's chat software. Once you have identified the IP address, enter it into one of several online services that track IP addresses, such as http://whatismyipaddress.com/. These online services will give you the city where the chat is coming from and the Internet Service Provider (ISP) that owns the IP address. The legal department of many ISPs will provide the physical address of their customers to local law enforcement when there is a risk of imminent danger. To find a phone number for the ISP's legal department in the case of imminent risk, use the website: http://www.search.org/programs/hightech/isp/.

Partnering with Local Emergency and Inpatient Facilities



PARTNERSHIP MODELS*

Referrals	Discharge Planners refer to crisis centers	Crisis centers engage ED staff and patients	ED sends patient information to crisis center	Crisis center housed within the ED
• Agencies refer to each other for patient care. • Centers provide marketing materials to EDs (ie business cards and brochures)	• Discharge planners at facilities discuss use of the crisis center services with patients before discharge. All materials are handed to patient	• Center staff provide assessment training and consultation to ED staff • Center staff discuss center services with patients before discharge • Centers help set up appointments with community mental health services for patients	• ED staff ask patients to consent to centers outreaching to them • Center involvement is pro forma with all patient discharges • Centers connect patients to appropriate mental health services if necessary	• Crisis center is located within a community mental health center with inpatient beds or within an ED setting • Follow-up with patients is integrated in discharge planning

* This table is not exhaustive and many centers have blended partnership models.

In an effort to address the high risk for suicide following discharge from an inpatient or ED setting, crisis centers have taken the lead on creating new partnerships to provide follow-up services with patients recently discharged. Centers across the network have varying levels of engagement with EDs and inpatient facilities. These partnerships can be informal or formalized by memoranda of understanding (MOU). Some centers are making the partnership into a development opportunity by contracting with the hospitals, charging a fee for their service.

Research indicates that emergency departments (ED) face significant overcrowding. In the United States, from 1992 – 2001, 52.8 million visits to the emergency department were mental health related (5.4% of total visits). Suicide attempts accounted for 7% of all mental health related visits and, as a fraction of total ED visits, increased by 47% over the course of the decade. (Larkin, Smith, & Beautrais, 2008)

Description of potential partnerships

- Marketing materials such as business cards and brochures can be placed in the ED or inpatient facility. Staff social workers and discharge planners at the partner facility can also include these materials in their discharge packets. The materials will build community awareness about the programs and services the center offers.
- Centers can provide suicide risk assessment training and consultation for ED staff. These assessments can be done in person (at the hospital) or by phone.

- Centers can establish contracts with the ED, inpatient facility or with the State to provide mental health assessments for all patients in the ED at admission and/or before discharge.

- Aftercare and after hours services are highly effective to help link patients to outpatient care and divert these patients to more appropriate services.

- EDs and inpatient facilities can obtain consent from patients to send crisis centers their contact information for follow-up services. These follow-up calls can be scheduled by the discharge planner, or they can simply ensure the patient that someone from the crisis center will follow-up with them to check in about how they are doing **within 24 to 72 hours**.

- Centers can become an important bridge between EDs and individuals in need of care. For example, your center can establish mobile crisis outreach teams to connect hotline callers with the appropriate services if they are at higher risk of suicide.

Building a partnership with EDs and inpatient facilities can be a time consuming process. It is important to build relationships with key stakeholders and be prepared. The Lifeline's Crisis Center – Emergency Department Partnership Tool Kit has information that may be very useful including planning exercises, sample letters and presentations. All of the materials can be customized to fit your agency's needs.

In particular, take the time to review the Partnership Planning Exercises. This set of exercises will be useful as you plan your approach to engage with hospitals in your area. The following exercises and topics are covered in the section:

1. **Examine the Situation:** This is an exercise to create a simple analysis of your crisis center's strengths, weaknesses, opportunities and threats. It will help you determine your center's capacity to partner with a hospital or inpatient facility.

2. **Assess the Attitudes:** This exercise helps you find out what attitudes different stakeholders may have about the services your center is offering. If you have time, it may be worth it to actually survey these stakeholders to get a more accurate understanding of their attitudes and perceptions. Free online tools like surveymonkey.com can be accessed to develop your survey.

3. **List Your Assets and Capabilities:** This exercise helps you define what services may be attractive to an ED or inpatient facility. Be realistic about the services you are able to provide. Think of the opportunities in phases – develop ideas for what you can provide today versus what you will be able to provide once a partnership is established and new infrastructure needs are met.

4. **Identify Your Communications Channels:** This exercise will help you determine other resources your center can provide in partnership with an ED. Although the exercise asks for communications resources, think about all of the community resources your center has that may be helpful in a partnership.

5. **Create Your Partnership Building Strategy:** Once you have analyzed your center's capabilities, resources and strengths, this exercise will help you build a strategy for establishing a relationship with an ED. Take the time to clearly establish goals, identify your target audience, find out who in the ED has the power to decide on a partnership, and get a sense of the attitudes of the ED personnel. After these steps, you will be ready to create messaging, talking points, and communications materials directed at the different identified audiences.

6. **Brainstorm Activity Ideas:** This exercise will help you in brainstorm the different partnership models that you can establish with an ED. For example, think about smaller programs that you can offer to pilot with the ED before you establish a more robust partnership with more services.

7. **Make an Action Plan:** Building from your strategy, create an action plan with deadlines and responsible parties listed so you are organized and ready to begin outreach efforts to your local ED or inpatient facility.

8. **Address Liability Concerns**: The following points should help decrease the hospital's liability concerns.
   - The hospital has already made the decision that the patient is safe to be discharged; crisis center follow-up program provides an extra layer of support after that decision has been made.
   - Follow-up provides an enhanced service to patients in addition to any other discharge planning protocol, so it should reduce liability.
   - MOU can clarify that both the hospital and the crisis center have liability insurance.
   - Patient is the one that has to consent to the follow-up contact, and participation in the service remains completely voluntary even after the consent is given.

In addition to the planning exercises, the Talking Points document can assist you in highlighting your agency's credibility and years of experience in prevention service delivery. The Tool Kit is accessible through the Lifeline's members-only website. In addition, the appendix of this document has an updated summary of the current research on follow-up and sample memoranda of understanding from member crisis centers.

Keep in mind that once a relationship with a facility is developed, your work is not over. Implementation of the program may take time as well. Continue to develop your partnership by regularly meeting with ED staff to ensure that they are honoring the established agreements and promoting crisis center services.

Sustainability and Development

Fundraising and development are important to maintain sustainability of new programs. The Lifeline's members-only site has information about responding to requests for proposals (RFPs) as well as sample proposals. The site also offers information on where to research RFPs online, including accessing information from agencies such as the Foundation Center. The Lifeline is currently developing a sustainability toolkit with information crisis centers can use to prepare documents and track relevant information for fundraising purposes. In addition to donations and grants available to non-profit centers, crisis centers have developed models to obtain fees for the services they provide. These materials – in draft form – are available on the members-only site. Further, see the appendix for a tip sheet on how you can diversify your center's funding streams.

Conclusion

Although our effort to develop best practices for follow-up protocols continues, these recommendations provide a framework for crisis centers to use as their programs evolve. Making follow-up a part of the crisis center's services will enable crisis centers to continue to play an invaluable, lifesaving role in the mental health system.

This document could not have been prepared without the crisis centers' participation in the Lifeline network; thank you for your continued support of the network and the amazing work that you do every day.

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Appendix A: Safety Planning Intervention

A safety plan is a list of coping strategies and sources of support callers can use who have been deemed to be at high risk of suicide. It is designed so that you can work collaboratively with a caller to create a prioritized plan that is brief and easy for the caller to follow. Ask the caller to keep the plan in a place where s/he can easily access it (in a wallet or cell phone) when they have thoughts of hurting themself.

The following are essential elements to explore and include in the development of a safety plan*. Work with the caller to create a plan based on these steps:

1. Recognize warning signs: What sorts of thoughts, images, moods, situation, and behaviors indicate to you that a crisis may be developing? Write these down in your own words.
2. Use your own coping strategies – without contacting another person: What are some things that you can do on your own to help you not act on thoughts/urges to harm yourself?
3. Socialize with others who may offer support as well as distraction from the crisis: Make a list of people (with phone numbers) and social settings that may help take your mind off things.
4. Contact family members of friends who may help to resolve a crisis: Make a list of family members (with phone numbers) who are supportive and who you feel you can talk to when under stress.
5. Contact mental health professionals or agencies: List names, numbers and/or locations of clinicians, local emergency rooms, crisis hotlines – carry the Lifeline number 1-800-273-TALK (8255).
6. Ensure your environment is safe: Have you thought of ways in which you might harm yourself? Work with your counselor to develop a plan to limit your access to these means.

The following pages come from the Suicide Prevention Resource Center's online library and includes the A Quick Guide for Clinicians and a Safety Plan Template. Note that the Quick Guide is meant to be folded in half.

* Stanley, B., & Brown, G. K. (2012). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice, 19*, 256-264.

- For methods with **low lethality**, clinicians may ask patients to remove or limit their access to these methods themselves.
- Restricting the patient's access to a **highly lethal method**, such as a firearm, should be done by a designated, responsible person – usually a family member or close friend, or the police.

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

ASSESS the likelihood that the overall safety plan will be used and problem solve with the patient to identify barriers or obstacles to using the plan.

DISCUSS where the patient will keep the safety plan and how it will be located during a crisis.

EVALUATE if the format is appropriate for patient's capacity and circumstances.

REVIEW the plan periodically when patient's circumstances or needs change.

REMEMBER: THE SAFETY PLAN IS A TOOL TO ENGAGE THE PATIENT AND IS ONLY ONE PART OF A COMPREHENSIVE SUICIDE CARE PLAN

THE WICHE Center for Rural Mental Health Research is supported by the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA), Public Health Services, Grant Award, U1CRH03713

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Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

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SUICIDE PREVENTION RESOURCE CENTER

Implementing the Safety Plan: 6 Step Process

Step 1: Warning Signs

- Ask: **"How will you know when the safety plan should be used?"**
- Ask: **"What do you experience when you start to think about suicide or feel extremely depressed?"**
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient's **own words**.

Step 2: Internal Coping Strategies

- Ask: **"What can you do, on your own, if you become suidical again, to help yourself not to act on your thoughts or urges?"**
- Assess likelihood of use: Ask: **"How likely do you think you would be able to do this step during a time of crisis?"**
- If doubt about use is expressed, ask: **"What might stand in the way of you thinking of these activities or doing them if you think of them?"**
- Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask: **"Who or what social settings help you take your mind off your problems at least for a little while?" "Who helps you feel better when you socialize with them?"**
- Ask for safe places they can go to be around people (i.e. coffee shop).
- Ask patient to list several people and social settings in case the first option is unavailable.
- Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
- Assess likelihood that patient will engage in this step; ID potential obstacles, and problem solve, as appropriate.

Step 4: Family Members or Friends Who May Offer Help

- Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
- Ask: **"Among your family or friends, who do you think you could contact for help during a crisis?"** or **"Who is supportive of you and who do you feel that you can talk with when you're under stress?"**
- Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask: **"Who are the mental health professionals that we should identify to be on your safety plan?"** and **"Are there other health care providers?"**
- List names, numbers and/or locations of clinicians, local urgent care services.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 6: Making the Environment Safe

- Ask patients which means they would consider using during a suicidal crisis.
- Ask: **"Do you own a firearm, such as a gun or rifle??"** and **"What other means do you have access to and may use to attempt to kill yourself?"**
- Collaboratively identify ways to secure or limit access to lethal means: Ask: **"How can we go about developing a plan to limit your access to these means?"**

Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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The one thing that is most important to me and worth living for is:

_____

WICHE Mental Health Program

SPRC Suicide Prevention Resource Center

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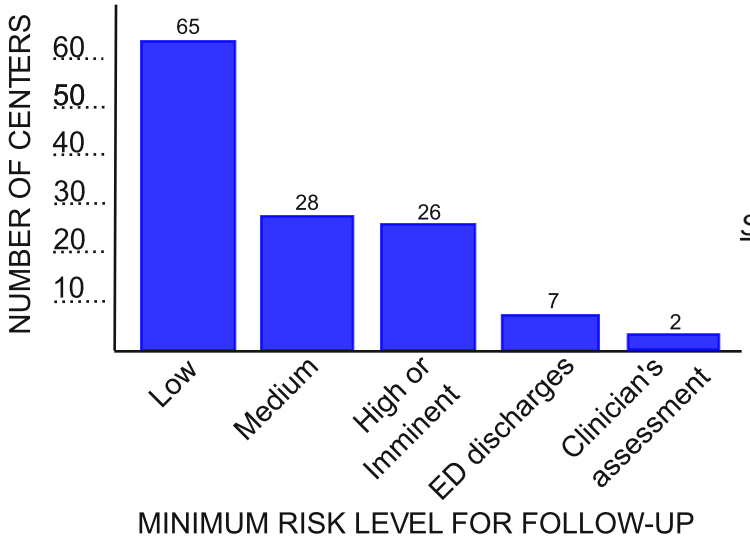
LIFELINE FOLLOW-UP PROGRAM INFORMATION

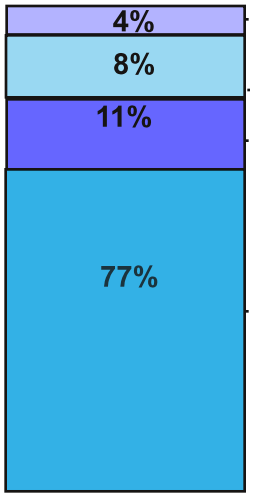
BACKGROUND - The following data is based on follow-up program information gathered between February and June 2012. Over 95% of the Lifeline centers (*sample size: 115*) that provided information had some kind of a follow-up program.

RISK LEVEL FOR ELIGIBILITY INTO FOLLOW-UP PROGRAM - All crisis centers have an established risk level for entry into their follow-up programs. Twenty-five centers have two programs, providing different follow-up services to each population. The programs range from follow-up services for frequent callers, monthly check-ins for high risk callers, ED/inpatient discharges , and third parties.



