RAND's Silent Monitoring Protocol for Assessing Suicide Crisis Line Call Content and Quality

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The California Mental Health Services Authority's (CalMHSA's) statewide prevention and early intervention initiative funded 12 crisis call centers to create, expand, or enhance their services related to suicide prevention. RAND conducted live monitoring of calls made to ten of 12 call centers as part of an evaluation of the suicide prevention funding. We designed this protocol for silent monitoring of incoming crisis calls, building on earlier work by other researchers. The protocol was designed with the following features:

- Assesses domains relevant to call content and quality
- Builds on prior work for potential comparability to national studies
- Allows for rapid coding and reliability across raters
- Might be useful for ongoing quality assurance monitoring beyond this study.

Designed for a diverse set of crisis call centers in California to assess aspects of best practice as well as to describe calls, the protocol may be useful for the evaluation of other call centers or for continuous quality improvement within call centers. Specifically, call centers that already use silent monitoring or record calls by supervisors or trainers may find the protocol useful for documenting strengths and weaknesses in their staff members or in the call center as a whole, helping to identify areas for further training. In addition, documentation of the types of calls received may help in planning future trainings, funding opportunities, and development of referrals for the most common needs among callers. Call centers that do not use silent monitoring or record calls may find the protocol useful for telephone counselor self-assessment.

In the remainder of this document, we describe our methods for developing and testing the protocol. Then, we describe our rationale for each of the items included in the protocol and present an appendix that briefly summarizes past evaluations of crisis lines. The protocol itself can be found at the end of this document.

Methods of Protocol Development

The design of this silent monitoring protocol began with a review of the literature of other studies that involved ratings of crisis line calls, and a review of protocols developed in those studies or currently in use by the researchers. A summary of this research is available in the appendix.

In addition, we consulted extensively with Dr. Madelyn Gould, who has used silent monitoring for research extensively in the past (Gould et al., 2013; Gould et al., 2007; Gould et al., 2012; Kalafat et al., 2007). She shared two of her past protocols with us (Gould et al., 2013; Gould et al., 2012) and discussed implementation issues as well as her team's findings to date. We used portions of her protocols but streamlined and simplified many parts to fit feasibility constraints in the CalMHSA evaluation as well as potential future use by crisis call centers for continuous quality improvement.

Next, we visited a National Suicide Prevention Lifeline (NSPL) call center and listened to taped crisis calls to pilot test our protocol.[1] This resulted in further streamlining and refinement. We visited a second center for training and refinement purposes. At this visit, the two individuals tasked with conducting all silent monitoring for this study double-coded taped crisis calls. All authors then discussed areas of confusion and made adjustments to the protocol. For instance, there were many more third-party and non-crisis informational calls than expected, so the protocol was adjusted to describe those calls more fully. Finally, two raters visited one of the CalMHSA crisis call centers to double-code 18 calls to examine reliability of coding (results presented in the appendix). We used the results to further refine the protocol and its instructions to improve reliability.

Protocol Description

Section A: Call Characteristics

This section was designed to describe basic aspects of the call itself, including its eligibility for silent monitoring. The section was modified from both Gould protocols (Gould et al., 2013; Gould et al., 2012). Our modifications included dropping some

questions that did not apply to our study, tailoring the eligibility criteria, and adding a question that allowed us to document that the silent monitor had difficulty hearing the call. The final protocol included one demographic question (gender), call characteristics (start and end time, technical issues that resulted in abrupt termination of the call, difficulty hearing the call, and whether the caller was put on hold), type of call (continuation of previous call with same counselor, repeat caller), and reasons for ineligibility for monitoring (caller under 18 years old, counselor not participating in evaluation, non–English-speaking caller, obscene/prank caller). A call selection status item was created to summarize these ineligibility criteria and indicates whether the call was included in the evaluation.

