

ESTABLISHED STANDARDS FOR THE ASSESSMENT OF SUICIDE RISK AMONG CALLERS TO THE NATIONAL SUICIDE PREVENTION LIFELINE

A Background Paper

**Thomas Joiner, Ph.D., John Kalafat, Ph.D., John Draper, Ph.D., Heather Stokes, LCSW,
Marshall Knudson, Ph.D., Lanny Berman, Ph.D., and Richard McKeon, Ph.D**

Introduction and Overview

As a primary component of the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Suicide Prevention Initiative, SAMHSA's Center for Mental Health Services oversees a three-year, \$6.6 million federal grant to establish and maintain a national network of certified suicide prevention hotlines. This grant, issued beginning September 30, 2004, has been awarded to Link2Health Solutions, Inc., an independent subsidiary of the Mental Health Association of New York City, along with its partners, the National Association of State Mental Health Program Directors, Columbia University's Research Foundation for Mental Hygiene, Inc., and the Rutgers Graduate School of Applied and Professional Psychology.

On January 1, 2005, SAMHSA and the grant's administrator launched The National Suicide Prevention Lifeline, 1-800-273-TALK. The Lifeline is a network of more than 120 crisis centers located in communities across the country that are committed to suicide prevention. Persons in emotional distress or in suicidal crisis can call this single toll-free number at anytime from anywhere in the nation and are routed to the networked crisis center nearest to them. Callers are then connected with a trained telephone worker who can provide emotional support, assessment, crisis intervention and/or linkages to local treatment and support resources, including emergency services.

Two major goals of the Lifeline are to promote efficient access to this service so it will reach more people nationwide at risk of suicide, and to ensure better quality of services to its callers so as to more effectively prevent suicide. Towards the latter goal of serving callers more effectively, in March 2005 the Lifeline established a subcommittee of suicide prevention experts (the Lifeline's Certification and Training Subcommittee) representing various regions nationwide and Canada to consult on developing standards and recommended practices for its network of crisis centers.

The Lifeline's Certification and Training Subcommittee's (CTS) extensive review of research and field practices yielded recommendations that are embodied in the Lifeline's Suicide Risk Assessment Standards, which will be phased in for implementation beginning January 2007 with the expectation of network-wide adherence by September 2007.

The purpose of this paper is to:

- provide the background on the need for these standards;
- describe the process that produced them;
- summarize the research and rationale supporting these standards;
- review how these standard assessment principles and their subcomponents can be weighted in relation to one another so as to more effectively guide crisis hotline workers in their everyday assessments of callers to the Lifeline; and
- discuss the implementation process and technical support that will be provided by the Lifeline Certification and Training Division.

The Need for Evidence-Based Risk Assessment Standards

Because of their unique accessibility, crisis hotlines are in a position to intervene with individuals at various points along the pathway to suicidal behavior, including the moments or hours prior to fateful decisions. This special contribution to suicide prevention is undermined if staff members are unable, unwilling, or reluctant to persistently inquire about and explore suicidal thoughts and feelings with callers.

Recently completed SAMHSA-sponsored evaluations of crisis hotlines' processes and outcomes employed monitoring of hotlines and follow-up of callers to hotlines. These studies provided overall evidence in support of crisis hotlines' role of responding to crisis and suicidal callers, while raising some concerns about suicide risk assessments.

In the SAMHSA study conducted by Kalafat, Gould, & Munfakh (in press), 1085 suicidal and 1617 non-suicidal crisis callers to eight crisis hotlines that agreed to use standardized, evidence-based suicide risk assessments and measures of crisis states were assessed near the start and at the end of their calls; and, for those who consented, at a follow up call approximately 3 weeks after the original call to the center. Significant reductions in crisis and suicide status occurred during the calls and continued to the follow up. Notably, in response to an open-ended question as to what was helpful about the call, 11.6% (n = 44) of suicidal callers said that the call prevented them from killing or harming themselves.

Follow-up assessments were conducted with 801 of the 1617 callers who had been categorized by centers as non-suicidal crisis callers. At follow-up 52 (6.5%) reported having suicidal thoughts when they had originally called the centers, and 27 of these callers said they had told the crisis worker of these thoughts. These callers were more distressed than callers who did not report suicidal thoughts. Crisis centers had not conducted risk assessments for these callers. This study highlighted the need to inquire about suicide on crisis calls, particularly with more distressed callers.

In a second SAMHSA study conducted by Mishara and colleagues (in press), 1431 calls to 14 centers were monitored. Overall, when changes occurred from the beginning to the end of the calls, they were positive. This report concluded that the centers had helped a significant number of callers and may have saved some lives. For example, at the end of the calls, 52.3% of callers were less confused and more decided about next steps, 48.7% were less helpless and more resourceful, and 40% were more hopeful.

Of the 1431 callers, 723 were not asked about suicidal thoughts. Of the 474 who were asked or spontaneously reported suicidal thoughts, no questions about the means were asked on 46% of the calls. Of the 159 calls in which the helper was aware that the caller was considering suicide and had determined what means to use, only during 30 calls did the helper ask if an attempt was in progress. Questions about prior attempts were asked of only 104 callers. The report qualified these risk assessments as following neither the accreditation guidelines of the American Association of Suicidology nor the procedures mandated by center directors.