Sample size: 111

FUNDING - Centers have reported a variety of funding streams that help support their follow-up programs.



5 centers received SAMHSA and Lifeline funds

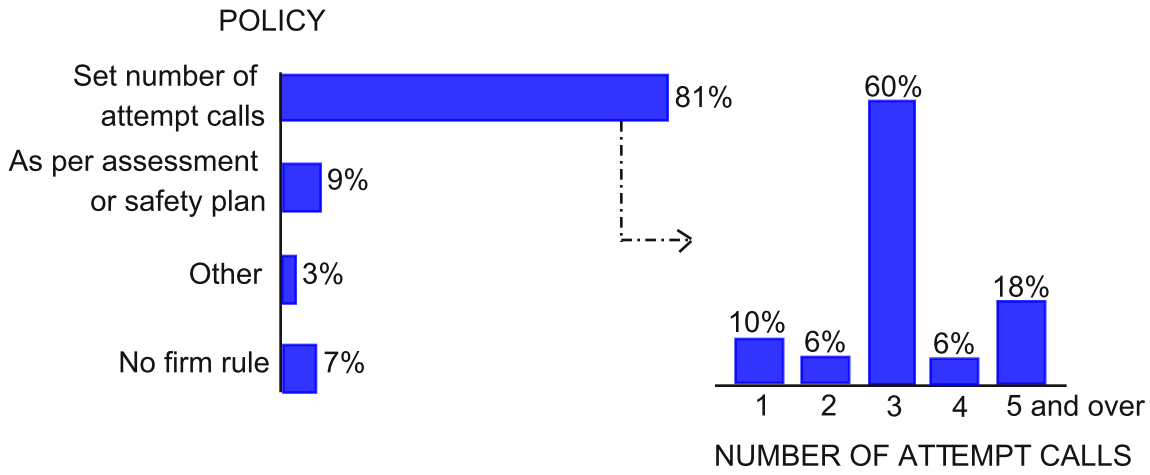
9 centers received funding from the Lifeline (2010)

13 centers received SAMHSA funding (Cohorts I, II, III)

The majority of centers fund their programs through Federal, State, and County grants, private foundations (including the United Way), donations, and contracted fee-for-service programs.

Sample size: 115

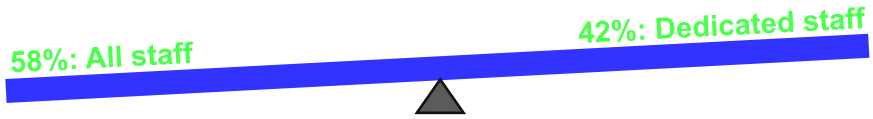
NUMBER OF ATTEMPTS TO REACH A CALLER - Many centers have developed a policy around the number of times hotline workers will attempt to reach a caller before they terminate them from the follow-up program. Below is a range of approaches that Lifeline centers take in attempting to reach a caller.



Sample size: 86

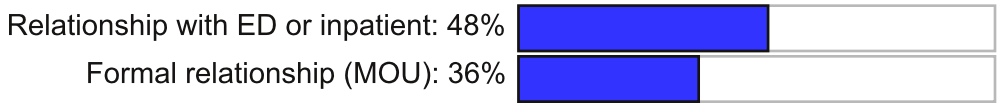
Sample size: 70

STAFFING - Most centers train all staff to do follow-up, while others have dedicated staff (only supervisors or one paid staff) that do follow-up.



Sample size: 102

ED OR INPATIENT - Many centers partner with EDs or inpatient facilities to provide services. These relationships are either informal or formalized by establishment of memoranda of understanding (MOU). Common programs include: pre-admission or pre-discharge risk assessment at hospitals, ED diversion programs, care coordination and outpatient service referrals, as well as follow-up after discharge.



Sample size: 112

For more information, please contact Manisha Vaze, Follow-up Coordinator at the National Suicide Prevention Lifeline: mvaze@mhaofnyc.org, 212-614-5704.

Appendix C: Summary Review of Select Follow-up Practices

ACCESS Line, DOH – Honolulu, HI
Belinda Vaovasa Danielson, ACCESS Supervisor:
belinda.danielson@doh.hawaii.gov

- Operates through the State Dept. of Health serving communities in Hawaii - The center was a private entity until it was brought in under the Hawaii Dept. of Health in 2002.
- Medium to high risk hotline callers and ED/inpatient hospitals if the client is ineligible for services through an informal relationship.
- All 14 staff makes follow-up calls. 1st is within 24 hours with the goal of reducing risk for suicide and linking to outpatient or other appropriate services.
- Outreach workers may also be sent to the outer counties (on other islands) to ensure safety of the caller.

Contact Crisis Line – Dallas, TX
Stephanie Blake, Crisis Line Program Manager:
sblake@contactcrisisline.org

- Crisis center providing hotline services serving communities in Dallas
- All callers with suicidal ideation and follow up with patients discharged from the ED through a formal agreement
- 3 staff makes all follow-ups over a period of one to two weeks. Calls are scheduled and made based on the callers' needs.
- Provided staff training on screening and protocols before implementing the program. Now have folded this protocol training into new staff orientations.

Crisis and Counseling Services – Augusta, ME
Abby Lourie, Director of Crisis Services:
alourie@crisisandcounseling.org

- Community mental health agency serving two counties and two jails in Maine. Provides crisis hotline, outpatient services, group and individual therapy, and survivor support groups.
- High risk callers and patients discharged from the hospital/ED through a formal agreement (5 agreements). Also have relationships with the local police and 911 dispatch
- 4 dedicated staff makes all follow-ups. 1st call within 24 hours, and continue to make calls based on callers' needs and until linked to outpatient services.
- Given that they serve a rural community, access to services may be limited and wait lists for services can be long. The center also has a face-to-face outreach program to serve the community and mitigate external barriers to accessing services.

HELPline! Center – Sioux Falls, SD
Lori Montis, Suicide and Crisis Director:
lori@helplinecenter.org

- Crisis center providing hotline services serving communities in South Dakota
- All callers and texters with any suicidal ideation
- 1 staff person handles all follow-ups and on average make two follow-ups (maximum of 6 contacts).
- This year they began a pilot texting programs with the local high school. They will evaluate this program and provide more information on it as the year progresses.

Personal Enrichment Mental Health Service (PEMHS) – Pinellas Park, FL
Amber Hagelstein, Project Director:
ahagelstein@pemhs.org

- Crisis center located within an inpatient hospital serving communities in Pinellas Park, Florida
- Medium to high risk hotline callers and discharged patients from their inpatient facility
- 3 dedicated staff makes all follow-ups. 1st call within 48 hours. Make at least 3 calls, and continue based on callers' needs. On average, calls are staggered over 6 weeks.
- They have significant access to patients discharged from their inpatient facility, mainly transient populations who have limited access to services.

Appendix D: Lifeline Sample Consent Form

We are concerned about you and we want to make sure that you are safe. Would it be okay for someone from our hotline (Hotline Name) to call you and see how you are doing? Making these follow-up calls is an important part of our services. We have found that these follow-up contacts can help keep people safe and feel supported until they are feeling better (and/or linked to treatment services). Would it be okay for (Hotline Name) to contact you in (time period to be decided by crisis worker completing this form)?

☐ YES ☐ NO

1. Name of patient: _____
2. Name of crisis worker completing this form: _____
3. Date of Referral: _____

Safety plan is complete and in the caller's record. (If not, fill the below information)

4. Telephone #: _____ Phone for? (circle): Home# Cell# Office#
5. Best day(s) and times to call: _____

6. Do you have an answering machine or voice mail on this telephone? ☐ YES ☐ NO

   If "Yes":

   If you are not able to answer when we call, is it okay for us to leave a message?

   ☐ Do NOT Leave Message
   ☐ Yes, Leave Hotline Message
   ☐ Yes, Leave Different Message: (Details)_____
   _____

7. If someone else answers when (Hotline Name) calls, is it okay for them to leave a message with the person who answers the phone? ☐ YES ☐ NO ☐ No one else will answer

   If "Yes":

   ☐ Do NOT Leave Message
   ☐ Yes, Leave Hotline Message
   ☐ Yes, Leave Different Message: (Details)_____
   _____

The information you have provided here and any other information exchanged between you and the (Hotline Name) staff is strictly confidential. If the (Hotline Name) wishes to share your information with others that can assist in your care, we must obtain your permission to do so. The only exception to this rule is if your life (or the life of others) is in danger. In this case, the (Hotline Name) may only share information about you with individuals or agencies that they believe can assure your immediate safety.

When a staff member from the (Hotline Name) calls you, they will ask you questions about how you are doing, how safe you are feeling at the time, and what actions you are taking to keep yourself safe. They will see what kind of help you may still need at the time, and do whatever they can do to help you.

You are also free to contact the (Hotline Name) directly at any time during or after your involvement in this follow up program to obtain more help.

Signed: _____
Date: _____

Appendix E: Follow Up Policy Sample, Empact (Arizona)

EMPACT - Suicide Prevention Center, Inc. | Category: Crisis Hotline | Title: Follow-Up Calls

I. PURPOSE
To ensure that follow-up phone calls are scheduled, completed, and documented correctly by all staff who answer the crisis line. To satisfy all of the requirements of the Follow-Up Grant awarded to Empact by the National Suicide Prevention Lifeline (NSPL).

II. SCOPE
This procedure outlines the steps for scheduling, completing, and documenting follow-up phone calls to a hotline caller. This procedure applies to all staff members who answer the crisis hotline.

III. METHODS
A. Criteria
In order to meet eligibility criteria and be offered a follow-up phone call, the caller must have expressed thoughts of suicide or be otherwise at risk for suicide, but cannot be in immediate or imminent danger by the end of the call. The caller must be stable and not likely to (re)escalate if offered follow-up services. The caller must be 18 years of age or older and must have the capacity to give consent, i.e. no current psychosis, intoxication/impairment, or dementia.

B. Procedure

Initial Call

1. Once eligibility has been established, complete the follow-up form starting with the invitation for follow-up. Complete items 1 through 9. (If caller declines, complete the appropriate fields on the Follow-Up (Declined Log) form)
2. If any items are not applicable, write N/A in that space to acknowledge that that field has not been overlooked.
3. Close with the concluding script. This must include our confidentiality policy, the three instances in which we will no longer attempt to contact them, and a reminder that the caller can request that we stop follow-up services at any time.
4. At the end of the call, ask the caller to rate their suicidality on a scale of 1 to 10, 1 being lowest risk and 10 being highest risk.

Follow-Up Call

1. For continuity of care and to build on established rapport, an attempt will be made for the initial clinician to also place the follow-up phone call(s).
2. Unsuccessful attempts to reach the caller should be logged in the space provided on the follow-up form.
3. If the caller is reached, the clinician will inquire as to how they are doing, how safe they are feeling, and what actions they have taken to keep themselves safe.
4. Ask the caller to rate their risk of suicide on a scale of 1 to 10, 1 being lowest risk and 10 being highest risk.
5. Address a change in score, or lack thereof, compared to their previous rating. If the caller's

reported rating/score has lowered, help them to identify the successful coping skills/mechanisms they utilized. If their reported rating/score has gone up or remained the same, re-assess for immediate safety and engage in an appropriate clinical intervention.

6. Identify any barriers to improvement and assist the caller in problem solving as you would on an initial call.
7. Schedule future follow-up as needed.
8. Summarize your call in narrative form in the space provided below the risk assessment scale on the follow-up form. If additional space is needed, communication logs should be attached and clearly marked with time/date of the call to which they are referring.

Issue Date: 8-17-10 **Revision Date:** **Approval:**

FOLLOW-UP CALL (Initial Call)

Please check that all of the following are true before proceeding:

□ Caller has expressed thoughts of suicide or is otherwise at risk for suicide.
□ Caller is not in immediate/imminent danger of suicide by end of call.
□ Caller is stable and not likely to (re)escalate if offered follow-up services.
□ Caller has the capacity to give consent. (No current psychosis, intoxication, or dementia)
□ Caller is 18 years old or older.

Follow-up Invitation to Lifeline Callers Considered Eligible for Follow-Up (standard script)
"Before we end the call, I want you to know that I am concerned about you and that we want to make sure that you are safe. We would like to call you back in a few days and see how you are doing. Would you be open to allowing us to re-contact you soon?"

□ **Yes** □ **No**

If the Caller says "yes", complete the following:

1. Caller's name:
2. Telephone number: Home / Cell / Work
3. Best days and times to call:
4. If you have caller ID, should we block our identity when we call? (*67) Yes No
5. Is it okay for us to leave a message? □ Yes □ No

Special instructions for message: _____
_____

6. If someone else answers when the crisis center calls, is it okay for us to leave a message with the person who answers the phone?

Special instructions for message with other person:

7. "Is there another contact person that could assist us if they are unable to reach you and are concerned? EMPACT will only use this contact following three unsuccessful attempts to reach you at the number you provided" □ Yes □ No
8. Additional contact's name: Relationship:
9. Telephone number for additional contact: Home / Cell / Work

Concluding Script

“Thank you for providing us with this information. I want you to know that the information that you have provided us with is strictly confidential. The only exception to this is if your life is in danger. In this case, EMPACT may only share information about you with individuals or agencies that we believe can assure your immediate safety.”

“I or a hotline specialist will attempt to stay in contact with you until: (a) You are connected to appropriate care; or (b) You are safe and no longer in need of crisis line follow up; or (c) The crisis line is unable to reach you and has made a minimum of three attempts.

“You can choose to have us stop following up with you at any time. You are also free to contact EMPACT directly at any time during or after your involvement in this follow up program to get more help, whenever you need it.”

“We look forward to checking back with you in [APPROXIMATE NUMBER OF DAYS]. If you need any help between now and then, please don’t hesitate to call. We want to make sure that you get through this difficult time, and we are here for you whenever you need us”.

