

Establishing Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline

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The National Suicide Prevention Lifeline was launched in January 2005. Lifeline, supported by a federal grant from the Substance Abuse and Mental Health Services Administration, consists of a network of more than 120 crisis centers located in communities across the country that are committed to suicide prevention. Lifeline's Certification and Training Subcommittee conducted an extensive review of research and field practices that yielded the Lifeline's Suicide Risk Assessment Standards. The authors of the current paper provide the background on the need for these standards; describe the process that produced them; summarize the research and rationale supporting the standards; review how these standard assessment principles and their subcomponents can be weighted in relation to one another so as to effectively guide crisis hotline workers in their everyday assessments of callers to Lifeline; and discuss the implementation process that will be provided by Lifeline.

On January 1, 2005, the National Suicide Prevention Lifeline (1-800-273-TALK) was launched. Lifeline, supported by a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), consists of 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 the toll-free number at

anytime from anywhere in the nation and are routed to the nearest networked crisis center. 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 Lifeline are to promote efficient access to this service so it will reach more people nationwide at risk of sui-

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This project is supported by a grant to Link2Health Solutions, Inc., from SAMHSA.

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cide, and to ensure high quality of services to its callers so as to more effectively prevent suicide. Lifeline established a subcommittee of American and Canadian suicide prevention experts in March 2005 to consult on developing standards and recommended practices for its network of crisis centers. Lifeline's Certification and Training Subcommittee's (CTS) extensive review of research and field practices yielded recommendations that are embodied in Lifeline's Suicide Risk Assessment Standards, which were phased in for implementation beginning in January 2007, with the expectation of network-wide adherence by September 2007.

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

THE NEED FOR EVIDENCE-BASED RISK ASSESSMENT STANDARDS

Because of their accessibility, crisis hotlines are in a unique 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 in responding to crisis and suicidal callers, while raising some concerns about the quality of suicide

risk assessments. Kalafat, Gould, Munfakh, and Kleinman (this issue) studied 1,085 suicidal and 1,617 nonsuicidal crisis callers to eight crisis hotlines. The hotlines had agreed to use standardized, evidence-based suicide risk assessments and measures of crisis states, 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. 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 at follow-up 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 1,617 callers who had been categorized by centers as nonsuicidal crisis callers. At follow-up, 52 (6.5%) reported having suicidal thoughts when they had originally called the centers, and 27 of these said they had told the crisis worker of these thoughts. Crisis centers had not conducted risk assessments for these callers, and these callers were more distressed than callers who did not report suicidal thoughts. This study highlighted the need to inquire about suicide on crisis calls, particularly with more distressed callers (see Gould, Kalafat, Munfakh, & Kleinman, this issue; Kalafat et al., this issue).

In another study Mishara and colleagues (this issue) silently monitored 1,431 calls to 14 centers. Overall, when emotional or cognitive changes occurred from the beginning to the end of the calls, such changes were positive. Their 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 1,431 callers, 723 were not asked about suicidality. Of the 474 who were asked or who reported suicidal thoughts, no questions about the means were asked on

46% of the calls. In 159 instances when the helper was aware that the caller was considering suicide and had determined what means to use, the helper asked only 30 of those callers if an attempt was in progress. Questions about prior attempts were asked of only 104 callers. The study characterized these risk assessments as not following the accreditation guidelines of the American Association of Suicidology or procedures mandated by their own 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 been found also among professional mental health providers (Bongar, Maris, Berman, & Litman, 1998; Coombs et al., 1992) and among primary care physicians (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 of the Lifeline Network to make the development of standards for evidence-based risk assessment a first priority.

Primarily due to their accessibility to callers in immediate suicidal crisis, crisis hotlines 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 of distress or suicidality.

The challenge, then, is to conduct a systematic and thorough risk assessment within the connection and flow of a telephone contact. 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 course of the call. Most importantly, crisis staff must be assured

that persistent assessment of suicidal thoughts, feelings, and plans, as well as of 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.

THE PROCESS OF DEVELOPING SUICIDE RISK ASSESSMENT STANDARDS FOR NETWORK CENTERS

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, Lifeline has engaged national and international experts and stakeholders in suicide prevention who provide ongoing consultation and advisement to the project. 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 into field practices, the CTS has strong representation of crisis center directors as well.

