Helping Callers to the National Suicide Prevention Lifeline Who Are at Imminent Risk of Suicide: The Importance of Active Engagement, Active Rescue, and Collaboration Between Crisis and Emergency Services

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In 2012, the SAMHSA-funded National Suicide Prevention Lifeline (Lifeline) completed implementation of the first national Policy for Helping Callers at Imminent Risk of Suicide across its network of crisis centers. The policy sought to: (1) provide a clear definition of imminent risk; (2) reflect the state of evidence, field experience, and promising practices related to reducing imminent risk through hotline interventions; and (3) provide a uniform policy and approach that could be applied across crisis center settings. The resulting policy established three essential principles: active engagement, active rescue, and collaboration between crisis and emergency services. A sample of the research and rationale that underpinned the development of this policy is provided here. In addition, policy implementation, challenges and successes, and implications for interventions to help Lifeline callers at imminent risk of suicide are detailed.

In 2012, the SAMHSA-funded National Suicide Prevention Lifeline (Lifeline) completed implementation of the Policy for Helping Callers at Imminent Risk of Suicide across its network of crisis centers. To our knowledge, this was the first policy in the United States implemented across a national system of care that provided comprehensive guidelines for assisting persons at imminent risk of suicide. With the establishment of the National Action Alliance for Suicide Prevention in 2011, federal, state, and local efforts to integrate suicide prevention in systems of health and behavioral health care have become a priority. To that end, this policy provides guidance in defining imminent risk for suicide and developing collaborative and less restrictive approaches to reducing suicidality across care systems.

ABOUT THE LIFELINE AND ITS NATIONAL NETWORK

On January 1, 2005, the Lifeline was launched through a grant from the Substance Abuse and Mental Health

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Services Administration (SAMHSA). The Lifeline network consists of over 160 independently operated crisis call centers nationwide that are linked to a series of toll-free numbers, the most prominent of which is 800-273-TALK. Callers who dial this number are routed to the nearest network center, where helpers are trained to provide emotional support, assessment, crisis intervention, and/or linkages to necessary community resources. The Lifeline Standards, Training and Practices Subcommittee (STPS), made up of national and international experts in the field of suicide prevention, provides recommendations and advice on developing policies, standards, and guidelines on practices for the network. In 2006, for example, following SAMHSA-funded network evaluations that indicated the need for more consistent, uniform suicide risk assessment practices for crisis centers, the STPS developed evidence-informed suicide risk assessment standards, which the Lifeline network adopted as policy (Joiner et al., 2007).

While the risk assessment standards attended to the need to more effectively identify suicidal risk among Lifeline callers, they did not provide guidance to crisis centers as to what subsequent actions they might take to keep suicidal callers safe. Recognizing this, the STPS surveyed research, field practice, and legal precedents to develop guidelines on crisis center intervention policies and procedures. In 2008, the STPS and Lifeline Steering Committee approved the Lifeline Policy for Helping Callers at Imminent Risk of Suicide (Lifeline IR Policy).

Need for an Imminent Risk Policy

The need for a clear and explicit policy for high-risk callers was highlighted by a series of SAMHSA-funded evaluations of network crisis centers. Gould, Kalafat, Munfakh, and Kleinman (2007), for example, noted significant differences in staff emergency intervention responses for high-risk suicidal callers at eight crisis centers. They

found that, of 88 callers who had taken some action to kill themselves immediately before connecting with a center, no emergency rescue was initiated in 54 (61.4%) of these cases. In another study, Mishara et al. (2007a,b) silently monitored calls to 16 Lifeline centers that were accredited by the American Association of Suicidology (AAS) and determined that intervention practices with callers at imminent risk were inconsistent and at times very different from accreditation mandates. Mishara et al. identified 33 instances where a suicide attempt was in progress: in six cases, emergency services were dispatched; in eight, center staff helped develop a safety plan; in nine, the caller refused help and no attempt was made to intervene. In 10 instances, no attempt was made to send emergency rescue or offer alternate interventions. While researcher observations have indicated that a great many lives have been saved by emergency interventions from helplines (Mishara et al., 2007a), the responses here were inconsistent. Although all Lifeline centers are required to have accreditation or licensure from an external body, many accreditation standards do not sufficiently address crisis center approaches to helping those at imminent risk. While AAS's certification standards moved the crisis center field forward, the Lifeline IR Policy is intended to provide its centers with greater clarity and guidance.