It should be noted that failure to conduct appropriate suicide risk assessments or to pursue clients' suicidal communications is not unique to crisis hotline staff, as this has also been found among professional mental health providers (Bongar, Maris, Berman, & Litman, 1998; Coombs, et al., 1992); and, among primary care physicians (Adamek, & Kaplan, 2000; Williams et al., 1999). Nevertheless, this finding for organizations, many of which include suicide intervention as a primary part of their mission, prompted the CTS to make the development of standards for evidence-based risk assessment their first priority.

Again, primarily due to their accessibility, crisis hotlines are one of the agencies that must engage in the assessment of imminent risk. As telephone services, crisis hotlines face unique challenges in conducting suicide risk assessments and intervening with suicidal persons. Crisis workers must establish and maintain rapport with callers with whom there is less control than in face-to-face situations, who may be using a phone service primarily because they wish to retain this control, and/or may be reluctant to commit to face-to-face contact or ongoing treatment. They may also be using a phone service because they are currently in an acute state.

The challenge, then, is to conduct a systematic and thorough risk assessment within the connection and flow of a telephone call. To accomplish this, crisis staff must be thoroughly familiar with the current risk and protective factors for suicide and be comfortable enough with the topic to weave the risk assessment into the ongoing flow of the call. Most importantly, crisis staff must be assured that the persistent pursuit of suicidal thoughts, feelings, and plans, as well as alternatives and inhibitors, is the most effective way to reduce callers' isolation, anxiety, and despair, and to begin the exploration of alternative ways of addressing their problems.

National Suicide Prevention Lifeline Response to the Need: The Process of Developing Suicide Risk Assessment Standards

Establishing Expert Consensus on Standards

In order to meet the goals of reaching more people nationwide at risk of suicide and serving them more effectively, the Lifeline has engaged national and international experts and stakeholders in suicide prevention who provide ongoing consultation and advisement to the project's Executive Leadership Team (ELT). The ELT consists of Lifeline's Administration at Link2Health Solutions, Lifeline's SAMHSA Project Officer, and the project's partners, the National Association of State Mental Health Program Directors and the project's evaluation team, Rutgers Graduate School of Applied and Professional Psychology and the Columbia University Research Foundation for Mental Hygiene, Inc. In addition, the Lifeline has formed a Steering Committee, a Certification and Training Subcommittee (CTS), and a Consumer-Recipient Subcommittee. These committees, also comprised of experts and stakeholders in suicide prevention from around the country, meet at least three times a year to discuss and provide recommendations for priorities and focal activities of the Lifeline Administration. For a complete listing and brief biographies of the Lifeline's Committee members, see Appendix 2 of this document.

The Lifeline created the CTS to help promote quality improvement practices among the network's crisis centers. This was to be accomplished through satisfying the following objectives: 1) identifying appropriate credentialing organizations for certifying reliable administration of a center in accordance with network needs; 2) establishing research-based standards for crisis center work with callers; and 3) analyzing, recommending and consulting in the development of best practice trainings and program evaluation tools to support the maintenance of the network's practice standards. The CTS reports to and seeks advisement from the Project's Steering Committee, which, together guide the ELT's final reviews and approval of their recommendations.

The CTS was established by the Lifeline's ELT in March of 2005 following a review of qualified nominees submitted by stakeholders in suicide prevention across the country. The CTS is comprised of experts in the field of suicide prevention research, training, crisis center evaluation and administration. In order to better ensure the application of crisis center research findings to field practices, the ELT also appointed to the CTS the primary investigators of two recently completed, groundbreaking studies examining process and outcomes related to crisis center work, Brian Mishara, Ph.D., John Kalafat, Ph.D., and Madelyn Gould, Ph.D., M.P.H.

At the first CTS meeting in May 2005, committee members concluded that the establishment of suicide risk assessment standards should be their first priority in enhancing quality service to all Lifeline callers. They based this decision upon several factors, including the research findings from the Mishara et al. (in press) and Kalafat, Gould & Munfakh (in press) studies indicating a need for more consistent, thorough assessment of caller risk by telephone crisis workers. In addition, the absence of evidenced-based suicide risk assessment standards for crisis centers further underscored the need to address this issue immediately. From this discussion, the CTS identified two goals relating to the Lifeline's suicide risk assessment standards initiative: 1) to identify the risk and protective factors most salient to assessing suicide risk via telephone; and 2) to work collaboratively with centers to develop and deliver a pilot training on conducting risk assessments that can be adapted to and incorporated into crisis centers' current training programs.

The process of arriving at the suicide risk assessment standards took place over one year. Initially, the group determined that the nature of crisis call center work required a distinction for assessing immediate (as opposed to long-term) risk factors. The group then examined the results of a factor analysis conducted by Gould on the suicide risk assessment instrument used in the Kalafat & Gould outcome study on crisis centers and compared that with a similar analysis by the Lifeline's Draper and Kessler of a research-based suicide risk assessment used by LifeNet, a Lifeline crisis center in New York City. Other sample suicide assessments currently being used by network crisis centers were reviewed by the CTS to survey common field practices. The findings from these analyses were then cross-checked with several studies isolating significant, imminent factors in suicide risk assessment not specific to crisis center work. The results of both the factor analysis and reviews supported the designated four core principles for the Lifeline's standards for suicide assessment: Suicidal Desire; Suicidal Intent; Suicidal Capability; and Buffers/Social Connectedness.