Unsuccessful attempts to reach client:

1. Staff:	Date:	Time:	Left Message?
2. Staff:	Date:	Time:	Left Message?
3. Staff:	Date:	Time:	Left Message?

GOALS: Re-assess risk; identify effective coping skills; identify barriers to follow-through w/ referrals.

<u>1st FOLLOW-UP</u>

Staff: Date: Time:

“How you are doing? How safe are you feeling today? What actions are you taking to keep yourself safe?”

RISK ASSESSMENT:

1 2 3 4 5 6 7 8 9 10

LOW RISK HIGH

Notes: _____

<u>2nd FOLLOW-UP</u>

Staff: Date: Time:

“How you are doing? How safe are you feeling today? What actions are you taking to keep yourself safe?”

RISK ASSESSMENT:

1 2 3 4 5 6 7 8 9 10

LOW RISK HIGH

Notes:_____

Appendix F: Follow Up Policy Sample, Careline (Alaska)

Title: Follow-Up Calls | Issue Date: Number: 2.9 | Revision Date: 3/8/2012

Policy: It is Careline policy to offer follow-up calls to at-risk individuals, as appropriate.

Background

Research has shown that phone calls to individuals in crisis is effective suicide prevention. Once Careline has contact with a suicidal person, who at the call's end has an assessed lower lethality risk, does not mean the job of keeping them safe is over. It is common for callers to contract to call Careline back, but then not to follow through. There is also the risk of callers taking their lives or attempting suicide after we have ended a call. When Careline staff have a sense that a caller will continue to be at risk after a call, it is appropriate to have continuing contact with the caller by calling them back at a prearranged, and agreed upon, time. To this end, staff shall offer follow-up calls to suicidal callers and to crisis callers (i.e. callers who are experiencing grief, trauma, emotional distress, victimization, loneliness, hopelessness, and/or depression or who may otherwise be at risk).

Procedure

Follow-up calls shall be offered to:

1. Persons experiencing crisis as outlined above;
2. Persons at-risk for suicide;
3. Third-parties who are concerned for others experiencing crisis or suicide ideation.

Staff shall:

a. Obtain the caller's consent to place a follow-up call at dates and times acceptable to the caller;
b. Discuss with the caller how to proceed if another person answers the call from Careline staff;
c. Determine whether or not the caller is agreeable to the staff member leaving a message if no answer;
d. Discuss with the caller how to proceed if they do not answer the follow-up call;
    i. Do Careline staff contact emergency services if no answer to follow-up call?
    ii. Shall staff try back again? At what intervals shall Careline staff attempt additional contacts?
e. Document the purpose of the follow-up call in the Call Log;
f. Inform future shifts of commitment to follow-up call;
g. Document the follow-up call information in the Careline Call Log Database and on the staff Outlook calendar;
h. Inform the caller of the Careline availability 24/7.

Continuation of follow-up calls shall occur:

6. At dates and times acceptable to the caller;
7. At sufficient frequency to assess risk (hourly, daily, weekly, etc.);
8. Until risk assessment indicates risk of harm has been reduced and protective factors, buffers and resources are in place and are being utilized by the caller.

Title: Follow-Up Calls, cont. | Issue Date: Number: 2.9 | Revision Date: 3/8/2012

Documentation:
Staff shall document all calls, texts, and chats in the Careline Call Log Database. Staff shall document in their call log all efforts to engage the caller to reduce risk. Staff shall document an emergency dispatch in the Call Log, as well. For scheduled follow-up calls staff will document follow-up call details, e.g. call date, time, and telephone number, in the Careline Call Log Database. Staff will also document the scheduled follow-up call time and client ID number on the staff Outlook calendar.

Title: Online Intervention[1] | Issue Date: | Number: 2.11 | Revision Date: 3/8/2012

Policy: It is Careline policy to utilize intervention and prevention efforts as detailed in these Policies and Procedures with individuals contacting the Careline via internet based resources (i.e. Facebook, e-mail, Careline chat, text, etc.).

Background
Due to the advances in technology and changes in preferred methods of communication, Careline has implemented online chat, as well as text, as options for communicating with Careline staff. Regardless of the mode of communication, intervention and prevention efforts as detailed in this document are to be followed.

Procedure
Careline staff shall apply crisis intervention and suicide prevention measures as detailed in this document to all internet based interactions.

Careline staff shall log onto chat services at the commencement of their shift. Staff shall also check the Careline email and the Careline Facebook page at the beginning of each shift (at a minimum). Log-in information for all Careline accounts can be found in the Administrative Log. If there are emails or Facebook contacts necessitating contact the Careline staff member currently on shift shall follow-up.

All chat and text transcripts shall be copied/pasted into the “Comments” section of the Call Log Database upon completion of each intervention/communication.

In the event that an imminent risk is present, staff shall follow the emergency dispatch directives outlined in these Policies and Procedures. Staff shall provide germane information to emergency responders necessary to facilitate rescue. If staff do not know a physical address where the PAR is located, staff shall provide the PAR’s IP address to emergency responders. The PAR’s IP address can be found in the upper right hand corner of the chat window.

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[1] Definition: Online intervention shall be defined as intervention provided to individuals through internet chat via Careline’s website, email, text, or Careline’s Facebook page.

If a crisis exists that requires additional staffing, staff shall notify the Director or other designee through a phone call or through text messaging to the Director's or other designee's cell phone.

Documentation:
Careline Staff shall document all internet based interactions in the Careline database. For online chats, Facebook exchanges, texts, and email exchanges staff shall copy the transcript into the "Comments" section of the Call Log. Staff shall also include in the their Call Log notes any assessment or notes not included in the transcript.

Tips for Managing Frequent and Abusive Callers[1]

Karen Carlucci, LCSW
Lifeline STP Manager
kcarlucci@mhaofnyc.org

Repeat callers to a hotline can be very challenging to manage, both clinically and operationally. Some calls can become quite disruptive to the operation and exhaustive to the staff. The goal is to always listen and acknowledge the caller's issue, conduct an assessment and determine an appropriate intervention, including when to end the call. A provocative caller can evoke certain reactions from call takers, even when well-trained. Some will endure the call and desperately try to make progress with such a caller due to the commitment to help, staying on the line for an extensive period of time. Some will have a lower tolerance for what may be perceived as a prank or abuse of the line and quickly end the call, even if it may be premature to do so. Striking the balance between empathy and limit-setting is an ongoing challenge for call takers, while applying the use of technology to trace or block certain callers is an important consideration for any crisis center supervisor.

The following are some basic clinical guiding tips and script examples for staff when responding to frequent or abusive callers:

Frequent Callers

- Acknowledge you are familiar with the caller *("We know you've called several times today.")*
- Refer to the last time s/he may have called if aware or if you spoke to her/him *("I think we spoke this morning.")*
- Ask if there is anything different from the last call or what prompted this call *("Has anything happened since then that you need help with?")*
- Directly ask if there is any current emergency *("Are you in any danger right now? Is there any emergency? Are you currently thinking of committing suicide?")*
- Remind caller of the purpose of the hotline and clearly list options *("We are here to help. We want to understand what you need and provide any referrals that may be helpful. If necessary we can set up a mobile crisis team visit or get help to you right away by calling 911.")*
- Once determined no assistance is required, explain you will end the call and instruct the caller to call back if something changes and further help is needed *("Since we reviewed all the options the hotline can offer and you are not in need of immediate assistance right now, I will be ending the call. Remember you can call back if your situation becomes more difficult and you need further help.")*

[1] This tip sheet was originally developed for the Standards, Training, and Practices Division's Newsletter, Issue 3, November 2011. It can be used as a guide for hotline callers as well as people enrolled in your center's follow-up program.

- Centers may decide to circulate a brief description of a frequent caller to the team in order to prepare consistent language and approach. This information may be tracked in the call management database as appropriate. It may prove to be necessary for a designated person to keep the frequent caller information updated and distributed to all call handlers.
- If a caller requests a certain worker, it is advised to not necessarily oblige and inform that all hotline workers are trained to assist all callers. *("I'm available and happy to assist you at this time. Tell me what's happening at the moment.")* Transferring to preferred workers will only enable and encourage repeat callers, in addition to impacting general operational productivity.
- Specific limits may be established, such as agreeing to speak with the caller for a certain length of time a specific amount of times a day or week- this should be clear among staff and enforced by supervisors. One call (for a maximum of 10 minutes) per shift or day is a possible limit to set.
- If it is known the caller is engaged in treatment, continue to refer back to that provider after assessing for any current risk. *("This sounds like something for you to discuss with your therapist.")* It may be worth connecting the caller to the provider to facilitate that transition, inform the practitioner of the frequent calls and minimize any splitting. This step requires at least verbal consent from the caller to engage a third party when it is not an emergency *("We can call your therapist right now together to let him/her know you are in need of an appointment.")*
- If a phone number is accessible, a supervisor may consider calling a frequent caller back to address the pattern directly.

Abusive Callers

- Address any inappropriate language, etc. immediately; state you cannot assist if s/he continues to use profanity, yell, or speak inappropriately *("We would like to help you but are unable to do so if you continue to speak or act out in such a manner.")*
- If the caller sounds intoxicated or under the influence, as about this directly *("Have you been drinking or using any drugs today/tonight?")* Remember these callers may be at higher risk of self-harm.
- Directly ask if there is any current emergency *("Are you in any danger right now? Is there any emergency? Are you currently thinking of committing suicide?")*
- State the purpose of the hotline and clearly outline options *("On this line, we can offer the following options: provide referrals, set up a mobile crisis team visit if appropriate, or get help to you right away by calling 911.")*
- Do not raise your voice if caller is raising his/her voice. Stay calm and say very little. This will usually lead caller to eventually stop and possibly end the call.
- When necessary, firmly state you will be ending the call due to inappropriate conduct which cannot be tolerated on the hotline *("Based on the program policy, I will have to end the call if we cannot communicate in a productive way.")* If this occurs multiple times with a caller, say the center is keeping track of the calls in order to take any necessary action (even if it is not clear if something can be done yet due to an unidentifiable or untraceable number.) This may still deter the caller from calling as often.

- Centers may decide to circulate a brief description of an abusive caller to the team in order to prepare consistent language and approach. This information may be tracked in the call management database as appropriate. It may prove to be necessary for a designated person to keep the frequent caller information updated and distributed to all appropriate staff.
- Staff may wish to debrief after the call. Allow for peer to peer support and discussions guided by supervisors as needed and/or arrange set supervision times.
- When center technology allows and the issue cannot be de-escalated, abusive callers may be routed to an extension with a message saying the use of the line is inappropriate and to call 911 for any emergency. This frees up the lines for other callers.
- If a phone number is accessible, a supervisor may consider calling a repeatedly abusive caller back to confront what is taking place, stating what action the center plans to take (call limits, notifying authorities, etc). Sometimes just receiving a call from a supervisor or director may have an impact, since it alters the controlling pattern the caller has been attempting to establish.
- If possible, reach out to local law enforcement agencies to explore what options may be available in tracing certain calls if necessary.
- If a caller becomes threatening, take all necessary measures to protect staff by alerting them and any building personnel of appropriate details.

An example of a policy to handle inappropriate calls from CONTACT 2-1-1 of Burlington County, NJ, who presented at the Crisis Centers Conference in July 2011, is available on the Lifeline members-only website.

Self-Care of Staff

In order to respond to all calls in an effective and empathic manner, call takers should pay attention to their own needs. The demanding work of a hotline can lead to compassion fatigue and burnout. It is recommended that supervisors acknowledge the stress experienced in the hotline environment, encourage peer support and be available for debriefing. Breaks can be worked into the shift or taken as needed after particularly draining calls. If possible, arrange supervision groups and/or offer perks to the team for their hard work. Vacations should be planned in a way that allows each person to have adequate time off according to program scheduling needs. Promoting a team environment and providing necessary tools to staff can make a difference in the quality of service as well as the quality of work life.

Both paid staff and volunteers should be prepared to encounter such calls since it is impossible to eliminate them, despite continued efforts to implement strategies and maintain boundaries. Empathy, resilience and professional perspective are qualities to be assessed for during the interview and selection process to help ensure that the call taker is equipped to work through these challenges.

View the Crisis Centers Conference slide show, Self-Care: Care for the Caregiver, presented by Agora Crisis Center and CONTACT Crisis Line on the Lifeline's members-only website.

Appendix H: Memorandum of Understanding Sample, Crisis Call Center (Nevada)

MEMORANDUM OF UNDERSTANDING
BETWEEN CRISIS CALL CENTER, Inc. AND West Hills Hospital

This MEMORANDUM OF UNDERSTANDING is hereby made and entered into by and between the WEST HILLS HOSPITAL, hereinafter referred to as COLLABORATING HOSPITAL and the CRISIS CALL CENTER.

A. PURPOSE:

The purpose of this MOU is to continue to develop and expand a framework of cooperation between COLLABORATING HOSPITAL and the CRISIS CALL CENTER to develop mutually beneficial programs for callers/clients that are in need of mental health/substance abuse services and follow-up services after suicidal ideation.

B. CRISIS CALL CENTER SHALL:

Make referrals for no charge assessments and referrals regarding suicidal ideation, mental health and substance abuse. CRISIS CALL CENTER may contact COLLABORATING HOSPITAL with the first name and phone number of the client, with their permission, may arrange a time or advise client to present for assessment. Any client deemed at immediate risk of lethality will be referred to emergency services for transport to an emergency room or COLLABORATING HOSPITAL.

CRISIS CALL CENTER will provide follow-up calls to all clients within seven days of their release from West Hills Hospital where the client presented with suicidal ideation and are agreeable to being contacted. No personal or treatment information will be provided to CRISIS CALL CENTER. An email or facsimile will be sent with first name and phone number only, allowing for follow-up contact after release to confirm safety and ascertain if any further referrals are needed.

C. COLLABORATING HOSPITAL SHALL:

Provide assessments and referrals at no charge to presenting clients referred by the CRISIS CALL CENTER. COLLABORATING HOSPITAL will assure client accesses needed services, either through their facility or a more appropriate treatment setting.