Process for Developing the Imminent Risk Policy

The Lifeline IR Policy emanates from an underlying set of values that emphasize: (1) taking all actions necessary to prevent a caller from dying by suicide; (2) active collaboration with the caller to secure his or her own safety; and (3) collaboration with community crisis and emergency services to ensure the safe, continuous care of callers at imminent risk. In developing the IR Policy, the Lifeline STPS conducted an expansive review of the literature and surveyed field practices. The STPS consulted extensively with the Lifeline

Consumer–Survivor Subcommittee (CSS), who played a critical role in underscoring the need for active engagement and use of least invasive interventions. The IR Policy review process also included substantial legal consultation on the use of active rescue and the exchange of confidential information for lifesaving purposes.

DEFINING IMMINENT RISK

There are a variety of tools that helpers may use to determine the best response to a caller in crisis. However, the ultimate arbiter of the degree of intervention is the concept of imminent risk. The Lifeline STPS defines *imminent risk of suicide* as the belief that there is a

> close temporal connection between the person's current risk status and actions that could lead to his/her suicide. The risk must be present in the sense that it creates an obligation and immediate pressure on Center Staff to take urgent actions to reduce the Caller's risk; that is, if no actions were taken, the Center Staff believes that the Caller would be likely to seriously harm or kill him/her self. Imminent risk may be determined if an individual states (or is reported to have stated by a person believed to be a reliable informant) both a desire and intent to die and has the capability of carrying through his/her intent.

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

The Lifeline policy for helping callers at imminent risk of suicide (Lifeline IR Policy) can be understood in terms of the three central areas: active engagement, active rescue, and collaboration with community crisis and emergency services. Other guidelines in the Lifeline IR Policy as noted in Table 1 include the presence of supervisory staff and use of caller ID, which will not be covered here (Draper et al., 2010).

Active Engagement

While crisis call centers typically seek to engage all callers, active engagement is distinctive in its focus on moving beyond an "active listening" approach to actively seeking collaboration with a caller at imminent risk. Actively engaging the individual at risk in a discussion of their thoughts of suicide includes supporting the experience of psychic pain, exploring strengths and resources, building hope for recovery, and empowering the caller to work toward securing their own safety. Although research related to the effect of active engagement is sparse, what little exists is strongly persuasive. One study of suicidal callers showed that a supportive approach and good contact, and to a lesser degree, collaborative problem-solving, were most related to positive outcomes (Mishara et al., 2007b). Helper qualities such as expression of empathy and respect and behaviors such as offers to call back, reframing, appropriate self-disclosures, and empowering the caller toward developing action plans had the greatest impact on reducing feelings of sadness, helplessness, and hopelessness. Further, these qualities led to fewer hang-ups and higher levels of helper–caller agreement (Mishara et al., 2007b).

But how does a helper actively engage a caller, and promote choice, without encouraging the very act they wish to prevent? Beginning with the assumption that some degree of ambivalence exists, it is critical that helpers both tolerate and invite the caller's expression of reasons for dying (Ramsay, 2004). As demonstrated in Living Works' Applied Suicide Intervention Skills

TABLE 1
Lifeline Policy for Helping Callers at Imminent Risk of Suicide

Center guidelines shall direct crisis center staff to:

- Practice *active engagement* with callers and make efforts to establish sufficient rapport so as to promote the caller's collaboration in securing his/her own safety
- Use the *least invasive intervention* and consider involuntary emergency interventions as a last resort, except for in circumstances as described below
- Initiate lifesaving services for attempts in progress—guidelines shall not require the individual's consent to initiate medically necessary rescue services
- Initiate active rescue to secure the immediate safety of the individual at risk if the caller remains unwilling and/or unable to take action to prevent his/her suicide and remains at imminent risk
- Practice active engagement with persons calling on behalf of someone else ("third-party callers") toward determining the least invasive, most collaborative actions to best ensure the safety of the person at risk
- Have supervisory staff available during all hours of operations for timely consultation in determining the most appropriate intervention for any individual who may be at imminent risk of suicide
- Maintain caller ID or other method of identifying the caller's location that is readily accessible to staff
- Staff must seek to confirm that emergency services have successfully made contact with the at-risk individual and, if not successful, take additional steps to address the safety needs of the at-risk individual.