Crisis Center Input

Representation from network crisis center leadership was present at every level of the standards development and review process. Network crisis center directors were represented on the CTS where the standards were developed (2 current center directors, 4 past directors) and the Steering Committee (4 current directors) where the standards were reviewed and approved.

After extensive revisions based on CTS member discussions and feedback from the Steering Committee and ELT, the CTS introduced the suicide risk assessment standards to over 40 crisis center directors across the country at the American Association of Suicidology (AAS) Conference in May 2006. During an interactive workshop conducted by John Kalafat, Ph.D and Shawn Shea, M.D., the crisis center directors and supervisors present expressed appreciation for the opportunity to engage in dialogue about the impending standards prior to their implementation. As a result of the workshop, Eduardo Vega, the Chair of Lifeline's Consumer Recipient Subcommittee, also provided essential feedback that enhanced emphasis on assessment of "protective factors" ("reasons for living"), the fourth core principle of the standards.

The Lifeline then hosted a conference call in June 2006 with the Lifeline network crisis center directors where the standards were presented and discussed. Many of the directors reinforced the standards by stating that their current suicide risk assessment closely reflects the core principles and subcomponents. The one principle that seemed to be omitted in many suicide assessments currently used by crisis centers was suicidal intent. However, consensus was reached regarding the importance and necessity of having suicidal intent assessed among crisis and suicidal callers. In addition, since the presentation of the standards at the AAS Conference,

several of the training directors reported that they had since incorporated suicidal intent into their suicide risk assessment and training.

Empirical Basis for the Standards

Empirical research and clinical experience suggest that suicidality is a multi-faceted phenomenon. Research to date indicates that three facets – suicidal desire, suicidal capability, and suicidal intent – cover the domain of the phenomenon (and importantly, are not redundant with one another). We believe a fourth facet – *buffers against suicidality* – also needs to be included to provide a full framework for suicide assessment in the context of crisis center hotline work. In what follows, the four facets are described, some research on each is summarized, and the interaction among facets is discussed.

Suicidal Desire

In studies by Beck, Joiner, Rudd, and colleagues (e.g., Beck et al., 1997; Joiner et al., 1997, 2003), suicidal desire has been shown to be made up of the following components: no reasons for living; wish to die; wish not to carry on; passive attempt (e.g., not caring if death occurred); and desire for suicide attempt. Influenced by several other strands of research (e.g., Rudd et al., 2006; Joiner [2005] on burdensomeness; Williams [2006] on feeling trapped), the CTS has emphasized psychological conditions that, while not the same as suicidal desire, are strong contributors to it – namely, feeling trapped, like there is no alternative course of action or escape, feeling hopeless and/or helpless, and feeling intolerably alone. Regarding feeling intolerably alone, theorizing and research on the need to belong is relevant (Baumeister & Leary, 1995). A fully satisfied need to belong includes interactions with others *and* a feeling of being cared about. It is this latter component – *not* feeling cared about – that seems to produce intolerable feelings of loneliness.

Additionally, a body of research demonstrates that psychological pain is a separate but critical factor indicating suicidal desire (Shneidman, 1998). Psychological pain, also described by Shneidman (1998) as "psychache," is commonly associated with feelings of worthlessness, intense shame, and loss/bereavement. Of the factors identified by the CTS as indicators of suicidal desire, two in particular (i.e., perceived burdensomeness and feeling trapped) may be unfamiliar in risk assessment contexts.

Joiner's (2005) theory of suicidal behavior asserts that *perceived burdensomeness* is a key component of the life-and-death psychological processes of people seriously contemplating suicide. Suicidal people perceive themselves to be ineffective or incompetent; moreover, they perceive that their ineffectiveness affects not only themselves but spills over to negatively affect others. Additionally, they perceive that this ineffectiveness that negatively affects everyone is stable and permanent, forcing a choice between continued perceptions of burdening others and escalating feelings of shame, on the one hand, and death on the other.

According to the current framework, a caller who voices some desire for death and exhibits psychological pain or expresses feeling trapped can be said to be experiencing suicidal desire. Regarding feeling trapped, several prominent models of the development of suicidal behavior emphasize that suicidal people wish to escape psychological pain, and that their state of extreme distress diminishes their ability to think of adaptive ways to do so. The combination of desperately wishing to escape and being unable to think of ways to do so leads some people to consider suicide as an escape. A roughly synonymous concept to feeling trapped is "cognitive constriction" – emotional crises tend to constrict people's ability to solve problems, leading in turn to a sense of desperation, feeling trapped and suicidal behavior as an escape.

A key point about suicidal desire is that, although it is of clinical import, it is not, by itself, very telling about suicide risk status. This is because suicidal desire is a very common symptom of mood disorders (Joiner et al., 1997), and indeed a relatively common experience in the general

population (Kessler et al., 2005). Regarding suicide risk status, suicidal desire is roughly as indicative as are the other prominent symptoms of depression like anhedonia (inability to experience pleasure in previously enjoyed activities) and insomnia, for instance. These symptoms are of concern (and should prompt referrals for treatment), but their endorsement alone is not enough to raise serious concern about imminent suicide risk. Rather, it is when suicidal desire occurs in combination with other facets of suicidality, described below, that concern escalates. The presence of suicidal desire alerts one to explore and elicit suicidal capability and suicidal intent.