Section B: Call Content

This section focused on the types of issues and problems raised during the call. In the case of calls made by individuals concerned about somebody else (i.e., third-party callers), this could include both problems for the caller and for the person they were calling about. We chose the topic areas by drawing from the list of presenting problems and stressful experiences on both Gould protocols (Gould et al., 2013; Gould et al., 2012), but added the assessment of problems "for someone else" to capture third-party call content. Problems listed included mental health problems, substance abuse, homelessness, relationship problems, exposure to violence or abuse, and suicidal ideation or intent. We included an "other" category to capture other important content not listed. Monitors were trained to check items regardless of whether the caller mentioned them spontaneously or call responders asked questions to bring them to light, and that these items did not have to be the reason for the call in order to be checked.

Section C: Suicide Risk Assessment

This section was designed to assess adherence to NSPL guidelines that call for suicide assessment for every crisis center call,[2] as well as the types of issues explored for those callers who expressed suicidal ideation or intent for themselves or a third party. These guidelines suggest that telephone responders should ask a minimum of three questions to determine suicide risk, unless the caller offers the information spontaneously: (1) Are you currently thinking of suicide? (current ideation); (2) Have you thought about suicide in the past two months? (recent ideation); and (3) Have you ever attempted to kill yourself? (attempt). It is recommended that all three questions be asked of all callers, regardless of how the caller responds to the other suicide risk questions, to provide a sense of callers' emotional instability as well as to build rapport (Joiner et al., 2007).

Items in this section were modified from the Gould Applied Suicide Intervention Skills Training (ASIST) protocol (Gould et al., 2013) to match the wording from the NSPL for the questions to ask each caller. The questions were expanded to include exploration of suicidal ideation or intent. For each question, the monitors also indicate whether the information was offered spontaneously by the caller or asked by the call responder. If offered spontaneously, the monitor indicates whether the call responder asked follow-up questions to explore the disclosure.

We also added two items pertinent to suicide assessment regarding individuals who had already taken steps to harm themselves (or that a third party took to harm him or herself) prior to the call: preparatory behaviors or an attempt in progress. This information appeared to be missing, and we deemed it necessary to gauge imminent risk in the next section.

In addition, this section contains information about the degree to which four risk factors related to suicide are explored on the call. These include suicide desires, suicide capability, suicide intent, and lack of buffers/connectedness. These items were based on NSPL guidelines for suicide assessment (Joiner et al., 2007) and draw from the Lifeline Quality Improvement Monitoring Tool (Lifeline QI Monitoring Tool).[3] Monitors were trained to indicate that a risk factor was assessed if it was mentioned on the call, regardless of which party introduced it.

Section D: Imminent Risk

This section begins with a global assessment of whether imminent risk of harm to the caller or third party was present at any point during the call, similar to an item in the Gould ASIST protocol (Gould et al., 2013) and the Lifeline QI Monitoring Tool but expanded to include third parties. If imminent risk was deemed to be present, another item assessed whether a rescue was initiated or whether risk was reduced enough during the call such that a rescue was not necessary. We also added items to indicate other types of imminent risk, including imminent threat of violence or impairment due to substance use, to capture the types of calls we sometimes heard when developing the protocol. Following the Gould ASIST protocol (Gould et al., 2013), the silent monitors had the ability to talk to a supervisor if they noted imminent risk that was not resolved by the end of the call. These circumstances were also recorded in this section, along with any reasons for not initiating a rescue.

Section E: Action Plan for Imminent Risk

This section was included only for those calls that were deemed to contain some element of imminent risk, whether for suicide or something else. In this section, an *action plan* is defined as a suggested course of action to alleviate distress or increase safety. The types of questions were drawn from multiple sources (Gould et al., 2013; Gould et al., 2012), including the Lifeline QI Monitoring Tool, but simplified considerably for this protocol. They include specific plans for self-help, increasing safety, increasing social interactions, and seeking professional help, as well as discussion about logistics and potential barriers to the plan, to increase the probability that it will be followed. A final question asks about the extent to which the caller agreed to the plan.