Training (ASIST), listening to a person's reasons for dying naturally evokes their counter impulse to express reasons for living (Ramsay, 2004). A recently published, SAMHSA-funded, evaluation of 17 ASIST-trained Lifeline centers determined that actively engaging callers in a discussion about reasons for living and ambivalence about dying was significantly associated with reductions in suicidal feelings (Gould, Cross, Pisani, Munfakh, & Kleinman, 2013).

Other collaborative therapeutic approaches have also shown great promise in reducing suicidal thoughts and behaviors. The Collaborative Assessment and Management of Suicidality (CAMS) is a problem-focused approach that hinges on a strong therapist–client treatment alliance and de-emphasizes the role of therapist as expert (Jobes, Moore, & O'Connor, 2007). Preliminary research on CAMS has shown reductions in suicidal thoughts for clients engaged in this model (Ellis, Green, Allen, Jobes, & Nadorff, 2012). In another study, which

investigated optimal crisis intervention models used by professionals, findings indicated that, while professionals preferred an authoritarian approach, the style that clients found most helpful was one that treated them as an active participant, if not the expert, in his or her care (Thomas & Leitner, 2005).

Least Invasive Intervention. A focus on the least invasive intervention emphasizes cooperation over coercion, with the use of involuntary methods as a last resort. Through actively engaging the caller, the goal is to include the person's own wishes in any plan to reduce risk. The use of the least invasive approach to treatment echoes throughout mental healthcare laws and recommended approaches to treatment for those with mental illness (National Action Alliance for Suicide Prevention: Clinical Care and Intervention Task Force, 2012; Simon, 2004; World Health Organization, 1996).

Fear of potential police intervention can deter individuals from discussing their suicidal thoughts with others, including crisis line helpers; involving the police can at

times have invasive, counterproductive results. While models of specialized police procedures, such as the Memphis Crisis Intervention Training (CIT) model, demonstrate more positive and less invasive approaches than departments without such specialized services (Compton et al., 2014a, b), use of these models is not widespread. To the degree that mobile outreach services are available, they can also provide alternatives to emergency dispatch for assisting those at risk. Further research on mobile outreach services has suggested that they can reduce psychiatric symptoms of persons not otherwise engaged in care, thereby reducing the number and costs of psychiatric hospitalizations (Bengelsdorf, Church, Kaye, Orlowski, & Alden, 1993; Guo, Biegel, Johnson, & Dyches, 2001).

Aside from avoiding interventions that could be unnecessarily stigmatizing and invasive, the need to engage and collaborate with callers in suicidal crisis becomes more critical given the current state of mobile technologies—very often, the ability of 911 to locate the individual at risk is limited unless they can confirm with the callers location.

A greater emphasis on active engagement and least invasive interventions may help some crisis centers broaden their views of what "rescue" means. Empowering an individual who was feeling hopeless and helpless to take action to help them feel more safe and hopeful can, in some cases, be experienced as a rescue. When researchers followed up with suicidal callers to eight Lifeline centers, nearly 12% spontaneously reported that the call itself prevented them from killing or harming themselves (Gould et al., 2007). A later evaluation of ASIST-trained Lifeline centers noted that helping suicidal callers identify informal supports was also associated with reductions in suicidal feelings (Gould et al., 2013).

Active Rescue

Active rescue refers here to actions independently undertaken that are intended to secure the safety of individuals at imminent risk of suicide. "Active" refers to the initiative to act on behalf of individuals who, in spite of the helper's attempts to actively engage, are unwilling or unable to take actions to secure their own safety.

Given the clear importance of actively engaging callers, there has been small but significant disagreement in the crisis center community as to whether actions to save a caller's life without his or her consent (active rescue) should be required at all. In response, the STPS cited several reasons for instituting a network guideline for active rescue. First, when suicidal individuals themselves choose to call a service whose clear mission is suicide prevention, there is some implicit understanding that this service has a responsibility to assist in securing the caller's safety. Second, a considerable body of research challenges the degree to which a helper can accept a caller's choice to die as a rational, responsible decision. Studies have indicated that individuals who are suicidal are often cognitively constricted, or constrained by tunnel vision, whereby options for addressing their psychological pain become narrow and dichotomous (Schneidman, 1996). This phenomenon of cognitive constriction in suicidal thinking can be successfully addressed in clinical settings, suggesting that treatment is often one among several rational choices other than suicide (Brown, Jeglic, Henriques, & Beck, 2006). In addition, there is evidence among survivors of suicide attempts that some degree of ambivalence toward dying exists among many suicidal individuals until the very instant of their attempt (Joiner, 2005). The number of suicide attempts and attempters to actual suicides —estimated at 25 attempts for every completed suicide in the United States—further suggests that ambivalence is prevalent among persons with suicidal intent (Borges et al., 2006).