CRISIS CALL CENTER may also contact COLLABORATING HOSPITAL regarding their Compass Mobile Assessment Team for a no cost, on site mental health and /or chemical dependency assessment.

COLLABORATING HOSPITAL will include options on discharge plannng for CRISIS CALL CENTER to provide follow up calls within 7 days of release of discharge for any clients presenting as suicidal on admission. If client signs release
of information, an email or facismile will be provided to the CRISIS CALL CENTER
with first name and phone number only to allow for follow-up contact. No personal or treatment information will be provided to CRISIS CALL CENTER.

Administration: Kathy Jacobs, Executive Director
Authorized Official: Debbie Gant-Reed, Crisis Lines Coordinator
CRISIS CALL CENTER
P.O. Box 8016
Reno, Nevada 89507

1. NON-FUND OBLIGATING DOCUMENT. This agreement is neither a fiscal nor a funds obligation document. Any endeavor or transfer of anything of value involving reimbursement or contribution of funds between the parties to this agreement will be handled in accordance with applicable laws, regulations, and procedures. Such endeavors will be outlined in separate agreements that shall be made in writing by representatives of the parties and shall be independently authorized by appropriate statutory authority. This agreement does not provide such authority. Each party shall be fiscally responsible for their own portion of work performed under the Memorandum of Understanding (MOU).

2. HIPAA COMPLIANCE. The parties agree to abide by all applicable Federal and State laws/regulations addressing patient confidentiality.

The Parties shall be responsible for obtaining consent from each client, prior to the client's participation in the referral process:

3. COMMENCEMENT/EXPIRATION DATE. This agreement is executed as of the date of signature and is effective through 2-11-2013 at which time it will expire unless extended.

4. LIABILITIES. It is understood that neither party to this Memorandum of Understanding is the agent of the other and neither is liable for the wrongful acts or negligence of the other. Each party shall be responsible for its negligent acts or omissions and those of its officers, employees, agents or students (if applicable), howsoever caused, to the extent allowed by their respective state laws.

IN WITNESS WHEREOF, the parties hereto have executed this agreement as of the last written date below.

FOR: WEST HILLS HOSPITAL:_____ Date:
Name and Title: _____

FOR: CRISIS CALL CENTER:_____ Date:
Kathy Jacobs, Executive Director
Crisis Call Center, Inc.

Appendix I: Memorandum of Understanding Sample, Pathways of Central Ohio (Ohio)

ABSTRACT

Pathways of Central Ohio's 2-1-1 Crisis/Hotline Follow Up Project proposes to provide follow up services to callers from the National Suicide Prevention Lifeline and callers to Pathways 2-1-1 Crisis/Hotline who were suicidal at the time of, or shortly before the call. It will also include suicidal adults, ages 18 and older, from Licking and Knox Counties who present at local Emergency Departments and VA Medical Centers.

The new project would expand upon follow up services already in place at the agency. Currently, per AIRS Standards, Pathways follows up with suicidal callers one time within three days after the initial call. The Crisis Response Specialists (CRSs) utilize a set of standard follow up questions. Depending on the response, additional referrals may be suggested or the call is treated as a crisis call again. This grant would also expand collaboration beyond the local public mental health outpatient agency (Moundbuilders Guidance Center) and include local Emergency Departments and VA inpatient and outpatient programs. A dedicated phone line for NSPL calls would also be added.

The overall goals, which support SAMHSA's goals for the project, are to maintain the safety of the callers and to increase the likelihood that they will receive services.

The objectives, over the three-year grant cycle, are increased access to the National Suicide Prevention Lifeline and the 2-1-1 Crisis/Hotline as measured by increases in the market penetration rate in Licking and Knox Counties; increased linkage to local treatment programs as measured by the number of suicidal callers that are seen by the local public mental health agency within one week using the start of the grant as baseline; and, increased awareness of the service in the community with special emphasis on veterans, older white males, GLBT persons and Spanish-speaking residents as measured by the number of calls from these special populations from the start of the grant.

Pathways expects to serve 400 unduplicated individuals with follow up services in Year One. In Year Two, it would increase to 500 and to 600 in Year Three. Over the entire project period, it is anticipated that 1500 unduplicated persons would be served.

Operating Principles: Shared Vision and Goals of the Parties
The overall goals for the project are:

1. To maintain the safety of the callers and
2. To increase the likelihood that they will receive services.

The grant objectives are:

1. Increased access to the National Suicide Prevention Lifeline and the 2-1-1Crisis/Hotline as measured by increases in the market penetration rate in Licking and Knox Counties;

2. Increased linkage to local treatment programs as measured by the number of suicidal callers that are seen by Behavioral Healthcare Partners or the Chalmers P. Wylie Outpatient Clinic (as appropriate) or another agency/facility within one week using the start of the grant as baseline.
3. Increased awareness of the service in the community with special emphasis on veterans, older white males, GLBT persons and Spanish-speaking residents as measured by the number of calls from these special populations from the start of the grant.

The population of focus for this project will consist of all people discharged from LMHED who meet the criteria. The discharged person must:

- Have been assessed as having some level of suicidal risk at discharge from a facility, but at a level that has not justified hospitalization.
- Be at least 18 years of age
- Reside in Licking or Knox County
- Have consented to receive follow up call or calls between the time of the facility discharge and completion of their first (or next) session with a treatment provider

Methods of Cooperation Understandings and Expectations for Cooperation

The SAMHSA project adds a "call out follow up service" as a natural extension of the traditional 211 Crisis Hotline "call in" model. The current standard practice at the 211 Crisis Hotline with all callers, not just those who report suicidal thoughts, can be summarized as follows:

1. Using an active listening approach, engage the caller and determine the client's purpose in calling, providing support, exploring feelings, exploring alternatives and clarification as appropriate.
2. Complete a standardized NSPL risk assessment to assess for suicide risk
3. As appropriate to the circumstances, provide up to three treatment referrals
4. As appropriate to the circumstances, offer or initiate an emergency 911 call, with subsequent follow up to determine if the client was transported by emergency personnel to a hospital emergency room.
5. Inform the caller that they should call back if they need additional assistance.
6. Document the call.

Goals and Objectives:

- To help assure that all suicidal people seen in a facility are connected or reconnected to treatment following their discharge
- To help assure that all suicidal callers are connected or reconnected to treatment
- To reduce the level of risk in those who choose not to be connected to treatment

Functional Elements

Contacts:

Questions, inquiries or comments should be directed to the staff contact person identified for the specific county or program listed below:

Protocols:

The SAMHSA project utilizes the follow up model described below. Staffing will include time from LMHED discharge personnel to obtain and transmit consents, and a designated staff member at LMHED for overall project management and coordination with the 211 Crisis Hotline SAMHSA Project Director for patient follow up.

1. Obtain consent at the time of the facility discharge to receive follow up calls from the 211 Crisis Hotline and transmit an (electronic) copy of the discharge plan to the 211 Crisis Hotline. The information transmitted must include the following elements on the Consent Form:
    a. Name
    b. Phone number
    c. Additional contact
2. 211 Crisis Hotline will initiate a follow up call with the person within 24 hours of discharge
3. 211 Crisis Hotline will develop a safety plan with the person.
4. Follow up calls will be the responsibility of a single designated individual (with appropriate back up coverage) for whom this function becomes their sole responsibility.
5. Place the next scheduled follow up call within 7 days of the initial contact (or sooner depending on need-but no later than)
    a. For clients who have agreed to enter treatment:
        i. Review the safety plan
        ii. Reassess the current level of risk (and as appropriate, initiate 911 emergency service)
        iii. Determine if/when the client has been able to obtain an appointment with a treatment provider
        iv. Provides alternative referrals as necessary
        v. Confirm the intent to place another follow up call within 7 days
        vi. Document the call
    b. For clients who have not agreed to enter into treatment but who have consented to follow up:
        i. Review the safety plan
        ii. Reassess the current level of risk (and as appropriate, initiate 911 emergency services)
        iii. Confirm the intent to place another follow up call within 7 days
        iv. Document the call
    c. For clients who cannot be reached by phone upon follow up:
        i. Make five attempts to establish contact
        ii. Discontinue the follow up after five unsuccessful attempts at contact
        iii. Document the attempts

6. Place the second scheduled follow up call
    a. For clients who have agreed to enter treatment:
        i. Review the safety plan
        ii. Reassess the current level of risk (and as appropriate, initiate 911 emergency service)
        iii. Determine if/when the client has been able to obtain an appointment with a treatment provider. End tracking if client has had the first appointment with the treatment provider
        iv. Provides alternative referrals as necessary
        v. Confirm the intent to place another follow up call within 7 days
        vi. Document the call
    b. For clients who have not agreed to enter into treatment but who have consented to follow up
        i. Review the safety plan
        ii. Reassess the current level of risk (and as appropriate, initiate 911 emergency services)
        iii. Confirm the intent to place another follow up call within 7 days, unless reassessment confirms minimal suicidal risk. End tracking if this is the second assessment of minimal risk.
        iv. Document the call
    c. For clients who cannot be reached by phone upon follow up:
        i. Make five attempts to establish contact
        ii. Discontinue follow up after five unsuccessful attempts at contact
        iii. Document the attempts
7. Subsequent follow up calls
    a. For clients who have agreed to enter treatment: Repeat the sequence under #Sa above until confirmation that the client has entered treatment.
    b. For clients who have not agreed to enter into treatment but who have consented to follow up: Repeat the sequence under #5b above until two successive assessments of minimal suicidal risk.
    c. For clients who cannot be reached by phone upon follow up:
        i. Make five attempts to establish contact.
        ii. Discontinue follow up after five unsuccessful attempts at contact
        iii. Document the attempts

<u>Points of Contact</u>

The points of contacts between the two organizations shall be:

- SAMHSA Project Director: Lisa Davies, 740-345-6166 x314
- LMH-ED: Rhonda Maddern, RN,BS; Dir Case Management: 740-348-4416
- Chalmers P Wylie VA Center: Bernard Williams 614-257-5425
- Chillicothe VA Center: Ben Stark, MSW, LISW-S, 740-773-1141 ext 6704

Training and Communication:
PATHWAYS 2-1-1 and LMHED will communicate program changes, updates, or service changes as needed and when appropriate in order to promote collaboration and effective referrals.

PATHWAYS 2-1-1 and LMHED will explore opportunities for cross-training and joint training to promote collaboration and share information. Referral protocols will be reviewed as needed.

Both parties affirm a mutual goal to work together to support suicide prevention in Licking County for the purpose of improving the effectiveness and efficiency of follow up with suicidal persons and to improve overall service delivery and avoid duplication.

Notwithstanding any other provisions of this MOU, neither party will use the name, logo, trademarks, service marks or other intellectual property of the other party without obtaining prior written consent from the other party for each use, except that it is not necessary to obtain such consent to use the name of the other party in any telephone referrals made pursuant to this MOU.

Term and Review
This MOU shall be in effect as of the date last signed below and shall remain in effect until terminated by either party by providing thirty (30) days written notification to the other party.

Appendix J: Memorandum of Understanding Sample, Network 180 (Michigan)

REFERRAL AGREEMENT BETWEEN:
NETWORK180 AND (Hospital)

The purpose of this agreement is to define understandings between Network180 and (hereinafter referred to as the “Hospital”), regarding hospital referrals for mental health services.

THE HOSPITAL AGREES TO THE FOLLOWING:

1. The Hospital is responsible for providing medical services for members of the community who are in an emergency medical condition.
2. The Hospital shall provide examination and stabilizing treatment before requesting evaluation from Network180.
3. In the event that a patient of the Hospital is medically stable and psychiatrically not at risk, the Hospital and Network180 may elect to transport the patient to the Network180 Access Center for evaluation. The Hospital agrees to assess the transportation options and needs of the patient in order to facilitate an evaluation at the Network180 Access Center. In the event the patient is unable to provide their own transportation it will be provided (paid for) by Network180.

NETWORK180 AGREES TO THE FOLLOWING:

1. In the event that Network180 refers a patient to the Hospital emergency room, the Network180 Access Center agrees to call the emergency room in advance with as much referral information as possible.
2. In the event that Network180 refers a client to the Hospital emergency room, Network180 agrees to provide and pay for transportation, as appropriate, depending on the extent of the medical condition.
3. In the event that the Hospital receives a patient who is demonstrating suicidal ideation, has made a suicide attempt, or is presenting acute symptoms of mental illness and who is Medicaid insured, has no insurance, or is a current client of the Network180 system, Network180 agrees to assist in the evaluation and crisis intervention at the Hospital Emergency Room, regardless of county of residence.
4. Network180 clinicians who respond to Hospital requests will be credentialed by Network180 to evaluate and authorize Network180 funded services.
5. Following Hospital’s medical evaluation, Network180 will make every effort to begin an assessment and provide crisis intervention in a timely manner. The timeliness of response will be influenced by concurrent demands for the available Network180 Access Center clinical capacity; however, every effort will be made to begin assessment within 2 hours. Network180 shall be available to Hospital 24 hours per day, seven days per week. In the event that the Network180 Access Center clinician cannot begin the assessment at the Hospital within 2 hours, the reason for the delay and the time expected will be communicated to the Hospital.

6. The Network180 clinician will document the consultation on the Hospital Patient Family Counseling Progress Note. A copy of this consultation will be given to the medical social worker for the purpose of being scanned into the medical record. A verbal report must be given to the medical social worker prior to the Network180 clinician leaving the Hospital.

CONFIDENTIALITY

Network180 and Hospital agree to maintain the confidentiality of patient records except to provide access as required by law to Accreditation bodies, Utilization Review, and quality assurance staff of both Network180 and Hospital and requirements of the Michigan Mental Health Code.

INDEMNIFICATION

Each party agrees to indemnify, defend, and hold harmless the other, its agents and employees from and against any and all liability or expense, including defense costs and legal fees incurred in connection with claims for damages of any nature, including, but not limited to, bodily injury, death, personal injury, property damage, or other damages arising from the performance of failure to perform its obligations under this agreement unless it is determined that the liability was the direct consequence of negligence of willful misconduct on the part of the other party, its agents or employees.