Suicidal Capability

The same series of studies that elucidated the nature of suicidal desire also characterized the components of suicidal capability. They are: a sense of fearlessness to make an attempt, a sense of competence to make an attempt, availability of means to and opportunity for an attempt, specificity of plan for an attempt, and preparations for an attempt.

It is important to note that the “suicidal capability” factor, as defined above, relates to imminent plans and fearlessness about suicidality. Fearlessness about suicidality is a key but under-recognized concept. Serious suicidal behavior is by definition fearsome and is often painful; many clinical case and research studies show that it is this fearsomeness that prevents many people from acting on suicidal ideas. Those that do act have come to terms with the prospects of fear, and often pain. This point does not relate (at least not as directly) to fearlessness in general, as there are many people who are fearless but who, as a function of their fearlessness, are not necessarily at risk for death by suicide (e.g., fighter pilots; NASCAR drivers).

The CTS, again influenced by past work (e.g., Rudd et al., 2006; Joiner, 2005), has identified the following factors as at least contributing to, and in some cases defining, suicidal capability:

- *History of suicide attempt, particularly multiple attempts* (Rudd et al., 1996). This factor indicates a clear risk for future suicidality due, in part, to the fact that past behavior is a strong predictor of future behavior. Relatedly, research indicates that for those who resort to suicidality in the face of distress, especially repeatedly, suicidality may have become a primary way of coping, to the exclusion of more adaptive coping methods.
- *History of/current violence to others* (Conner et al., 2003). This factor’s relevance resides in the fact that those who are capable of violence or injury in general are capable of self-injury in particular.
- *Exposure to/impacted by someone else’s death by suicide*. Some research has suggested that the impact of suicide on those left behind is associated with future suicidal behavior and increased frequency of mental health issues (Agerbo, 2003).
- *Availability of means*. Seeking access to means of suicide is a clear warning sign; past research has shown that it is part of a cluster of symptoms reflecting dangerous parameters like capability and intent (Joiner et al., 1997, 2003).
- *Current intoxication* (Bartels et al., 2002). Current intoxication diminishes problem-solving abilities and reduces inhibitions; lowered problem-solving and lowered inhibitions, in turn, contribute to elevated risk for suicidal behavior.
- *Tendency toward frequent intoxication* (Bartels et al., 2002). The tendency toward frequent intoxication makes intoxication in the near future more likely, with attendant risks of decreased problem-solving and lowered inhibitions noted above.
- *Acute symptoms of mental illness* (Cavanagh et al., 2002). The experience of severe and acute symptoms of the vast majority of mental disorders contributes to many risk factors noted herein; for example, psychological pain, agitation, insomnia, being out of touch with reality, etc.

- *Recent dramatic mood change* (Cavanagh et al., 2002). A dramatic mood change can be indicative of the onset or worsening of a mood disorder or other disorders – disorders which in turn heighten the risk for suicidal behavior.
- *Out of touch with reality* (Cavanagh et al., 2002). Problem-solving ability and inhibitions are both lowered by psychosis; command hallucinations (e.g., hearing a voice telling one to injure or kill oneself) are a related concern.
- *Extreme rage* (Conner et al., 2003). Rage indicates loss of control and potential for violence, both of which are common precursors to serious suicidal behavior.
- *Increased agitation* (Busch et al., 2003). Increased agitation (extreme physical restlessness combined with emotional turmoil) suggests intense psychological pain, which, as noted above, constitutes an important risk factor for serious suicidality.
- *Decreased sleep* (Sabo et al., 1990). Insomnia can lead to mood changes and lack of clarity in thinking and is a key symptom of mood disorders. Research has documented insomnia as a key risk factor for suicidality.

Past research has made it clear that the suicidal desire and suicidal capability factors are not similarly related to key suicide-related indices. For instance, Joiner et al. (1997, 2001) showed that, although the presence of either factor is of clinical concern, the “suicidal capability” factor is, relatively speaking, of more concern than the “suicidal desire” factor – the “suicidal capability” factor was more related than the “suicidal desire” to pernicious suicide indicators such as having recently attempted suicide as well as eventual death by suicide.

Suicidal Intent

Some past research has viewed suicidal intent as part of suicidal desire or suicidal capability, but the CTS has separated it out for two key reasons. First, even more than desire and capability, its relation to suicidality is plain – those who intend a behavior often enact it. In the previously noted SAMHSA hotline evaluation by Kalafat, Gould & Munfakh (in press), during the weeks following the suicidal callers’ original calls to crisis lines, callers’ hopelessness and psychological pain continued to lessen but the intensity of their intent to die did not continue to diminish. Moreover, a substantial proportion of the callers (43.2%) continued to express suicidal ideation a few weeks after the initial call and nearly three percent had made a suicide attempt after their call. The callers’ intent to die score at the end of the crisis intervention was the only significant independent predictor of suicidality following the call, although having made any specific plan to hurt or kill oneself prior to the call and persistent suicidal thoughts at baseline were also significant, albeit not independent, predictors of any suicidality (ideation, plan or attempt).

Second, neither desire nor capability necessarily imply intent, as evidenced by those who have desire and capability but do not intend and thus do not attempt or die by suicide because they are buffered by the factors addressed in the next section (e.g., ties to family and friends).