Finally, respecting the choice of callers who wish to kill themselves does not account for significant others in the person's

life who are not included in this choice. It is estimated that at least six and as many as hundreds of people are emotionally affected by every suicide (Crosby & Sacks, 2002; Provini, Everett, & Pfeffer, 2000). Family members of a suicide loss have been found to have a suicide risk that is twice as high as the general population (Runeson & Asberg, 2003), and complications from the grief related to a peer's suicide are associated with a five times higher rate of suicidal ideation among adolescents and young adults (Melhem et al., 2004). Although it is frequently the perception of the suicidal individual that his or her choice to die may make life better for others, experts suggest that these perceptions are more often the likely product of depression and its related cognitive constriction rather than an accurate description of the true social impact of an individual's suicide (Joiner, 2005).

While American legal systems and many state laws observe the use of least restrictive alternatives for treatment, they are unanimously balanced by a recognition of the state's rights to authorize intervention to prevent a suicide (Siegel & Tuckel, 1987). In a review of the research on the short- and long-term impact of involuntary hospitalizations, Siegel and Tuckel noted that the data are largely mixed with some reporting that such an event can be experienced as punitive and damaging to self-esteem and social reputation, while others report a positive impact with positive perceptions of hospital stays and improved relationships.

Collaboration with Community Crisis and Emergency Services

A vital component of the Lifeline IR Policy underscores the importance of working with services most likely involved with suicidal callers (e.g., police, 911, hospitals). The requirement to establish and maintain formal and/or informal relationships with local crisis and emergency systems relates directly to Lifeline's value of a shared responsibility for the continuous, safe care

of suicidal callers. There are a wide variety of police/crisis center partnership models in the Lifeline network, and research demonstrates that training police to work more effectively with those who may have a mental illness can reduce unnecessary hospitalizations and incarceration, while reducing burdens on the police and the criminal justice system (Borum, Deane, Steadman, & Morrissey, 1998; Compton, Bahora, Watson, & Oliva, 2008; Lamb, Shaner, Elliott, DeCuir, & Foltz, 1995).

Confirmation of Emergency Services Contact. Crisis center staff contact emergency services with the presumption that if the caller is not seen immediately, he or she could die by suicide. When callers at risk can be actively engaged to consent, confirming that emergency services made contact with the caller is uncomplicated. In situations where crisis center staff initiate active rescue with a nonconsenting caller, it is not always clear if the caller will be found or, if found, transported to the hospital emergency department (ED) for evaluation. Not only do those at risk often avoid being transported, but local responders also vary widely by training, leading to uncertainties as to how they will respond to nonconsenting individuals at imminent risk. To the degree that network centers are able to determine that rescue service contact has not occurred, the Lifeline IR Policy requires staff to continue actions to assure that the caller is safe. Such follow-up actions include calling the at-risk individual back, contacting third parties, making a referral to a mobile outreach team, or requesting that local law enforcement conduct a safety check.

Prior to the implementation of these guidelines, just over half (54%) of Lifeline centers reported knowing whether callers they sent rescue to were actually found. Others reported barriers in obtaining this information, such as concerns related to privacy and the large number of 911 centers that may cover a given jurisdiction. The National Emergency Number Association

(NENA), a trade organization focused on 911 policy and operations, confirmed this and suggested the development of a national standard operating procedure (SOP) that would encourage such information sharing. As noted later in this article, this IR Policy spearheaded a collaboration between Lifeline and NENA that established this unprecedented SOP in 2013.