AGREEMENT REVIEW

This agreement is subject to review and modification at the request of either party. Administrative review will be conducted annually.

“NAME OF HOSPITAL”	NETWORK180
Signature _____	Signature_____
Title_____	Title _____
Date	Date

CRISIS CENTER FOLLOW UP TO SAVE RESOURCES AND SAVE LIVES

Suicide is a national public health crisis, and is the tenth leading cause of death in the United States, with over 38,000 reported lives lost to suicide in the US in 2010. (Centers for Disease Control and Prevention (CDC), 2014). Research indicates that follow-up with hotline callers and people recently discharged from an emergency department (ED) or inpatient setting has positive results for both consumers and providers of mental health services. Follow-up has been shown to be cost effective and prevent suicides and crisis centers are uniquely positioned to be a crucial resource for people in need of follow-up care.

WHAT IS FOLLOW-UP?

Follow-up care can involve home visits, letters, phone calls, emails, or texts that are designed to check in with individuals who have recently experienced a suicide crisis to assess their well-being and level of risk and to support them as they continue their journey towards recovery. Follow-up is usually by telephone and typically occurs between 24 – 48 hours after the initial contact. Phone calls are brief and while they can be tailored to the individuals need, they are structured and focus on continued assessment of risk.

WHY IS FOLLOW-UP IMPORTANT?

Follow-up ensures continuity of care, provides support during a time of heightened risk, and facilitates linkages to outpatient care. It fills the significant gap and acts as a safety net for those at risk of suicide.

- Suicide risk is highest in the first week after discharge from an inpatient setting. This risk is 102 times higher in men and 246 times higher in women than their counterparts in the general population (Qin & Nordentoft, 2005).
- As many as 70% of suicide attempters never attend their first appointment or maintain treatment for more than a few sessions (multiple references).

BENEFITS OF FOLLOW-UP: SAVING LIVES

- Use of 24 hour crisis teams and 7 day follow-up programs show a significant reduction in suicide within 3 months of a patient's discharge from inpatient services (While et al., 2012).
- A study based in five countries indicated that follow up after emergency department discharge significantly reduced suicide. The follow-up program included 9 contacts by trained professionals at crisis centers over a maximum period of 18 months (Fleischmann, 2008).
- Patients who receive follow-up have a lower suicide rate in five years and a significantly lower suicide rate in the first two years after discharge (Motto & Bostrom, 2001).
- Following up with patients by telephone within one month after an emergency department discharge for a suicide attempt significantly reduces the likelihood that the person re-attempts suicide (Vaiva et al., 2006).
- In Australia, a study indicated that proactive telephone support for individuals with recurrent admissions reduced the number of hospital days per patient by 45% and saved $AU895 per person (Andrews & Sunderland, 2009).
- Further, telephonic follow up before a service appointment results in improved motivation, a reduction in barriers to accessing services, and higher attendance rates (Zanjani, Miller, Turiano, Ross, & Oslin, 2008).
- In one year, a crisis center in St. Louis, Missouri reduced psychiatric hospitalization state-wide by 7% by referring some callers to more appropriate mobile outreach services and outpatient facilities based on the callers' needs (National Suicide Prevention Lifeline, 2011).

BENEFITS OF FOLLOW-UP: SAVING RESOURCES

- 45% of incurred costs for suicide attempt admissions are a result of readmissions to the ED (Beautrais & Gibbs, 2004).
- In a study of the return on investment (ROI) of post-discharge follow-up calls for suicidal ideation or deliberate self-harm, Truven Health Analytics estimated what the cost savings could be if an investment was made in crisis centers to place the follow-up calls. Truven estimated the amount of savings by reviewing data from crisis centers' cost of implementing follow-up calls and their potential to reduce hospital readmissions and additional emergency department visits within 30 days of discharge. The conclusion of this ROI analysis was that insurance providers could save money by investing in crisis centers to provide follow-up calls as both a measure to prevent suicidal behavior as well as the subsequent need for additional inpatient or emergency department intervention (Richardson, Mark, McKeon, 2013).

THE USE OF CRISIS HOTLINES IN FOLLOW-UP

Crisis hotlines are uniquely positioned to provide follow up care – crisis hotlines:

- Provide free, 24-hour access to staff trained in suicide assessment and intervention
- Thoroughly assess for risk of suicide, provide support, offer referrals, develop a safety plan, and dispatch emergency intervention, if necessary
- Connect directly with local mobile crisis teams
- Avert unnecessary ED visits and better ensure needed ED visits
- Intervene when a caller is not willing or able to ensure his or her own safety

Crisis centers have been shown to reduce emotional distress and suicidal ideation in callers (Gould, Kalafat, Munfakh, & Kleinman, 2007; Kalafat, Gould, Munfakh, & Kleinman, 2007).

Preliminary findings from an evaluation of crisis center follow-up to suicidal callers found that 80% of participants perceived the follow-up calls as helping at least a little in stopping them from killing themselves, while more than half of interviewed callers said the follow-up intervention helped a lot in stopping them from killing themselves. Callers who received more follow-up calls perceived the follow-up intervention to be more effective. Callers also perceived the intervention as more effective when counselors engaged in the following activities: discussing social contacts/settings as distractors; discussing social contacts to call when needing help; discussing warning signs; and exploring reasons for dying (Gould et al., unpublished).

Many Lifeline centers have a relationship with an ED and/or inpatient facility in their area.

- In Sacramento, California, WellSpace Health partners with Sutter Medical Center to provide follow-up for discharged patients. From 2010-2011, 98 patients consented to follow-up services and 93 were contacted by WellSpace Health. Of these, 90% were connected to referrals, 100% reported reduced distress, and 100% followed a safety plan. Only 2 re-attempts and readmissions were reported.
- In Cleveland, Ohio, FrontLine Service partners with 3 local hospitals. From 2010-2011, 49 patients consented to follow-up services and 46 were contacted by FrontLine Service. Of these, 100% reported lower risk for suicide, 72% followed a safety plan, and 50% linked to services referred by the crisis center. There were no reported attempts or readmissions.
- Thirteen Lifeline centers received SAMHSA funding in 2013 to undertake follow-up those discharged from local EDs and/or inpatient settings.

References:

For full list of references, please contact Naomi Carey at ncarey@mhaofnyc.org

Appendix L: Article "A Model of Mobile Crisis Intervention, Suicide Intervention and Collaboration with Law Enforcement"

by Mark Boschelli, M.S., Laurie Schrader, M.B.A. and Gary Borrell, M.D.[1]

A 911 dispatch to the scene of a behavioral health emergency answered only by the police resulted in the shooting death of a mentally ill patient. Community outcry led to the development of a centralized crisis hotline and mental health mobile teams with a unique rotational system partnered as first responders to the scene with law enforcement to intervene in mental health or substance abuse crises in a multicultural community. This model is designed for municipalities with populations under 100,000 and brings immediate outreach mental health, suicide intervention and substance abuse services to those in need twenty-four hours a day.

On July 3, 1993, police in Santa Fe, New Mexico, responded to a call regarding a naked man who was wielding a knife. Upon arrival at the scene, police encountered Francisco “Pancho” Ortega, an individual well known to police and emergency rescue personnel. Mr. Ortega had a long history of emotional problems and had, on several occasions, injured himself during outbursts of self-destructive rage.

On that evening, Ortega had been drinking. He was waving a steak knife, slashing at his own flesh, and challenging officers to shoot him. When Ortega lurched forward in what was interpreted as a menacing action, two of the officers discharged their weapons, firing seven rounds into Ortega. He was pronounced dead at St. Vincent Hospital, where he had recently signed up for an outpatient mental health program. Included among his possessions at home was an unfilled prescription for anti-depressant medication.

This disturbing event polarized the community, sending forth an outcry for significant changes in the community crisis response system. Public outrage led to community round table discussions, a crisis response task force and a commitment from the city to search for funding to create a new service delivery system. The Crisis Response Task Force recommended a centralized community twenty-four hour crisis hotline be established, that it be answered live by people rather than a messaging service, and that a mobile crisis response alternative using specially trained mental health professionals be used to assist with and augment the response services provided by law enforcement.

Models of Mobile Crisis Services

Since the second wave of de-institutionalization in the mid-1980s, the police have had to become de facto mental health workers. In a January, 1999 survey of police departments in 194 cities with a population of 100,000 or more, 78 police departments reported to have some form of designated program to address individuals suffering from acute psychiatric emergencies (Steadman et al, 1999).

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[1] Boschelli, M., Schrader, L., & Borrell, G. (2003). A model of mobile crisis intervention, suicide intervention, and collaboration with law enforcement. *Rural Mental Health*, 28 (1).

The Crisis Intervention Team (CIT) model designed originally by the Memphis Police Department (1988) was deemed incompatible for the city population of Santa Fe, New Mexico of 70,000, and a modest police force of 139 sworn officers with only eight patrol duty officers working an evening shift. The County of Santa Fe is considered rural and consists of a population of 123,000. The CIT model has been shown to be effective, but is designed for large urban police forces and uses specially trained officers as mental health counselors. The design of the Santa Fe crisis service would be modeled after the Mclean County Center for Human Services in Illinois (Spear and Story, 1983), which is ideally suited for small cities within a rural county. The Mclean County model used four mental health counselors dispatched in a team of two to community mental health crises by a separate hotline staffed by trained volunteers. Emergency crisis mental health protocol elaborated by psychiatrist Joseph Zealberg (Zealberg and Santos, 1996) would be adapted and employed. The Santa Fe crisis services model works to achieve a decrease in psychiatric hospitalizations by providing immediate on-site counseling and assistance. In Cuyahoga County, Ohio, there has been a measurable decrease of psychiatric hospitalizations of consumers served by a mobile crisis team (Johnson, March 2000).

Additional enhancements to the Mclean County original model would include: a separate specialized team specifically serving youth and their families, a core crisis hotline service directly under the administrative and clinical control of the crisis service, and credentialed proficiency in community mental health disaster and grief counseling. This model would provide the police with immediate assistance and expert experienced licensed mental health workers out in the field with the officer. Since the job of the mental health worker would be solely designated to crisis response and crisis counseling, response time would be quick and well focused.

A four-year Robert Wood Johnson Local Initiatives Funding Partners grant was awarded to the City of Santa Fe in October 1996. Services began July of 1997. Presbyterian Medical Services (PMS) a non-profit JCAHO accredited agency was awarded the subcontract to serve as the managing agency for a network of eight local health and human service providers, which would comprise the Crisis Response of Santa Fe (CRSF). This network of agencies covers a broad range of both inpatient and outpatient mental health and substance abuse services for all segments of the population. All the members of this network have a primary mission of serving low income or indigent populations. Many are community-based, nonprofit organizations, which were specifically established to reach underserved people. At least 70% of the people currently being served by CRSF are low income.

The city-sponsored Crisis Response of Santa Fe provides 24-hour crisis hotline and mobile psychiatric interventions in the county of Santa Fe, New Mexico. Located in north central New Mexico, the program serves primarily Hispanics, Caucasians and Native Americans. One administrator, a clinical director, 11 full and part-time licensed counselors, a volunteer coordinator and thirty volunteers operate the program funded through the Robert Wood Johnson grant, Santa Fe County DWI Program, Victim of Crime Act, Bureau of Justice Assistance, and other local grant programs.

The overall objective of Crisis Response of Santa Fe was to develop a community-wide system that would more effectively address the need for a more efficient, compassionate and cost-effective way of treating people who are experiencing a psychiatric or substance abuse crisis. The Crisis Response of Santa Fe has developed a comprehensive crisis intervention strategy that integrates a variety of psychiatric and substance abuse services with follow-up community-based mental health and substance abuse services. Crisis Response of Santa Fe is the designated community-based mobile crisis outreach service and acts as a gatekeeper to the hospital and community system. Crisis Response of Santa Fe has developed and maintained ongoing collaborative relationships with their mobile crisis outreach workers, hospital-based crisis workers and human service agencies to enhance referral networks. The program pays particular attention to populations that have been underserved and provide information to raise awareness of this community-based outreach mobile service.

Prior to the CRSF the widespread and fragmented problems associated with our community crisis response system related specifically to:

- The high prevalence of alcoholism and substance abuse
- Persistent mental health emergencies
- A shortage of affordable alcohol and mental health treatment services
- A high rate of emergency service user recidivism
- Numerous hotlines which led to a confusion of service delivery and inconsistent help for callers
- A domino effect of alcohol related crimes and behavior including assaults, rape, domestic violence, abuse, suicide, and use of weapons and drunk driving

Santa Fe, the capitol city of New Mexico incurs direct costs of more than $6.5 million each year addressing mental health and substance abuse emergencies. One in three of the 7,000 calls to 911 operators in 1995 were alcohol or drug related. Almost 3,500 visits to the St. Vincent Hospital emergency room annually were caused by mental health problems; another 4,600 were ascribed to excessive drinking or drug abuse. The nearby federal Indian Health Service Hospital (IHS) recorded 2,000 ER visits for the same reasons. The cost is $300 for the ambulance ride, if the fire department transports the patient, and an average of $600 for the medical patch-up at St. Vincent, $700 at the IHS.

New Mexico's suicide rate is one of the highest in the nation (Fullerton, Sklar and Olson, 1998). The state of New Mexico with a total population of one and a half million residents ranked second highest nationally for suicide rates. Suicide death rates in New Mexico for all age groups are 50% higher than U.S. national rates. Suicide rates for New Mexico youth aged 15-24 years are 60% higher. Firearms are easily accessible. In New Mexico 64% of the suicides were the result of a gunshot wound. The risk of suicide is increased nearly five times in homes with guns. In 1997, Santa Fe County had the highest county youth suicide rate 55.8 per 100,000 in New Mexico.