According to the current framework, suicidal intent is made up of the following:

- *Plan or attempt in progress*. This factor is of course the clearest indicator of intent to attempt, in that the attempt is already in progress.
- *Imminent plan to hurt self/other (e.g., method known)*. Virtually all risk assessment frameworks emphasize plans for suicide as a key danger sign (e.g., Joiner et al., 1999), a practice affirmed by research demonstrating that plans for suicide represent among the most dangerous aspects of suicidality (Joiner et al., 1997, 2001). Plans to hurt others are relevant too, in light of the research on violence and aggression noted above.
- *Preparatory behaviors*. These behaviors (e.g., arranging suicide method, leaving possessions to others) are noteworthy for the same reasons that imminent plans are. They can be viewed as behavioral expressions of imminent plans.

- *Expressed intent to die.* It is common for suicidal behaviors to be accompanied by relatively low intent to die or ambivalence about death. When intent to die is high, the protective aspects of ambivalence about death are removed. Intent to die is a strong predictor of lethality of attempt (Brown et al., 2002).

Suicidal intent deserves considerable weight in a suicide risk assessment, but it should be recognized that some studies have documented a low association between intent and lethality of method (e.g., Eaton & Reynolds, 1985). We believe our framework partly explains this – the relationship of intent to lethality is qualified by factors like buffers (described below) and capability.

Buffers against Suicidality

In even the most suicidal person, there is likely some will to live. This is demonstrated by numerous instances of extremely suicidal individuals who have survived highly lethal attempts and have reported back on their states of mind. For instance, a *New Yorker* article in 2003 quoted a man who had jumped off the Golden Gate Bridge and survived as saying: “I instantly realized that everything in my life that I’d thought was unfixable was totally fixable – except for having just jumped.” A man who jumped into the water leading up to Niagara Falls in 2003 described changing his mind the instant he hit the water. “At that point,” he said, “I wished I had not done it. But I guess I knew it was way too late for that.” He survived the plunge over the falls and now feels a new lease on life. Harry Stack Sullivan (1953, pp. 48-49) described people who had ingested bichloride of mercury: “One is horribly ill. If one survives the first days of hellish agony, there comes a period of relative convalescence – during which all of the patients I have seen were most repentant and strongly desirous of living.” Unfortunately for these patients, another phase of several days of agony then resumes, usually ending in death. The will to live is powerful enough that it returns even in people who have suppressed it enough to imbibe bichloride of mercury, to jump off the Golden Gate Bridge, or to go over Niagara Falls.

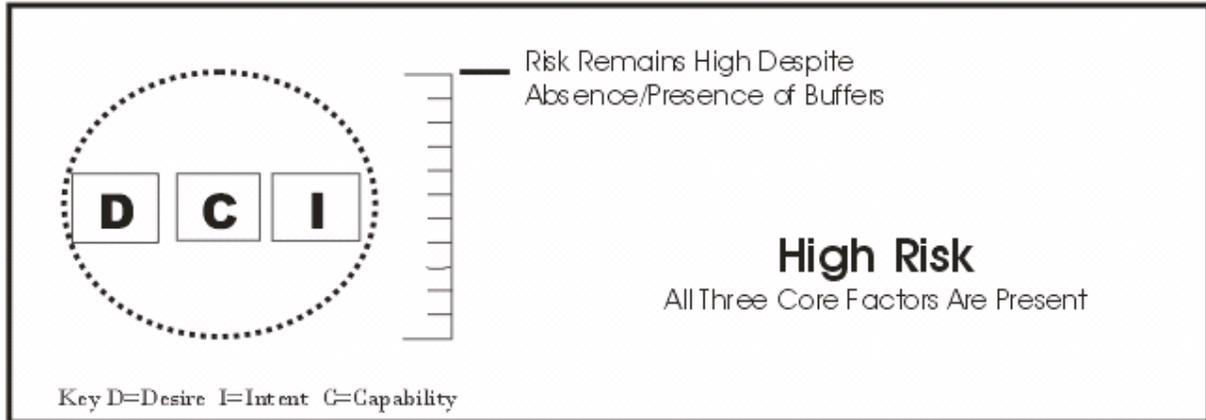
The CTS has identified the following buffers as key:

- *Perceived immediate supports* (e.g., person present with the caller). This factor is of clear pragmatic importance – callers who are with a supportive other will experience the buffering effects of social support as well as the practical effects of removal of means, access to emergency care, etc.
- *Other social supports.* Lack of access to social support is a strong predictor of suicidal behavior (e.g., Joiner, 2005); its presence, by converse, is protective.
- *Planning for the future.* Expressed reasons for living, both in the long-term (e.g., life goals) and the short-term (e.g., plans to complete a project) have been documented as protective against suicidal behavior (Strosahl et al., 1992).
- *Engagement with helper (telephone worker).* This factor is a specific instance of those more general factors on social support which are noted above.
- *Ambivalence for living* (see below).
- *Core values/beliefs* (see below).
- *Sense of purpose.* This factor, as well as some reasons for living (i.e., an ambivalence about death that includes attraction to life) and core values/beliefs (e.g., duty to family, religious beliefs) all represent the same process as “planning for the future,” noted above. Specifically, each of these factors reflects a connection to living.