CONFIDENTIALITY ISSUES

A major barrier to preventing critical information exchanges between crisis centers, external crisis and emergency services, and other third parties has been concerns related to privacy. While most crisis centers compel staff to breach confidentiality of callers if there is an imminent threat to safety, many centers are uncertain as to how far this exception to confidentiality extends. Can they, for example, contact a receiving hospital or family member to provide them with information about the caller? In addition, external crisis or emergency services are often reluctant to exchange vital information with crisis centers for fear of violating the individual's privacy. Conversations about whether or not to exchange information often come to an end when one or the other party raises questions or concerns related to the Health Insurance Portability and Accountability Act [HIPAA]. In reviewing HIPAA and related legal interpretations, however, this regulation appears in no way to be an impediment to exchanging information that could, in effect, better ensure an individual's personal safety. HIPAA Standard 164.512(j) states that:

A covered entity may … use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure: (i) (A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (B) Is to a person or persons reasonably able to prevent or lessen the threat; or (ii) Is necessary for law enforcement authorities to identify or apprehend an individual. (Health Insurance Portability & Accountability Act of 1996 [HIPAA], 2013)

When the individual is not present or it is impractical due to emergency circumstances, HIPAA does not prevent disclosure of information to those responsible for the individual's care if it is believed that, in exercising professional judgment, such disclosure is in the best interest of the individual (see HIPAA Section 164.510(b); HIPAA, 2013). Simon (2004) noted that it is standard practice for psychiatrists seeking to protect their patients from self-harm to take such measures as to notify and/or counsel the individual's family or caretakers, inform them of suicide risks and possible methods, and mobilize them to remove access to lethal means or other actions to better ensure the individual's safety. Simon cites Gross v. Allen, a 1994 California appellate court decision, which ruled that caretakers of patients with a history of self-harm are legally responsible for informing the individual's new caretakers.

In considering HIPAA regulations, a few caveats are in order. First, HIPAA does not require nonconsensual disclosures of individual health information in emergency situations; it simply does not preclude it. Throughout the document, HIPAA regulations consistently reinforce the need to provide individuals with the opportunity to agree or object to disclosures of their information. Second, state laws, if they are more stringent in their privacy protections of health information, supersede HIPAA's regulations.

DISCUSSION AND IMPLICATIONS FOR FURTHER WORK

By March 2012, the Lifeline IR Policy had been implemented network-wide. While two Samaritans centers in the network had historically resisted active rescue

on philosophical grounds, they too agreed to adopt the Lifeline IR Policy, noting the compelling research on cognitive constriction, ambivalence, and the "lucky to be alive" testament of attempt survivors. In some respects, this historic shift in philosophy and practice by Samaritans centers was one of the most groundbreaking developments in the policy's implementation.

The development of the Lifeline IR Policy occurred within an ongoing SAMHSA-funded network evaluation process designed to assess its impact on actual practice. The Lifeline provided training and supervision tools to support the policy implementation and partnered with Living Works to provide ASIST for Trainers (T4T) and to ensure that upgrades to the ASIST model reflected the Lifeline values and policies. Lifeline also contracted with Simmersion Inc. to develop a simulation-based training for network centers to focus on callers at imminent risk. A recent SAMHSA-funded evaluation of ASIST-trained Lifeline centers demonstrated significant reductions in suicidality among callers after staff were trained in practices consistent with active engagement of callers (Gould et al., 2013).

Since the release of the Lifeline IR Policy, key aspects have been cited as frameworks for public health policy change relative to those at imminent risk of suicide. The themes of collaboration and active engagement between providers were underscored in National Action Alliance for Suicide Prevention white papers released by the Suicide Attempt Survivors Task Force and the Clinical Care and Intervention Task Force (National Action Alliance for Suicide Prevention: Clinical Care and Intervention Task Force, 2012; National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force, 2014). Further, the NENA Suicide Prevention Standard (NENA, 2013) noted earlier in this article arose from the Lifeline IR Policy and promotes active collaboration between local crisis centers and 911 communications centers to: (1) enhance information sharing to ensure continuity of care and safety for callers at imminent risk of suicide; as well as (2) cross-trainings and cross-referrals between 911 and crisis centers to promote less invasive interventions.

Elements of the Lifeline IR Policy may evolve over time, particularly given the ongoing evaluation of crisis center practice and the recent addition of online interventions. However, the policy's three principles of active engagement, active rescue, and collaboration between crisis and emergency services are likely to continue to be the primary framework for any service that accepts the responsibility for ensuring the safety of those at imminent risk of suicide.

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