Alcohol and illegal drug abuse, especially heroin, are above the national average. In addition, Santa Fe Police make approximately 1,600 drunk-driving arrests yearly. Nearly one-third of the police department's annual budget, in fact, covers the expense - $74 per person per day - of warehousing for their own well-being the 42 people swept up each week in the throes of acute alcohol, drug, or mental health crises. There were only seven detox beds in the entire county in 1996, all at Recovery of Alcoholics Program (RAP), and the waiting list for each could be up to 90 days. No detox beds are available to adolescents. Eight of every ten people who shuttle through Santa Fe's detention center on substance abuse or mental health holds have been there before.

Specific objectives for the program to address were:

- Increase the number of persons receiving crisis assessment and acute crisis stabilization services in non-hospital, non-jail setting
- Increase the number of persons receiving detox and temporary shelter services
- Increase the number of persons receiving outpatient treatment services in the local community
- Increase the number of persons receiving post crisis case management services
- Decrease the number of persons with repeated incidents of public drunkenness
- Decrease the frequency of repeated incidents of acute mental illness crisis
- Increase the number of persons receiving appropriate substance abuse and mental health services while being held in jail for protective custody or mental health holds
- Decrease the number of persons from Santa Fe County who are admitted to the state mental health hospital for stays of less than seven days
- Increase the proportion of costs paid by third party insurance payers
- Increase the number of persons with DWI arrests who receive immediate substance abuse interventions

This program reduces the use of emergency services and works to drive down the cost of acute health care and law enforcement costs by channeling people directly into more appropriate and effective mental health and substance abuse treatment services.

Design of Program

The Crisis Response of Santa Fe program staffed by licensed master level counselors and trained community volunteers provides:

- A single community-wide 24-hour toll-free crisis hotline for confidential telephone counseling and referral to follow-up services.
- A four-member licensed mental health counselor Core Mobile Crisis Team. Two members, Primary Counselor and Secondary Counselor, are dispatched to the scene by the crisis hotline counselor or volunteer to any type of crisis situation, in order to provide on-site counseling and assistance in making assessments and referrals to needed services. Response time to the scene of the community intervention is twenty minutes.

The staffing design consists of the four counselors moving through a nontraditional four- week staff rotation. It is designed to decrease staff burnout for providing the 24-hour services. In week one the counselor answers the hotline 8:00 p.m. to 8:00 am. During week two the counselor is on-call 24 hours a day for 7 days in the role of Secondary Counselor for community face-to-face interventions. In week three the counselor is the Primary Counselor for community face-to-face interventions and is the main decision-maker, and is responsible for summoning the Secondary Counselor for face-to-face assistance. Week four is one week paid off duty.

- A Victim Specialist mental health counselor is one of the four-member Core Mobile Crisis Team. This person provides immediate assistance, counseling and on-going support to victims of all violent crimes.
- A two-member licensed mental health counselor Youth Mobile Crisis Team responds to the extraordinarily high youth suicide rates experienced in Santa Fe County by providing counseling to youth and their families in crisis, as well as participates actively in prevention and education programs.

The staffing schedule is on a two-week rotation. The first week one of the Youth Mobile Crisis Team counselors is in the office answering the hotline 8:00 am to 8:00 p.m., with the other mental health counselor on-call 24 hours a day, available for face-to-face interventions with youth and their families. The second week the counselors switch roles.

- A Jail Diversion Program provides assessments for individuals placed in protective custody or in mental health holds at the Santa Fe County Detention Center and provides case management in order to divert to appropriate health and human service agencies.
- A psychiatrist on 24-hour consultation in order to consult regarding difficult to handle individuals and psychotropic medications.
- CRSF staff teaches a forty-hour crisis hotline training for volunteers, university interns and community members. In addition, CRSF provides six on-going in-service training sessions for all staff, volunteers, interns and community members.
- CRSF provides a state mandated training on special needs populations to law enforcement cadets at the NM State Law Enforcement Academy focusing on identifying and interacting with individuals suffering from mental illness and substance abuse issues.
- Free gunlock program. CRSF has dispensed over 150 gunlocks to families indicating they have an unsecured gun on the premises during a mobile crisis intervention.

Other communities in the nation may have 24-hour crisis hotlines, however, CRSF is unique because CRSF has a mobile crisis intervention component that responds on-site to juvenile and adult crisis situations. In a statistical study of crisis intervention, Dew, et. al. (1987) and King (1977) found that crisis center hotlines were successful in attracting the targeted underserved population. Initially answering calls on the hotline, and then responding to the crisis situation on-site, has shown an increase in linkage to community services. Mental health and substance abuse consumers who were seen by a mobile outreach team were 17 percent more likely than those served by a hospital-based team to receive follow-up services (Johnson, March 2000).

The forty-hour training for volunteers, interns and community members creates a standard of care and consistency on the hotline for individuals calling for counseling and referrals. Several researchers have found that training of staff and volunteers improves the quality of hotline counseling (Bleach and Claiborn, 1982; France, 1975; Gentleer, 1974; Kalaft, Boroto, and France, 1979). The CRSF training provides participants with thirty-six educational credits from the Social Work and Therapy and Counseling boards. This training session is conducted every winter and summer for community volunteers and interns for CRSF. As the program matures the crisis hotline volunteers have been assisting and augmenting the clinical staff phone responsibilities.

CRSF is invited into various community mental health and substance abuse agencies and homeless shelters to de-escalate mental health and substance abuse crisis situations. First responders, such as the police department and the fire department enlist CRSF to assist and augment them in providing on-site delivery of mental health and substance abuse crisis services, thus reducing the burden placed on these services. CRSF initiates follow-up to individuals in crisis ensuring a continuum of service delivery. A recent study (Johnson, March 2000) by the Cuyahoga County Community Mental Health Research Institute (CCCMHRI) has found that adults with severe mental illness are more likely to avoid hospitalization during a psychiatric crisis when they receive services from a mobile outreach team, rather than from an assessment team at a hospital emergency room.

An important design component of this program is the state-of-the-art communications system. This includes cell phones, pagers and laptop computers for all the mobile counselors. The cell phone and pagers are necessary for immediate communication with counselors in the field. Confidential information collected on consumers of the hotline and mobile intervention services is used by the counselors to track consumers' progress and to generate outcome data to evaluate the effectiveness of the program use.

Innovation

Crisis Response of Santa Fe is innovative in responding to individuals with substance abuse problems by assisting people in need of substance abuse detox and treatment to enter a community treatment program. In the past, the police have picked up those in need of detox, transported them to the hospital, and then taken them to the treatment facility. Two officers out of only eight on duty at any given time would be dedicated to transportation and paperwork, which reduced the police availability for law enforcement. Strong relationships existed between the local substance abuse program, the community mental health center and Crisis Response of Santa Fe, all being part of the original eight-member Crisis Response network to develop this community initiated program. The CRSF model of crisis intervention has created better alternatives to the burden placed on the police having to transport individuals in need of substance abuse and mental health treatment. As an alternative to incarceration or hospitalization, a seven-day inpatient detoxification program was contracted

by CRSF. The mobile intervention team facilitated the process for an individual seeking treatment entry into the detox program, assessed the individual, provided a free taxi service to the hospital for medical clearance and a taxi to the treatment center, thus eliminating the need for police intervention.

Another innovation of CRSF was the creation of a medical emergency fund for people who have a doctor's prescription and are in need of medications for detox or psychological problems. This intervention functions as a crisis averting process. This fund is available to those who do not have money or insurance and are in need of immediate medications. Additionally, for those who are in need of assistance from a social service agency, CRSF will provide a free taxi to and from the service. This is an innovative way CRSF fills a gap in the lack of alternatives for transportation in this community.

CRSF provides community disaster debriefings. Two examples are the March 2, 1999, traumatic bus crash resulting in the death of an elementary student and an adult chaperone. The buses contained students from five local Santa Fe public elementary schools. Upon request by the school district and law enforcement, CRSF staffs were present on the scene at the crash site, and conducted more than thirty interventions and debriefings in a two-week period for children, parents, teachers, police, and emergency response personnel. Another example, the Cerro Grande Fire in Los Alamos, a community adjoining to Santa Fe, burned 47,000 acres and over 200 homes. CRSF escorted the residents back to view their destroyed homes, and provided 20 large group community debriefings to this devastated community.

Impact of Program

The outcome data gathered by a centralized computer database system at CRSF consists of crisis line calls, clients seen and the services offered. It is fully developed and utilized by all crisis employees and volunteers. General demographic data, presenting problems, psychological assessment data, and a plan for the future are gathered and entered into the computerized database. Counselors in the field have laptop computers to enter or recall data on clients, which is later downloaded into the database.

Between July 1, 1997, and December 2001, 28,591 hotline crisis calls were received and counselors conducted 2,430 mobile crisis interventions. Since April 1998, with the inception of the Jail Diversion Program, 741 assessments of people in protective custody or mental health hold have been completed at the Santa Fe County Detention Center. During this time period, there were an average of 539 crisis calls and 49 mobile interventions on a monthly basis. Out of the total mobile interventions, 35.5 percent have been with young people under the age of eighteen. Out of the total CRSF crisis calls that were noted for ethnicity, 22 percent have been Hispanic, 50 percent have been Anglo, and 1 percent have been Native American. Out of the CRSF mobile interventions that were noted for ethnicity, 44 percent have been Hispanic, 42 percent have been Anglo, and 6 percent have been Native American (update stats).

Face-to-face crisis intervention appears to increase the rate of successful linkage to community services, thus decreasing crisis recidivism. Within thirty days of a mobile contact CRSF re-engages the client via phone to ascertain continued service reception. CRSF records this rate of follow-up contact. The Core Mobile Crisis Team which focuses on adults, averaged 68% successful linkages recorded for the year 1998, an average of 89% was reported for the year 1999, and 91% for 2000. The Youth Mobile Crisis Team which specializes on the target population under 18 years of age, recorded an average of 68% for 1998, 85% for 1999 and 80% for the year 2000.

Finally, in 1997 the first year of the implementation of CRSF, Santa Fe County had a suicide rate for 15-24 year olds of 55.8 per 100,000 while New Mexico overall had a rate of 22.5 per100,000. In 2000, Santa Fe County's rate fell to 12.5 per 100,000 for 15-24 year olds while the overall state rate remained constant at 23.2 per 100,000. (add reference of Shaening & Associates paper presentation to SF County Health and Human Services Commission of statistics reported by NM Bureau of Vital Records) The average rate for completed suicides of 15-24 year olds from 1998 through 2000 is 9.83 per 100,000.

Conclusion

This model of community crisis hotline and on-site immediate mobile intervention decreases psychiatric hospitalization through immediate linkage and referral to substance abuse and mental health providers. The hotline acts as hub for consumers in need of mental health and substance abuse services to be directly linked through initial intervention and follow-up. CRSF counselors seek immediate placement for consumers, which has shown to reduce mental health and substance abuse recidivism among consumers. The CRSF model provides timely and appropriate suicide interventions, assessments and linkage to services for adults and juveniles in mental health and/or substance abuse crises. The CRSF Youth Mobile Crisis Team has proven to be an innovative and effective model in the delivery of youth oriented mental health and suicide intervention services to a population in need. This relatively low cost replicable program has gained acceptance within the community and is being utilized by youth, local schools, law enforcement, and the community.

The relationship with law enforcement, network and non-network human service providers of Santa Fe County continues to develop and flourish. This allows thorough service coordination and a realization of the task force goals for a coordinated crisis response system overseen by mental health professionals in support of law enforcement. This comprehensive mental health crisis hotline and mobile psychiatric intervention program effectively works with other service providers to make sure there are no gaps in services for people in need of substance abuse and mental health services. CRSF is the only comprehensive program in the county that works to tie together all the human service providers through referrals for treatment and other services, therefore preventing future crisis incidents.

CRSF has effectively targeted the underserved of this community through a wide array of crisis intervention services and linkages to human service providers. The CRSF model has been shown to be an effective design for a small city located within a rural county. This model increases the number of responders to a psychiatric crisis scene in Santa Fe by one quarter, thus enhancing the effectiveness of a small police force to provide immediate and appropriate mental health services. This model eliminates the gap in services, prevalent in the mental health and substance abuse healthcare field to the underserved populations, and effectively increases the response services provided by law enforcement. The overall goal of the program in reducing the cost of mental health and substance abuse issues to the law enforcement and hospital is being achieved and warrants additional study in the future.

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SUSTAINABILITY

Diversify your center's funding streams

NATIONAL SUICIDE PREVENTION LIFELINE

FEES FOR SERVICE

BILL CONSUMER - Standard or sliding scale fees to the consumer for your services

BILL AGENCY - Standard fees for your services based on a contractual agreement

- Market your services to hospitals, inpatient facilities, emergency departments, insurance companies, government agencies (federal, state, local) to bring more resources to your center
- Provide follow-up for recently discharged patients - show that your center fills an important gap in services in inpatient units and EDs
- Provide aftercare services for other mental health providers
- Use research evidence and service models from other communities to make your case

SHARE EXPERTISE - Your center has valuable expertise that other agencies can benefit from

- Provide suicide risk assessment training and consultation

DONATIONS AND GRANTS

INDIVIDUAL GIVING - Financial or in-kind contributions to your center from community members

- Donation drives by phone
- Fundraising events
- Donations through social media
- "10 for 10" fundraisers
- Direct appeals to regular donors
- Suggestions for in-kind donations on your web-site
- Collect donations at community trainings

MAJOR DONORS - Donors who give a larger financial contribution consistently or every year

- Expanding your major donor list by outreach and face-to-face appeals
- Yearly direct appeals to major donors

GIVING CIRCLES - Groups of people pool their money and give to one or two causes every year

Encourage a board member or a member of the community to begin a giving circle that supports your center. Also, find out if giving circles exist in your area at: http://www.givingcircles.org/

PUBLIC CHARITIES - Grant-making organizations that have their own fundraising programs - funded by multiple sources including the public

PRIVATE FOUNDATIONS - Grant-making organizations that are funded by a small group, usually through an endowment or trust from a single family

Outreach to foundations by creating funding briefings and inviting funders to center events. Resources for writing proposals and finding RFPs are available on the Lifeline's members-only site. Also, check out resources available at the Foundation Center: http://foundationcenter.org/

CORPORATE GIVING - Corporations donate some of their profits to non-profit organizations. These can be financial or in-kind donations

Find out about corporate social responsibility and resources at the Foundation Center: http://foundationcenter.org/

GOVERNMENT GRANTS - Financial award given by a government office or department to a grantee

Resources for Federal grants are available on the Lifeline's members-only site. Also, find out and advocate for more mental health resourncs through your State, County or City. Attending public hearings, city council meetings and town halls are good way to advocate for more funding for mental health services.