In addition to the research findings from the Mishara et al. (this issue) and Kalafat et al. (this issue) studies indicating a need for more consistent, thorough assessment of caller risk by telephone crisis workers, the absence of evidenced-based suicide risk assessment standards for crisis centers further underscores the need to address this issue immediately. Based on this, the CTS identified two goals relating to Lifeline's suicide risk assessment standards initiative: (1) identify the most salient evidence-based risk and protective factors that can inform our efforts to assess suicide risk during a telephone contact; and (2) work collaboratively with centers to develop and deliver a pilot training program on conducting risk assessments that can be adapted to and incorporated into crisis centers' current training programs.

Initially, the CTS determined that the nature of crisis call center work required the

ability to assess immediate (as opposed to long-term) risk factors. The group then examined the results of a factor analysis conducted by Gould et al. (this issue) on the suicide risk assessment instrument used in the Kalafat et al. study (this issue), and compared that with a similar analysis by Lifeline 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 networked 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, acute factors in suicide risk assessment not specific to crisis center work. The results of both the factor analyses and reviews supported the designated four core principles for 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. Network crisis center directors were represented on the CTS where the standards were developed and the Steering Committee where the standards were reviewed and approved.

After extensive revisions based on CTS member discussions and Steering Committee and Executive Leadership Team feedback, 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. This allowed interactive input from the crisis center directors and supervisors present; members of Lifeline's Consumer Recipient Subcommittee also provided essential feedback that enhanced emphasis on assessment of protective factors ("reasons for living"), part of the fourth core principle of the standards.

Lifeline then hosted a conference call in June 2006 with 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 reflected the core principles and subcomponents. The one principle that seemed to be omitted in many suicide assessments was suicidal intent; however, consensus was reached regarding the importance and necessity of having suicidal intent assessed among crisis and suicidal callers.

Empirical Basis for the Standards

Empirical research and clinical experience suggest that suicidality is a multifaceted 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; Beck, Brown, & Steer, 1979; Joiner, Rudd, & Rajab, 1997; Joiner et al., 2003). 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. These four facets, as well as their subcomponents, were influenced by and are compatible with the "IS PATH WARM?" warning signs mnemonic (where I = ideation, S = substance abuse, P = purposelessness, A = anxiety, T = trapped, H = hopeless, W = withdrawal, A = anger, R = recklessness, and M = mood changes; Rudd et al., 2006). In what follows, the four facets are described, some research on each is summarized, and the inter-relations of the facets are discussed (the four core principles and their subcomponents are summarized in Figure 1).

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 comprised 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

CORE PRINCIPLES & SUBCOMPONENTS			
SUICIDAL DESIRE	SUICIDAL CAPABILITY	SUICIDAL INTENT	BUFFERS/CONNECTEDNESS
Suicidal Ideation • Killing self and/or others	History of suicide attempts	Attempt in progress	Immediate supports
	Exposure to someone else's death by suicide		Social supports
	History of/current violence to others		
Psychological pain	Available means of killing self/other	Plan to kill self/other • Method known	Planning for the future
	Currently intoxicated		
Hopelessness	Substance abuse		Engagement with helper • Telephone worker
	Acute symptoms of mental illness, for example: • Recent dramatic mood change • Out of touch with reality	Preparatory behaviors	Ambivalence for living/dying
Helplessness	Extreme agitation/rage, for example: • Increased anxiety • Decreased sleep		Core values/beliefs
		Expressed intent to die	Sense of purpose
Perceived burden on others			
Feeling trapped			
Feeling intolerably alone			

Figure 1. National Suicide Prevention Lifeline Suicide Risk Assessment Standards

strands of research (e.g., Rudd et al., 2006; Joiner, 2005, on burdensomeness; Williams, Duggan, Crane, & Fennell, 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, feeling like there is no alternative course of action or escape, feeling intolerably alone, intense psychological pain, hopelessness, helplessness, and perceiving oneself as a burden on others. Of these factors, two in particular (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 also perceive that their ineffectiveness affects not just them, but spills over to negatively affect others. Furthermore, they perceive that this ineffectiveness that negatively affects everyone is stable and permanent, forcing a choice between on the one hand, continued perceptions of burdening others and escalating feelings of

shame, or on the other hand, death by suicide. The mental calculation in the mind of the suicidal person, according to this perspective, is "my death will be worth more to loved ones than will my life."