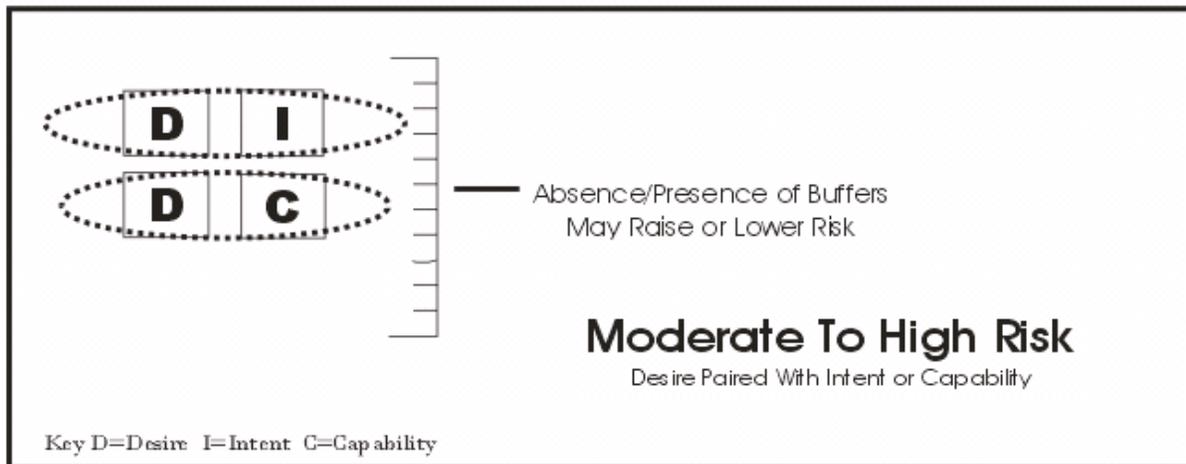
Presence of these buffers does not automatically offset risk based on the other three facets of suicidal desire, suicidal capability, and suicidal intent, but as will be seen in the next section, they may affect risk calculations in significant ways.

The Inter-Relations of the Four Facets and Attendant Implications for Crisis Calls

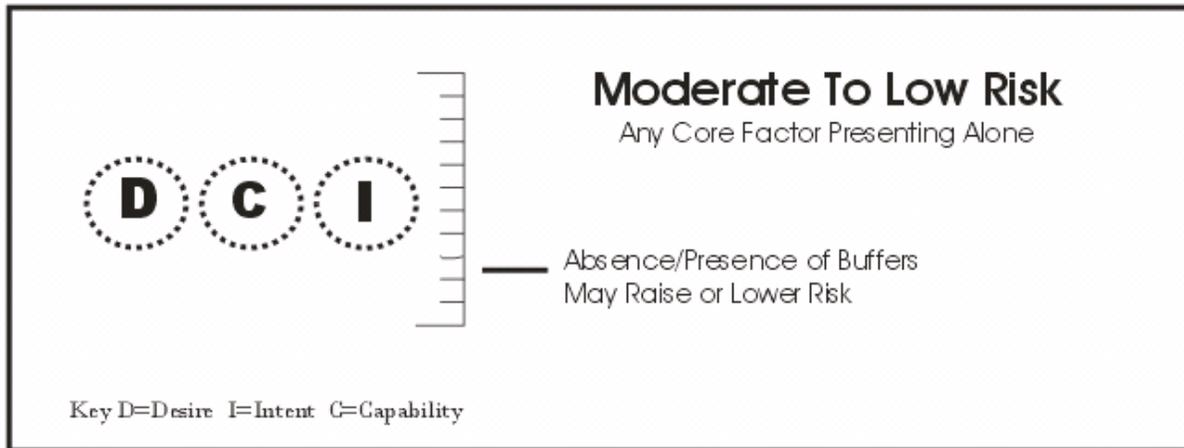
As previously noted, suicidal desire occurring independent of suicidal capability and/or suicidal intent typically presents a low-risk-of-suicide scenario. However, when desire combines with capability and/or intent, then suicidal risk may dramatically increase and the intervening impact of buffers may also need to enter into the equation. Below are representations of possible combinations of factors. It is important to emphasize the non-empirical basis for the risk formulations (and a need for more research).



Starting with the clearest – and highest risk – scenario, when suicidal desire, suicidal capability, and suicidal intent are all present, risk is high, *and this is essentially true regardless of the presence of buffers.*



When desire is paired with either intent or capability (but not with both), risk is lower but still considerable, and the determination of whether risk is particularly high rests with the safety afforded by buffers. If safety is high, risk is more moderate (though still elevated and in need of regular monitoring); if safety is low, risk is approximately as high as when desire, capability, and intent are all present.



Desire by itself is best viewed as a symptom of a mood disorder and does not entail significant risk by itself. Capability and intent are more pernicious, and here again, the safety afforded by buffers is partly determinative. If safety is high, capability and/or intent do not convey the higher risk categories but may convey moderate risk and require regular monitoring. If safety is low, capability and/or intent is a more serious concern and requires active intervention, though probably not to the level of rigor or immediacy occasioned by the combinations of desire, capability, and intent, as noted in the prior graphics.

It is important to note that formulating an individual's risk for suicide is best practiced through a highly collaborative process whereby efforts to engage and intervene with the caller are often seamlessly interwoven throughout the worker's assessment process. For example, research has shown that an individual's self-assessment of suicide risk may outperform clinical judgments (Joiner, Rudd, & Rajab, 1999), suggesting that workers can further enhance their assessment by asking the caller to rate his/her own risk of suicide. In addition, the previously cited work by Kalafat, Gould and Munfakh (in press) showed that "intent to die," assessed at both the beginning *and* end of the call, was the best predictor of the caller's later suicidality, indicating that interventions during the call itself can affect the degree to which the caller is ultimately assessed to be at risk.