For more information, contact: Follow-up Coordinator, Manisha Vaze: 212-614-5704, mvaze@mhaofnyc.org

MARKETING YOUR SERVICES TO CREATE MORE SUSTAINABLE FUNDING SOURCES

NATIONAL SUICIDE PREVENTION LIFELINE

Your center's services are valuable – By charging a fee for some of your center's services, you can contribute to your overall budget and continue to diversify your funding streams. Below are examples of fee-for-service models that may be relevant to your agency's practice. Fee-for-service model ideas:*

1. Mobile outreach services can be contracted by the State and/or billed to Medicare/Medicaid (in some states)

2. Psychological assessment services in EDs can be billed to hospitals or inpatient units. These assessments can be billed per assessment.

3. After hours and aftercare services for other mental health providers, State crisis hotlines, substance abuse treatment centers, after hour appointment scheduling, employee assistance and violation reporting programs, University after hours crisis calls, and National Guard after hours crisis calls

4. State contracts to provide utilization management for toll-free telephonic mental health services paid by Medicaid and other insurance

5. Encourage mental health providers and funders to leverage new funds for those who are low-income but ineligible for Medicaid

6. Establish an MOU with EDs to provide follow-up services for recently discharged patients and (if relevant) link them to outpatient services.

7. Work with the County and community mental health agencies to secure funds for those that are frequent users of emergency services. The funds can be used to fund diversion programs and provision of more appropriate mental health services

8. Administer ASIST and Safe TALK trainings for mental health providers, law enforcement, and 911 dispatch

9. Market mental health first aid trainings

10. Using credibility and follow-up program experience to launch statewide advocacy for more funds and to gain access to statewide policy planning meetings.

** These ideas were gathered during the March 2012 monthly conference call. Please contact Lesley Levin, Cheryl Plotz, Pat Morris, Stacie Loegering, Gia Song, Leslie Storm, Sherry Blyth, and Debbie Zwetchkenbaum for more information.*

For general inquiries related to follow-up contact:
Manisha Vaze, Follow-Up Coordinator - mvaze@mhaofnyc.org, 212-614-5704

Appendix O: Annotated Bibliography

Andrews, G. & Sunderland, M. (2009). Telephone case management reduces both distress and psychiatric hospitalization. *Australian and New Zealand Journal of Psychiatry, 43*, 809-811.

Objectives: The aim of the present study was to improve the health care of people repeatedly admitted to private hospitals. Method: An open trial in which frequent utilizers were offered telephone case management over a 12 month period, was conducted. Results: An average of 24 phone calls were made to the 99 who remained in the programme for the 12 months. Psychological distress declined significantly over the 12 months, and the number of days in hospital was reduced compared to the previous year. The cost benefit ratio was 1:8.4. Conclusions: The changes in well-being and hospitalization over the 12 months were substantial and are unlikely to be due to regression to the mean. A prospective randomized controlled trial comparing telephone case management with treatment as usual is indicated.

Appleby, L., Shaw, L., Amos, T., McDonnell, R., Harris, C., McCann, K., . . . Parsons, R. (1999). Suicide within 12 months of contact with mental health services: National clinical survey. *British Medical Journal, 318*, 1235-1239.

Objective: To describe the clinical circumstances in which psychiatric patients commit suicide. Design: National clinical survey. Setting: England and Wales. Subjects: A two year sample of people who had committed suicide, in particular those who had been in contact with mental health services in the 12 months before death. Main outcome measures: Proportion of suicides in people who had had recent contact with mental health services; proportion of suicides in inpatients; proportion of people committing suicide and timing of suicide within three months of hospital discharge; proportion receiving high priority under the care programme approach; proportion who were recently non-compliant and not attending. Results: 10,040 suicides were notified to the study between April 1996 and March 1998, of whom 2,370 (24%; 95% confidence interval 23% to 24%) had had contact with mental health services in the year before death. Data were obtained on 2,177, a response rate of 92%. In general these subjects had broad social and clinical needs. Alcohol and drug misuse were common. 358 (16%; 15% to 18%) were psychiatric inpatients at the time of death, 21% (17% to 25%) of whom were under special observation. Difficulties in observing patients because of ward design and nursing shortages were both reported in around a quarter of inpatient suicides. 519 (24%; 22% to 26%) suicides occurred within three months of hospital discharge, the highest number occurring in the first week after discharge. 914 (43%; 40% to 44%) were in the highest priority category for community care. 488 (26% excluding people whose compliance was unknown; 24% to 28%) were non-compliant with drug treatment while 486 (28%; 26% to 30%) community patients had lost contact with services. Most people who committed suicide were thought to have been at no or low immediate risk at the final service contact. Mental health teams believed suicide could have been prevented in 423 (22%; 20% to 24%) cases. Conclusions: Several suicide prevention measures in mental health services are implied by these findings, including measures to improve compliance and prevent loss of contact with services. Inpatient facilities should remove structural difficulties in observing patients and fixtures that can be used in hanging. Prevention of suicide after discharge may require earlier follow up in the community. Better suicide prevention in psychiatric patients is likely to need measures to improve the safety of mental health services as a whole, rather than specific measures for people known to be at high risk. Key messages: Around a quarter of people who commit suicide have been in contact with mental health services in the

year before death[---]over 1,000 cases annually Of these cases, 16% are psychiatric inpatients and 24% have been discharged from inpatient care in the previous three months. Problems of observation caused by ward design and nursing shortages are common in cases of inpatient suicide. Suicide in former inpatients occurs most commonly in the week after discharge. Non-compliance with treatment and loss of contact with services are common before suicide.

Beautrais, A., & Gibb, S. (2004). Attempted Suicide in Canterbury. C. S. Project. Christchurch, New Zealand: Canterbury Suicide Project, Christchurch School of Medicine & Health Services.

Aims: Non-fatal suicide attempts incur substantial costs in morbidity, subsequent mortality, and service utilisation. This study reviews trends in admissions to Christchurch Hospital for attempted suicide during the 10-year period 1993-2002, inclusive. The influences of age, gender, and method of suicide attempt on time trends were examined. Methods: Participants were a consecutive series of 3,711 individuals admitted to Christchurch Hospital for attempted suicide from 1993 to 2002. The following measures were available: age, gender, method of suicide attempt, and admission date. Logistic regression analysis was used to test trends over time. Results: The number of admissions for attempted suicide increased from 1993 to 2002. Admissions increased for females (but not for males) and for those persons aged over 25. There was an increase in the number of admissions for female youth, but not for male youth or youth overall. Admissions for cutting/stabbing increased, while admissions for overdose/poisoning decreased. Conclusions: Trends observed at Christchurch Hospital for admissions for attempted suicide contrast with New Zealand's death by suicide rate, which has declined slightly over the last decade. Increases in attempted suicide admissions in adults, older adults, and females highlight the need for intervention strategies to be targeted at both males and females of all ages.

Boschelli, M., Schrader, L., & Borrell, G. (2003). A model of mobile crisis intervention, suicide intervention, and collaboration with law enforcement. *Rural Mental Health 28*.

A 911 dispatch to the scene of a behavioral health emergency answered only by the police resulted in the shooting death of a mentally ill patient. Community outcry led to the development of a centralized crisis hotline and mental health mobile teams with a unique rotational system partnered as first responders to the scene with law enforcement to intervene in mental health or substance abuse crises in a multicultural community. This model is designed for municipalities with populatios under 100,000 and brings immediate outreach mental health, suicide intervention and substance abuse services to those in need twenty-four hours a day.

Centers for Disease Control and Prevention (CDC). (2012). Deaths: Preliminary Data for 2010 Retrieved February 29, 2012, from http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf.

Objectives: This report presents preliminary US data on deaths, death rates, life expectancy, leading causes of death, and infant mortality for 2010 by selected characteristics such as age, sex, race, and Hispanic origin. Methods: Data in this report are based on death records comprising more than 98 percent of the demographic and medical files for all deaths in the United States in 2010. The records are weighted to independent control counts for 2010. Comparisons are made with 2009 final data.

Results: The age-adjusted death rate decreased from 749.6 deaths per 100,000 population in 2009 to 746.2 deaths per 100,000 population in 2010. From 2009 to 2010, age-adjusted death rates decreased significantly for 7 of the 15 leading causes of death: Diseases of heart, Malignant neoplasms, Chronic lower respiratory diseases, Cerebrovascular diseases, Accidents (unintentional injuries), Influenza and pneumonia, and Septicemia. Assault (homicide) fell from among the top 15 leading causes of death in 2010, replaced by Pneumonitis due to solids and liquids as the 15th leading cause of death. The age-adjusted death rate increased for 5 leading causes of death: Alzheimer's disease, Nephritis, nephrotic syndrome and nephrosis, Chronic liver disease and cirrhosis, Parkinson's disease, and Pneumonitis due to solids and liquids. Life expectancy increased by 0.1 year from 78.6 in 2009 to 78.7 in 2010.

Crandall, C., Fullerton-Gleason, L., Aguero, R., & LaValley, J. (2006). Subsequent suicide mortality among emergency department patients seen for suicidal behavior. *Academic Emergency Medicine, 13*, 435-442.

Objectives: To determine whether suicide mortality rates for a cohort of patients seen and subsequently discharged from the ED for a suicide-related complaint were higher than for ED comparison groups. Methods: This was a nonconcurrent cohort study set at a university-affiliated urban ED and Level 1 trauma center. All ED patients 10 years and older, with at least one ED visit between February 1994 and November 2004, were eligible. ED visit characteristics defined the cohort exposure. Patients with visits for suicide attempt or ideation, self-harm, or overdose (exposed) were compared with patients without these visits (unexposed). Exposure classification was determined from billing diagnoses, E-codes (E950-E959), and free-text searching of the ED tracking system data for suicide, overdose, and spelling variants. Emergency department patient data were probabilistically linked to state mortality records. The principal outcome was suicide death. Suicide mortality rates were calculated by using person-year (py) analyses. Relative rates (RR) and 95% confidence intervals (95% CIs) were calculated from Cox proportional hazards models. Results: Among the 218,304 patients, the average follow-up was 6.0 years; there were 408 suicide deaths (incidence rate [IR]: 31.2 per 100,000 py). Males (IR: 48.3) had a higher rate than females (IR: 13.5; RR: 3.6; 95% CI = 2.8 to 4.6). A single ED visit for overdose (RR: 5.7; 95% CI = 4.5 to 7.4), suicidal ideation (RR: 6.7; 95% CI = 5.0 to 9.1), or self-harm (RR: 5.8; 95% CI = 5.1 to 10.6) was strongly associated with increased suicide risk, relative to other patients. Conclusions: The suicide rate among these ED patients is higher than population-based estimates. Rates among patients with suicidal ideation, overdose, or self-harm are especially high, supporting policies that mandate psychiatric interventions in all cases.

Fleischmann, A. (2008). Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries. *Bulletin of the World Health Organization, 86*, 703-709. doi: 10.2471/blt.07.046995

Objective: To determine whether brief intervention and contact is effective in reducing subsequent suicide mortality among suicide attempters in low and middle-income countries. Methods: Suicide attempters (n = 1867) identified by medical staff in the emergency units of eight collaborating hospitals in five culturally different sites (Campinas, Brazil; Chennai, India; Colombo, Sri Lanka; Karaj, Islamic Republic of Iran; and Yuncheng, China) participated, from January 2002 to October 2005, in a randomized controlled trial to receive either treatment as usual, or treatment as usual plus brief intervention and contact (BIC), which included patient education and follow-up.

Overall, 91% completed the study. The primary study outcome measurement was death from suicide at 18-month follow-up. Findings: Significantly fewer deaths from suicide occurred in the BIC than in the treatment-as-usual group (0.2% versus 2.2%, respectively; $c^2 = 13.83$, $P < 0.001$). Conclusion: This low-cost brief intervention may be an important part of suicide prevention programmes for underresourced low- and middle-income countries.

Gould, M. S., Kalafat, J., Munfakh, M. L. H., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers*. Suicide and Life Threatening Behavior, 37*, 338-352.

In this study we evaluated the effectiveness of telephone crisis services/hotlines, examining proximal outcomes as measured by changes in callers' suicide state from the beginning to the end of their calls to eight centers in the US and again within 3 weeks of their calls. Between March 2003 and July 2004, 1,085 suicide callers were assessed during their calls and 380 (35.0%) participated in the follow-up assessment. Several key findings emerged. Seriously suicidal individuals reached out to telephone crisis services. Significant decreases in suicidality were found during the course of the telephone session, with continuing decreases in hopelessness and psychological pain in the following weeks. A caller's intent to die at the end of the call was the most potent predictor of subsequent suicidality. The need to heighten outreach strategies and improve referrals is highlighted.

Kalafat, J., Gould, M. K., Munfakh, J. L. H., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 1: Nonsuicidal crisis callers. *Suicide and Life Threatening Behavior, 37*, 322-337.

The effectiveness of telephone crisis services/hotlines, examining proximal outcomes as measured by changes in callers' crisis state from the beginning to the end of their calls to eight centers in the U.S. and intermediate outcomes within 3 weeks of their calls, was evaluated. Between March 2003 and July 2004, 1,617 crisis callers were assessed during their calls and 801 (49.5%) participated in the followup assessment. Significant decreases in callers' crisis states and hopelessness were found during the course of the telephone session, with continuing decreases in crisis states and hopelessness in the following weeks. A majority of callers were provided with referrals and/or plans of actions for their concerns and approximately one third of those provided with mental health referrals had followed up with the referral by the time of the follow-up assessment. While crisis service staff coded these callers as nonsuicidal, at follow-up nearly 12% of them reported having suicidal thoughts either during or since their call to the center. The need to conduct suicide risk assessments with crisis callers and to identify strategies to improve referral follow-up is highlighted.