Section F: Telephone Counselor Response

This section addressed the types of actions and behaviors that call responders engaged in. Items were adapted from the Gould ASIST

protocol (Gould et al., 2013), but the response options were modified to improve reliability across raters. Behaviors assessed include positive responses, such as reflective listening and sensitivity, as well as negative responses, such as criticism or judging.

Section G: Changes During Call

Two items assessed the level of caller distress at the beginning of the call and at the end of the call. This is similar to Mishara's study of call outcomes (Mishara, Chagnon, and Daigle, 2007b) but simplified into a single global distress item rather than items on several emotional distress dimensions (e.g., sad/happy, agitated, desperate). We added a rating for third-party calls as well.

Section H: Overall Ratings

This section required subjective ratings on the overall content of the call and how the call ended. We based these items on several sources (Gould et al., 2013; Gould et al., 2012) and the Lifeline QI Monitoring Tool but simplified them into seven main areas: good contact/rapport, problem-solving, referrals, an overall effectiveness rating for each of three types of calls (urgent, distressed, or routine), how challenging the situation was, how challenging the caller was, and how satisfied the caller appeared to be at the end of the call.

Summary

This live-monitoring protocol contains questions about call content and characteristics, suicide risk assessment, telephone counselor characteristics, call outcomes, and quality. Developed for use in a specific study of crisis call centers, the protocol may be useful for future evaluation efforts or for ongoing quality assurance purposes.

Notes

[1] All call monitoring activities described in this document were reviewed by the RAND Human Subjects Protection Committee.

[2] See National Suicide Prevention Lifeline, "Suicide Risk Assessment Standards," April 17, 2007.

[3] The Lifeline QI Monitoring Tool is designed for crisis hotlines that are part of the NSPL to "facilitate supervision of counselors and guide the appraisal of their behaviors during calls." It is available to members of the NSPL and was provided to us when we were developing our quality monitoring form.

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Appendix
Review of Crisis Line Evaluation Studies