NSPL Implementation Process for Suicide Risk Assessment Standards

In January 2007, the suicide risk assessment standards will become policy for all Lifeline network crisis centers. The implementation process will involve a formal announcement to all the Lifeline network centers. All centers will receive by direct certified mail: 1) the Policy; 2) the standards; 3) the network implementation timeline and process; and 4) this background paper.

Extensive technical assistance will be provided by the CTS and the Lifeline Certification and Training Division through various means to the network centers. Some of these methods include: network-wide conference calls, newsletter articles, email communications, sample suicide risk assessment questions and instruments, and individualized assistance when requested/needed. All network centers will be required to submit their suicide risk assessment instrument to the Lifeline Certification and Training Division for review to ensure that it meets the standards. Centers will also be encouraged to submit examples of suicide risk assessment trainings that demonstrate how they have incorporated the standards into their routine educational and skill-building activities for crisis line workers. Once reviewed by the CTS to ensure adherence to the standards, these examples will be posted online and be available to all

network crisis centers, with the permission of the crisis centers. It is expected that all Lifeline network centers will be in adherence with the new standards by September 1, 2007.

The Lifeline is actively promoted nationally as a resource for suicidal persons. Lifeline's policy regarding the suicide risk assessment standards will require some degree of suicide risk assessment on every Lifeline call. As a suicide prevention hotline, it is essential that every Lifeline caller be assessed for potential suicidality.

A common misconception is that asking about suicidality might aggravate or upset callers, or, in the extreme, "plant the idea in the person's mind." Research does not support this assumption. A study examining the impact of suicide risk questions on at-risk youth (e.g., impaired from substance abuse, depressed or with a past history of suicide attempt) as well as a general youth population found that neither group was distressed nor more suicidal following the introduction of the questions (Gould, et al., 2005). However, as noted earlier, research has shown that failure to routinely ask hotline callers about suicidality can allow for a significant number of suicidal persons to be missed (Mishara, et al., in press; Kalafat, Gould & Munfakh, in press).

Lifeline's administrator recognizes that a full suicide risk assessment covering all four core principles will not be appropriate for some callers. Therefore, for every Lifeline call, Lifeline's policy will require that telephone workers ask the callers about suicidality. The CTS will be recommending that crisis center staff ask a minimum of three "prompt questions" that, if answered affirmatively, would prompt a full scale assessment (e.g., "Are you thinking about suicide?" - see appendix 1). These questions will address current suicidal desire, recent (previous two months) suicidal desire and past suicide attempts. Clearly, it is important to elicit current suicidal desire given the caller is calling the Lifeline *now*. What is happening in the caller's life today that motivated him/her to reach out by calling the Lifeline *now*? If the caller denies current suicidal ideation, inquiring about recent suicidal ideation (i.e., past two months) may indicate the caller's emotional instability. In addition, a caller may feel more ready to acknowledge previous thoughts/behaviors rather than to discuss the more immediate situation. Depending on how the crisis center worker responds, discussing previous suicidal desire and/or attempts can increase rapport and trust leading to disclosure of current suicidal desire, if present. Inquiring about previous suicidal attempts also allows for the telephone worker to engage the caller in a discussion about what happened during and after the attempt, which has the potential to increase awareness of the caller's coping skills, reasons for living and awareness of available resources.

Centers can incorporate these standards and recommendations into their current risk assessments by simply adding those subcomponents of the standards that are not addressed in their assessments or, by adopting an alternative risk assessment instrument that addresses all of the subcomponents. The CTS also recognizes that telephone workers conducting risk assessments need not address each subcomponent in a rote, survey-like manner. Often, risk status can be established based on clear statements by callers, by their answers or elaborations in response to a few questions, or by obvious behaviors, such as an attempt in progress (for example, the caller reporting the ingestion of a lethal dose of pills).

Lifeline's Certification and Training Division will offer free (to Lifeline network centers), evidence-informed trainings on how to incorporate the suicide risk assessment questions into the dialogue with a caller. These trainings will also address how to establish rapport with callers to enhance assessment and intervention practices, as well as how the assessment can be utilized in the context of collaborating with callers to better ensure their safety.