Knesper, D. J. (2011). Continuity of Care for Suicide Prevention and Research: Suicide Attempts and Suicide Deaths Subsequent to Discharge from the Emergency Department or Psychiatry Inpatient Unit. Newton, MA: American Association of Suicidology & Suicide Prevention Resource Center.

This is a comprehensive report offering recommendations for the ongoing care of patients at risk for suicide who have been treated in emergency departments and hospitals. Based on an encyclopedic review and analysis of existing research, the 150-page report is the first review of continuity of care as a means to prevent suicide. The

report includes ten principles for improved continuity of care, and provides real-world examples of seven integrated systems of care in the U.S. and Europe. Other key recommendations for practice and research address: targeting high-risk individuals; improving education and training for suicide risk assessment; responding to patients who have become disengaged from treatment; coordinating care; and improving infrastructure to provide continuity of care.

Larkin, G. L., Smith, R., & Beautrais, A. (2008). Trends in US emergency department visits for suicide attempts, 1992–2001. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 29*, 73-80.

This article describes trends in suicide attempt visits to emergency departments in the United States (US). Data were obtained from the National Hospital Ambulatory Medical Care Survey using mental-health-related ICD-9-CM, E and V codes, and mental-health reasons for visit. From 1992 to 2001, mental-health-related visits increased 27.5% from 17.1 to 23.6 per 1000 ($p < .001$). Emergency Department (ED) visits for suicide attempt and self injury increased by 47%, from 0.8 to 1.5 visits per 1000 US population (ptrend = .04). Suicide-attempt-related visits increased significantly among males over the decade and among females from 1992/1993 to 1998/1999. Suicide attempt visits increased in non-Hispanic whites, patients under 15 years or those between 50–69 years of age, and the privately insured. Hospitalization rates for suicide attempt-related ED visits declined from 49% to 32% between 1992 and 2001 ($p = .04$). Suicide attempt-related visits increased significantly in urban areas, but in rural areas suicide attempt visits stayed relatively constant, despite significant rural decreases in mental-health related visits overall. Ten-year regional increases in suicide attempt-related visits were significant for the West and Northeast only. US emergency departments have witnessed increasing rates of ED visits for suicide attempts during a decade of significant reciprocal decreases in postattempt hospitalization. Emergency departments are increasingly important sites for identifying, assessing and treating individuals with suicidal behavior.

Motto, J. A., & Bostrom, A. G. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services, 52*, 828-833.

Objective: This study tested the hypothesis that professionals' maintenance of long-term contact with persons who are at risk of suicide can exert a suicide-prevention influence. This influence was hypothesized to result from the development of a feeling of connectedness and to be most pertinent to high-risk individuals who refuse to remain in the health care system. Methods: A total of 3,005 persons hospitalized because of a depressive or suicidal state, populations known to be at risk of subsequent suicide, were contacted 30 days after discharge about follow-up treatment. A total of 843 patients who had refused ongoing care were randomly divided into two groups; persons in one group were contacted by letter at least four times a year for five years. The other group--the control group--received no further contact. A follow-up procedure identified patients who died during the five-year contact period and during the subsequent ten years. Suicide rates in the contact and no-contact groups were compared. Results: Patients in the contact group had a lower suicide rate in all five years of the study. Formal survival analyses revealed a significantly lower rate in the contact group ($p=.04$) for the first two years; differences in the rates gradually diminished, and by year 14 no differences between groups were observed. Conclusions: A systematic program of contact with persons who are at risk of suicide and who refuse to remain in the health care system appears to exert a significant preventive influence for at least two years. Diminution of

the frequency of contact and discontinuation of contact appear to reduce and eventually eliminate this preventive influence.

National Suicide Prevention Lifeline (2011). *Crisis hotlines: A reliable safety net in a challenging budget environment.* Unpublished fact sheet.

Qin, P., & Nordentoft, M. (2005). Suicide risk in relation to psychiatric hospitalization. *Archives of General Psychiatry, 62*, 427-432.

Background: Persons with a history of admission to a psychiatric hospital are at high risk for suicide, but little is known about how this is influenced by factors related to psychiatric hospitalization. Objective: To explore suicide risk according to time since admission, diagnosis, length of hospital treatment, and number of prior hospitalizations. Design: Nested case-control design. Setting: Individual data are drawn from various Danish longitudinal registers. Participants: All 13 681 male and 7488 female suicides committed in Denmark from January 1, 1981, to December 31, 1997, and 423 128 population control subjects matched for sex, age, and calendar time of suicide. Main Outcome Measure Risk of suicide is estimated by conditional logistic regression. Data are adjusted for socioeconomic factors. Results: This study demonstrates that there are 2 sharp peaks of risk for suicide around psychiatric hospitalization, one in the first week after admission and another in the first week after discharge; suicide risk is significantly higher in patients who received less than the median duration of hospital treatment; affective disorders have the strongest impact on suicide risk in terms of its effect size and population attributable risk; and suicide risk associated with affective and schizophrenia spectrum disorders declines quickly after treatment and recovery, while the risk associated with substance abuse disorders declines relatively slower. This study also indicates that an admission history increases suicide risk relatively more in women than in men; and suicide risk is substantial for substance disorders and for multiple admissions in women but not in men. Conclusions: Suicide risk peaks in periods immediately after admission and discharge. The risk is particularly high in persons with affective disorders and in persons with short hospital treatment. These findings should lead to systematic evaluation of suicide risk among inpatients before discharge and corresponding outpatient treatment, and family support should be initiated immediately after the discharge.

Simon, G. E., VonKorff, M., Rutter, C., & Wagner, E. (2000). Randomised trial of monitoring, feedback, and management of care by telephone to improve treatment of depression in primary care. *British Medical Journal, 320*, 550-554.

Objective: To test the effectiveness of two programmes to improve the treatment of acute depression in primary care. Design: Randomised trial. Setting: Primary care clinics in Seattle. Patients: 613 patients starting antidepressant treatment. Intervention: Patients were randomly assigned to continued usual care or one of two interventions: feedback only and feedback plus care management. Feedback only comprised feedback and algorithm based recommendations to doctors on the basis of data from computerised records of pharmacy and visits. Feedback plus care management included systematic follow up by telephone, sophisticated treatment recommendations, and practice support by a care manager. Main outcome measures: Blinded interviews by telephone 3 and 6 months after the initial prescription included a 20 item depression scale from the Hopkins symptom checklist and the structured clinical interview for the current DSM-IV depression module. Visits, antidepressant prescriptions, and overall use of health care

were assessed from computerised records. Results: Compared with usual care, feedback only had no significant effect on treatment received or patient outcomes. Patients receiving feedback plus care management had a higher probability of both receiving at least moderate doses of antidepressants (odds ratio 1.99, 95% confidence interval 1.23 to 3.22) and a 50% improvement in depression scores on the symptom checklist (2.22, 1.31 to 3.75), lower mean depression scores on the symptom checklist at follow up, and a lower probability of major depression at follow up (0.46, 0.24 to 0.86). The incremental cost of feedback plus care management was about $80 (£50) per patient. Conclusions: Monitoring and feedback to doctors yielded no significant benefits for patients in primary care starting antidepressant treatment. A programme of systematic follow up and care management by telephone, however, significantly improved outcomes at modest cost.

Stanley, B., Brown, G. K. (2012). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice, 19*, 256-264.

The usual care for suicidal patients who are seen in the emergency department (ED) and other emergency settings is to assess level of risk and refer to the appropriate level of care. Brief psychosocial interventions such as those administered to promote lower alcohol intake or to reduce domestic violence in the ED are not typically employed for suicidal individuals to reduce their risk. Given that suicidal patients who are seen in the ED do not consistently follow up with recommended outpatient mental health treatment, brief ED interventions to reduce suicide risk may be especially useful. We describe an innovative and brief intervention, the Safety Planning Intervention (SPI), identified as a best practice by the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention (www.sprc.org), which can be administered as a stand-alone intervention. The SPI consists of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis. The basic components of the SPI include (a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts and social settings as a means of distraction from suicidal thoughts; (d) utilizing family members or friends to help resolve the crisis; (e) contacting mental health professionals or agencies; and (f) restricting access to lethal means. A detailed description of SPI is described and a case example is provided to illustrate how the SPI may be implemented.

Substance Abuse and Mental Health Services Administration (2009). *Results from the 2008 National Survey on Drug Use and Health: National findings.* (NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockland, MD.

This report presents the first information from the 2008 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States aged 12 years old or older. The survey interviews approximately 67,500 persons each year. Unless otherwise noted, all comparisons in this report described using terms such as "increased," "decreased," or "more than" are statistically significant at the .05 level.

Vaiva, G., Ducrocq, F., Meyer, P., Mathieu, D., Philippe, A., Libersa, C., & Goudemand, M. (2006). Effect of telephone contact on further suicide attempts in patients discharged

from an emergency department: Randomised controlled study. *British Medical Journal, 332,* 1241-1245.

Objective: To determine the effects over one year of contacting patients by telephone one month or three months after being discharged from an emergency department for deliberate self poisoning compared with usual treatment. Design Multicentre, randomised controlled trial. Setting: 13 emergency departments in the north of France. Participants 605 people discharged from an emergency department after attempted suicide by deliberate self poisoning. Intervention: The intervention consisted of contacting patients by telephone at one month or three months after discharge from an emergency department for attempted suicide to evaluate the success of recommended treatment or to adjust treatment. Control patients received treatment as usual, in most cases referral back to their general practitioner. Main outcome measures: The primary outcome measures were proportion of participants who reattempted suicide, number of deaths by suicide, and losses to follow-up at 13 months' follow-up. Secondary outcome measures were types and number of contacts with health care. Results: On an intention to treat basis, the three groups did not differ significantly for further suicide attempts, deaths by suicide, or losses to follow-up: contact at one month (intervention 23% (34/147) v controls 30% (93/312), difference %, 95% confidence interval − 2% to 15%), three months (25% 36/146) v 30%, difference 5%, − 4% to 14%). Participants contacted at one month were less likely at follow-up to report having reattempted suicide (12% v 22% in control group, difference 10%, 2% to 18%). Conclusion: Contacting people by telephone one month after being discharged from an emergency department for deliberate self poisoning may help reduce the number of reattempted suicides over one year.

While, D., Bickley, H., Roscoe, A., Windfur, K., Rahman, S., Shaw, J., . . . Kapur, N. (2012). Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and-after observational study. *The Lancet, Early Online Publication,* 1-8.

Background: Research investigating which aspects of mental health service provision are most effective in prevention of suicide is scarce. We aimed to examine the uptake of key mental health service recommendations over time and to investigate the association between their implementation and suicide rates. Methods: We did a descriptive, cross-sectional, and before-and-after analysis of national suicide data in England and Wales. We collected data for individuals who died by suicide between 1997 and 2006 who were in contact with mental health services in the 12 months before death. Data were obtained as part of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. When denominator data were missing, we used information from the Mental Health Minimum Data Set. We compared suicide rates for services implementing most of the recommendations with those implementing fewer recommendations and examined rates before and after implementation. We stratified results for level of socioeconomic deprivation and size of service provider. Findings: The average number of recommendations implemented increased from 0·3 per service in 1998 to 7·2 in 2006. Implementation of recommendations was associated with lower suicide rates in both cross-sectional and before-and-after analyses. The provision of 24 hour crisis care was associated with the biggest fall in suicide rates: from 11·44 per 10 000 patient contacts per year (95% CI 11·12—11·77) before to 9·32 (8·99—9·67) after ($p<0·0001$). Local policies on patients with dual diagnosis (10·55; 10·23—10·89 before vs 9·61; 9·18—10·05 after, $p=0·0007$) and multidisciplinary review after suicide (11·59;

11·31—11·88 before vs 10·48; 10·13—10·84 after, p<0·0001) were also associated with falling rates. Services that did not implement recommendations had little reduction in suicide. The biggest falls in suicide seemed to be in services with the most deprived catchment areas (incidence rate ratio 0·90; 95% CI 0·88—0·92) and the most patients (0·86; 0·84—0·88). Interpretation: Our findings suggest that aspects of provision of mental health services can affect suicide rates in clinical populations. Investigation of the relation between new initiatives and suicide could help to inform future suicide prevention efforts and improve safety for patients receiving mental health care.

Zanjani, F., Miller, B., Turiano, N., Ross, J., & Oslin, D. (2008). Effectiveness of telephone-based referral care management: A brief intervention to improve psychiatric treatment engagement. *Psychiatric Services, 59*, 776-781.

Objective: This study examined the effectiveness of a telephone-based referral care management (TBR-CM) intervention for improving engagement in psychiatric treatment. Methods: From September 2005 to May 2006, 169 primary care patients at the Philadelphia Veterans Affairs Medical Center completed a psychiatric diagnostic interview and were identified as needing psychiatric care. From this total of eligible patients, 113 (67%) gave informed consent and were randomly assigned to receive either usual care or the intervention. Usual care consisted of participants' being schedule for a behavioral health care appointment, followed by a letter and reminder by telephone. The intervention group received the same, plus one or two brief motivational telephone sessions. Participant interviews and medical records provided study data. Results: Research participants were primarily African American and 22-83 years old. In the sample, 40 patients (39%) had severe depression, 40 (39%) had substance use problems, and 33 (22%) had co-occurring severe depression and substance abuse. Overall, 40 participants (70%) in the intervention group compared with 18 (32%) in the usual care group engaged in at least one psychiatric treatment appointment (p<.001). Analyses also indicated that on average the intervention group attended more appointments (more than three) compared with the usual care group (less than two) (p=.008). Conclusions: The TBR-CM intervention program was effective at improving psychiatric treatment engagement. Future research is necessary to examine effectiveness of TBR-CM in more heterogeneous and larger samples and to evaluate economic benefits versus costs of intervention delivery.