Regarding feeling trapped, several prominent models of the development of suicidal behavior emphasize that suicidal people wish to escape psychological pain (e.g., Shneidman, 1996), and that their state of extreme distress diminishes their ability to think of adaptive ways to do so. The combination of desperately wishing to change their situation yet 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*; that is, emotional crises tend to constrict people's ability to solve problems, leading to a sense of desperation and feeling trapped, and suicidal behavior becomes the option for 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 common presentation in those calling crisis hotlines in distress, is a common symptom of mood disorders (Joiner et al., 1997), and indeed is a

relatively common experience in the general population (Kessler, Berglund, Borges, Nock, & Wang, 2005). Regarding suicide risk status, suicidal desire is roughly as indicative of risk as are high distress in a hotline caller, or as the other prominent symptoms of depression like anhedonia (inability to experience pleasure in previously enjoyed activities) and sad mood. These symptoms and crisis-related distress are of concern (and should prompt rapid referrals for timely treatment), but their endorsement alone is not enough to raise serious worry about imminent suicide risk. Rather, it is when suicidal desire occurs in combination with other facets of suicidality—described next—that concern escalates. The presence of suicidal desire should alert one to explore and elicit information regarding suicidal capability and suicidal intent.

Suicidal Capability

The same series of studies that elucidated the nature of suicidal desire has 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 attempt; specificity of plan for attempt; and preparations for 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 underrecognized concept. Serious suicidal behavior is by definition fearsome and is often painful; many studies and clinical case 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). Relatedly, this point is not intended to romanticize suicidal behavior as brave or tough; rather, it is in-

tended to underscore that severe suicidal behavior is fear-inducing and often painful—high tolerance for fear and pain is thus relevant.

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

- *History of suicide attempt, particularly multiple attempts* (Rudd, Joiner, & Rajab, 1996). This factor is a clear risk for future suicidality because, in part, past behavior is a strong predictor of future behavior. Relatedly, research indicates that for those who resort to suicidality (especially repeatedly) in the face of distress, suicidality may have become a primary way of coping, to the exclusion of more adaptive coping methods.
- *History of/current violence to others* (Conner, Duberstein, Conwell, & Caire, 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. Moreover, this factor has special relevance to those at risk for homicide-suicide.
- *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; Rudd et al., 2006).
- *Current intoxication* (Bartels et al., 2002). Current intoxication (e.g., with alcohol, cocaine, or LSD) diminishes problem-solving abilities

and reduces inhibitions, thus contributing to elevated risk for suicidal behavior.

- *Tendency toward frequent intoxication* (Bartels et al., 2002). This tendency makes intoxication in the near future more likely, with attendant risks of decreased problem-solving abilities and lowered inhibitions as noted above.
- *Acute symptoms of mental illness* (Cavanagh, Owens, & Johnstone, 2002). The onset or recurrence 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) and delusions in the context of bipolar disorders are related concerns.
- *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, Fawcett, & Jacobs, 2003). Increased agitation (extreme physical restlessness combined with emotional turmoil) suggests intense psychological pain, which as noted above, constitutes an important risk factor for suicidality.
- *Decreased sleep* (Sabo, Reynolds, Kupfer, & Berman, 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.

Research results indicate that suicidal desire and suicidal capability factors are *not* similarly related to key suicide-related indices. For instance, Joiner et al. (1997, 2003) 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 closely 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 researchers have 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 study by Kalafat et al. (this issue), in 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 (43.2%) of the callers continued to express suicidal ideation a few weeks after the initial call and nearly 3 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, often 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 the clearest indicator of intent to attempt, in that the attempt is already in progress.
- *Plan to hurt self/other.* Virtually all risk assessment frameworks emphasize plans for suicide as a key danger sign (e.g., Joiner, Rudd, & Rajab, 1999), a practice affirmed by research demonstrating that plans for suicide (e.g., method known) represent among the most dangerous aspects of suicidality (Joiner et al., 1997, 2003). Plans to hurt others are relevant too, in light of the research on violence and aggression noted above.
- *Preparatory behaviors.* Behaviors such as arranging the suicide method and 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.* Stated intent to die is a very clear indicator of suicidal intent. 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, Comtois, & Linehan, 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 ex-

plains this—the relationship of intent to lethality is qualified by factors like buffers and capability.