References

- Adamek ME, & Kaplan MS. (2000). Caring for depressed and suicidal older patients: a survey of physicians and nurse practitioners. *International Journal of Psychiatric Medicine*, 30, 111 –25.
- Bartels, S.J., Coakley, E., Oxman, T.E., Constantino, G., Oslin, D., Chen, H., Zubritsky, C., Cheal, K., Durai, U., Gallo, J.J., Llorente, M., & Sanchez, H. (2002). Suicidal and death ideation in older primary care patients with depression, anxiety, and at-risk alcohol use. *American Journal of Geriatric Psychiatry*, 10, 417-427.
- Baumeister, R.F., & Leary, M.R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, 117, 497-529.
- Beck, A. T., Brown G. K., & Steer, R. A. (1997). Psychometric characteristics of the Scale for Suicide Ideation with psychiatric outpatients. *Behaviour Research and Therapy*, 35, 1039-1046.
- Bongar, B., Maris, R. W., Berman, A. L., & Litman, R. E. (1998). Outpatient standards of care and the suicidal patient. In B. Bongar, A. Berman, R. Maris, M. Silverman, E. Harris, & W. Packman (Eds.), *Risk management with suicidal patients* (pp 4-33). New York: Guilford.
- Brown, M.Z., Comtois, K.A., & Linehan, M.M. (2002). Reasons for suicide attempts and nonsuicidal self-injury in women with borderline personality disorder. *Journal of Abnormal Psychology*, 111, 198-202.
- Busch, K.A., Fawcett, J., & Jacobs, Douglas G. (2003). Clinical correlates of inpatient suicide. *Journal of Clinical Psychiatry*, 64, 14-19.
- Cavanagh, J.T.O., Owens, D.G.C., & Johnstone, E.C. (1999). Suicide and undetermined death in southeast Scotland. A case-control study using the psychological autopsy method. *Psychological Medicine*, 29, 1141-1149.
- Conner, K.R., Duberstein, P.R., Conwell, Y., & Caine, E.D. (2003). Reactive aggression and suicide: Theory and evidence. *Aggression & Violent Behavior*, 8, 413-432.
- Coombs, D. W.; Miller, H. L., Alarcon, R. D., Herlihy, C., Lee, J. M., & Morrison, D. P. (1992). Presuicide attempt communications between parasuicides and consulted caregivers. *Suicide & Life-Threatening Behavior*, 22, 289-302.
- Eaton, P., & Reynolds, P. (1985). Suicide attempters presenting at an emergency department. *Canadian Journal of Psychiatry*, 30, 582-585.
- Gould, M.S., Marrocco, F.A., Kleinman, M., Thomas, J.G., Mostkoff, K., Cote, J., & Davies, M. (2005). Evaluating iatrogenic risk of youth suicide screening programs: A randomized controlled trial. *Journal of the American Medical Association*, 293(13), 1635-1643.
- Joiner, T. (2005). Why people die by suicide. Cambridge, MA: Harvard University Press.
- Joiner, T., Steer, R.A., Brown, G., Beck, A.T., Pettit, J.W., & Rudd, M.D. (2003). Worst-point suicidal plans: A dimension of suicidality predictive of past suicide attempts and eventual death by suicide. *Behaviour Research & Therapy*.

- Joiner, Jr., T. E., Rudd, M. D., & Rajab, M. H. (1997). The Modified Scale for Suicidal Ideation among Suicidal Adults: Factors of suicidality and their relation to clinical and diagnostic indicators. *Journal of Abnormal Psychology*, 106, 260-265.
- Joiner, Jr., T. E., Rudd, M.D., & Rajab, M.H. (1999). Agreement between self- and clinician-rated suicidal symptoms in a clinical sample of young adults: Explaining discrepancies. *Journal of Consulting & Clinical Psychology*, 67, 171-176.
- Kalafat, J., Gould, M. S., & Munfakh, J. L. H. (2005). *Final Progress Report: Hotline Evaluation and Linkage Project Category II*. Washington, DC: Substance Abuse and Mental Health Services Administration.
- Kessler, Ronald C.; Berglund, Patricia; Borges, Guilherme; Nock, Matthew; Wang, Philip S. (May 2005) Trends in Suicide Ideation, Plans, Gestures, and Attempts in the United States, 1990-1992 to 2001-2003. *JAMA: Journal of the American Medical Association*. 293(20), 2487-2495.
- Mishara, B. L. et al. (2005). *A silent monitoring study of telephone help provided over the Hopeline Network and its short-term effects*. Washington, DC: Substance Abuse and Mental Health Services Administration.
- Rudd, M.D., Joiner, Jr., T.E., & Rajab, M. (1996). Relationships among suicide ideators, attemptors, and multiple attemptors in a young-adult sample. *Journal of Abnormal Psychology*, 105, 541-550.
- Rudd, M.D., Berman, A.L., Joiner, Jr., T.E., Nock, M.K., Silverman, M.M., Mandrusiak, M., Van Orden, K.A., and Witte, T. (2006) Warning Signs for Suicide: Theory, Research, and Clinical Applications. *Suicide and Life-Threatening Behavior*. 36(3), 255-262.
- Sabo, E., Reynolds, C.F., Kupfer, D.J., Berman, S.R. (1990). Sleep, depression, and suicide. *Psychiatry Research*, 36, 265-277.
- Shneidman, E.S. (1998). Perspectives on suicidology: Further reflections on suicide and psychache. *Suicide & Life-Threatening Behavior*, 28, 245-250.
- Strosahl, Kirk; Chiles, John A.; Linehan, Marsha. (Nov-Dec 1992). Prediction of suicide intent in hospitalized parasuicides: Reasons for living, hopelessness, and depression. *Comprehensive Psychiatry*, 33(6), 366-373.
- Sullivan, H.S. (1953). Conceptions of Modern Psychiatry: Collected Works of Harry Stack Sullivan, Volume I. New York: Norton.
- Williams, J.M.G., Duggan, D., Crane, C., & Fennell, M. (2006). Mindfulness-based cognitive therapy for prevention of recurrence of suicidal behavior. *Journal of Clinical Psychology*, 62, 201-210.
- Williams, J. W., Rost, K., Dietrich, A. J., Ciotti, M. C., Zyzanski, S. J., & Cornell, J. (1999). Primary care physicians' approach to depressive disorders: Effects of physician specialty and practice structure. *Archives of Family Medicine*, 8, 58-67.