Buffers Against Suicidality

In almost every suicidal person, there is likely still some will to live. This is demonstrated by numerous instances of suicidal individuals who have survived high lethality 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: “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 headwaters of Niagara Falls in 2003 said that he changed 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) 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” (pp. 48–49). (Unfortunately for those patients, another phase of several days of agony then resumed eventually ending in death.) The will to live is apparently powerful enough that it returns even in people who have suppressed it enough to make a suicide attempt with a high likelihood of pain and/or death. For most people, this will, as well as a number of other factors, usually provides a protective buffer against a suicide attempt. The CTS identified the following buffers based on pragmatic, clinical, and scientific considerations:

- *Perceived immediate supports.* 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, Chiles, & Linehan, 1992).
 - *Engagement with helper* (telephone worker). This factor is a specific example of those more general factors on social support noted above. It is exemplified by elements like openness with and disclosure to the worker, as well as the worker's sense that a collaborative connection has been established.
 - *Ambivalence for living—core values/beliefs—sense of purpose.* This factor, as well as some reasons for living (i.e., an ambivalence about death that includes attraction to life; Linehan, Goodstein, Nielsen, & Chiles, 1983) 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 do not automatically offset risk based on suicidal desire, suicidal capability, and suicidal intent, and, in particular, are of little importance if acute risk is high, but as will be seen in the next section, they may affect risk calculations in significant ways.

THE INTERRELATIONS OF THE FOUR FACETS, AND ATTENDANT IMPLICATIONS FOR CRISIS CALLS

Suicidal desire occurring independent of suicidal capability and/or suicidal intent

typically presents a low-risk-of-suicide scenario. When desire combines with capability and/or intent, then suicidal risk may dramatically increase and the intervening impact of buffers may enter into the equation. Below are representations of possible combinations of these factors, but it is important to emphasize that assigning risk status to callers should not interfere with or take precedence over establishing empathic contact with callers.

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*. This last phrase is key, as clinical experience points to many people who have died by suicide even in 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. Suicidal desire is best viewed as an indicator of acute distress or a symptom of a mood disorder, and does not entail significant risk on its own. 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 (see Figure 2 for graphic representation).

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

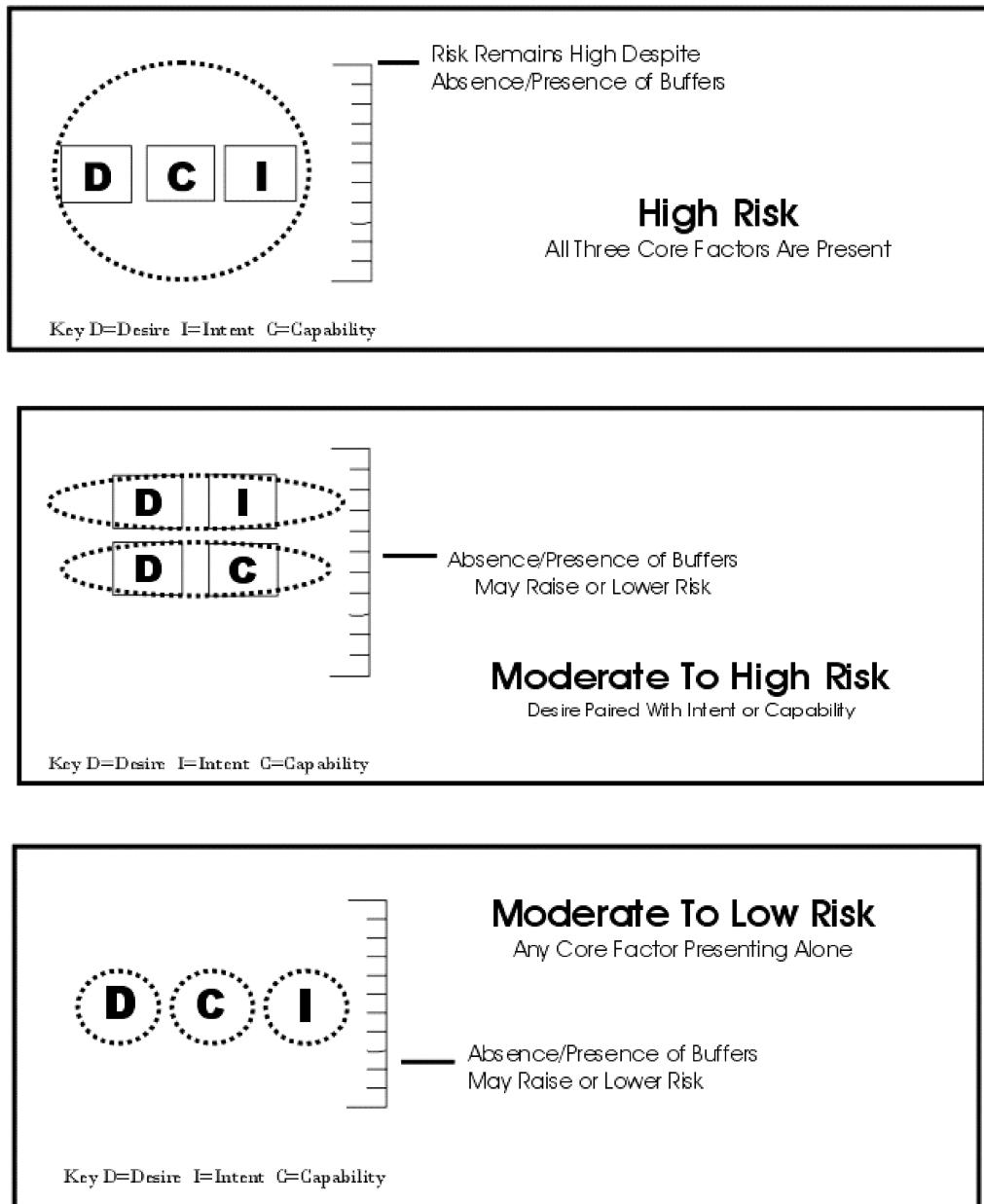


Figure 2.

that an individual's self-assessment of suicide risk may outperform clinical judgments (Joiner et al., 1999), suggesting that workers can further enhance their assessment by asking the caller to rate his/her own risk of suicide. In the work by Kalafat et al. and Gould

and colleagues (both this issue), the "intent to die" assessed at the 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.

IMPLEMENTATION PROCESS OF STANDARDS FOR SUICIDE RISK ASSESSMENT

In January 2007, the suicide risk assessment standards became policy for all Lifeline network crisis centers. Extensive technical assistance will be provided by the CTS and Lifeline. Some of these methods include: network-wide conference calls; newsletter articles; e-mail 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 their tool meets network standards. Centers will also be encouraged to submit examples of suicide risk assessment trainings which 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 and available to all network crisis centers, with the permission of the submitting crisis centers. It is expected that all Lifeline network centers will be in adherence with the new standards by late September 2007.

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 suicide risk. A common misconception is that asking about suicide 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 to at-risk-youth (e.g., impaired from substance abuse, depressed, or 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 ques-

tions (Gould et al., 2005). However, as noted earlier, research has shown that failure to routinely ask hotline callers about suicide can allow for a significant number of suicidal persons to be missed (see Kalafat et al. and Mishara et al., this issue).

Lifeline's administrators recognize 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, could prompt a full scale assessment (e.g., "Are you—or the person you are calling about—thinking about suicide?"). These questions will address current suicidal desire, recent (previous 2 months) suicidal desire, and past suicide attempts. Clearly, it is important to elicit current suicidal desire given that the caller is calling the Lifeline at that specific moment. What is happening in the caller's life that motivated him/her to reach out by calling? If the caller denies current suicidal ideation, inquiring about recent suicidal ideation (e.g., past 2 months) may provide insight into the caller's emotional state. 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 before, 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 adopt-

ing an alternative risk assessment instrument that addresses all 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 judged based on clear statements by callers; by their answers or elaborations in response to a few questions; or by obvious indicators, 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 networked centers), evidence-informed trainings on how to incorporate the suicide risk assessment questions into the dialogue with a caller. These trainings will also include 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.

In closing, we emphasize that these guidelines are specific to crisis hotline contexts, in which factors like appearance and observed behaviors are inaccessible. Further, it should be noted that the framework described herein, though research-based, has not itself been empirically evaluated. Relatively, we view these guidelines as current as of early-mid 2007, but we note that they may evolve as more information on them is gathered. Indeed, we are planning longitudinal, empirical work to evaluate and improve the standards, and we encourage others to do so as well.

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Manuscript Received: January 9, 2007
Revision Accepted: February 16, 2007