Citation (listed chronologically)	Evaluation Design	Evaluation Findings
Weiner, 1969	A comparison of suicide rates in Los Angeles County before and after the introduction of a crisis hotline. Also, comparisons were made with the suicide rates in other California counties (one of the other three counties had a prevention program, two did not).	Researchers did not find a decrease in the suicide rate of Los Angeles Country after implementation of the program, but rather an increase. The suicide rate seemed to increase slightly with the rise in number of calls.
Bidwell, Bidwell, and Tsai, 1971	An evaluation of the demographic data records from a three-year period from September 1, 1966, to August 31, 1969, of crisis hotline calls were compared with data from those who had died by suicide. Names were compared to see whether the reported names of those who had committed suicide were found within the call logs of the help line.	The findings support the hypothesis that suicidal attempters and suicides constitute two epidemiological populations, albeit overlapping, and that the crisis intervention method of the suicide prevention programs can reach the first group but not the second. In other words, the demographics of the callers more closely resembled the attempters group, rather than the suicide completion group.
Lester, 1971	The census tract of 214 callers (of 626 possible) was identified and correlated with census tracts of local suicides for 1966–68.	Census tracts in Buffalo with one or more suicide in 1966–68 accounted for 86 percent of callers and 81.6 percent of the population.
Litman, 1976	Among a group of persons in contact with a crisis center, this study compared an experimental group that received outbound calls (Continuing Relationship Maintenance, or CRM), once per week for an average of 18 months per person with a control group.	No differences in completed suicides, suicide risk, or willingness to accept help. CRM group was less likely to live alone, had more improved personal relationships, better use of professional help, and less depression.
Leenaars and Lester, 1995	Pearson correlation between provincial suicide rates and (a) absolute number of crisis centers, (b) density of crisis centers per capita, and (c) density of crisis centers per area.	All correlations negative, though no statistical tests of significance were performed.
Mishara and Daigle, 1997	Trained observers listened to and coded calls in real time to ascertain the relative effectiveness of the volunteers' various intervention styles on the reduction of psychological distress of the callers. The volunteers' ability to encourage the caller to make a "no suicide contract" was also assessed.	An overall decrease in depressed mood was found from the beginning to the end of calls, but depression only decreased in 14 percent of calls and remained the same in 85 percent of calls. There was also a significant decrease in suicide urgency from the beginning to the end of the call (urgency decreased in 27 percent of calls), especially for non-chronic callers. Contracts were made in 68 percent of calls, more frequently with chronic callers. Calls were classified as "Rogerian style" or "directive style." Those volunteers using Rogerian style had significantly more decreases in caller depression and more contracts.
Fiske and Arbore, 2000	The study measured depressive symptoms, hopelessness, and life satisfaction before and after clients received 1 year of services (including warmline with both inbound and outbound calls) from the agency.	A paired t-test revealed a significant reduction in hopelessness among the clients. There were no significant changes in depressive symptoms or life satisfaction. There were no changes in hopelessness, depressive symptoms, or life satisfaction in the comparison group.
King, Nurcombe, Bickman, Hides, and Reid, 2003	Independent raters quantify changes in suicidality over the course of a call or counseling session by reviewing the first 5 minutes when suicidality first became evident and last 5 minutes of the call.	Decreases in callers' mental state and suicidal ideation occurred from the beginning to the end of the call; a decrease in calls rated to be at "imminent risk" and an increase in those rated as "no suicide urgency" was also observed.
Mishara, Houle, and Lavoie, 2005	Pre-test, post-test, and follow-up questionnaires were administered to participants who received each of five different support styles, including telephone counseling, though participants were not randomly assigned. Questionnaires contained questions about the callers themselves as well as about the suicidal man. Questionnaires to family/friends addressed issues such as coping mechanisms and utilization of resources, whereas the questionnaires related to the suicidal man included topics such as suicidal behaviors and alcoholism. Some topic areas overlapped. No control group.	There were no differences across the five support styles. Participants reported that suicidal men were less likely to have suicide attempts or ideation and depressive symptoms post-training, and these effects were maintained at the 6-month follow-up. The programs did not increase knowledge/use of resources for the participants or suicidal man. Participants reported that treatment did not reduce the suicidal man's use of alcohol/drugs. On the pre-test questionnaire, participants also reported some reasons for not discussing the man's suicidal intentions with him: 32 percent cited not wanting to upset the suicidal person and 21 percent reported feeling embarrassed or ashamed to discuss the issue of suicide.

Citation (listed chronologically)	Evaluation Design	Evaluation Findings
Mishara, Chagnon, and Daigle, 2007a	Trained observers listened to and coded calls in real time. The professional helpers were rated on different categories: their ability to conduct a suicide risk assessment in accordance with American Association of Suicidology accreditation, their ability to send emergency rescue if needed, and their ability to intervene according to existing theories related to active listening and collaborative problem-solving models.	81 percent of calls had a good initial rapport between helpers and callers. Only one-half of helpers asked about suicidal ideation. Of the callers who were reporting ideation, 46 percent were not asked about a plan; most were not asked about prior attempts.
Mishara, Chagnon, and Daigle, 2007b	Trained observers listened to and coded calls in real time. This evaluation is related to Mishara, Chagnon, and Daigle, 2007a. It looks to analyze whether there is a correlation between the behavior of the helpers and any short-term outcomes seen in the callers.	Empathy, respect, supportive approach, good contact, and collaborative problem solving were significantly related to positive outcomes. Active listening was not related to outcomes.
Meehan and Broom, 2007	Call logs were completed by volunteers, and 535 callers between March and September 2004 were mailed a questionnaire on their perceptions of the service (only 41 mailed the form back). The form included satisfaction for call, reasons for call, and time it took after learning about hotline to call.	Demographic data on callers presented; those who completed the questionnaire were generally happy with how their call was handled.
Gould, Kalafat, Munfakh, and Kleinman, 2007	Counselors at eight crisis centers conducted standardized assessments at the beginning and end of calls, and also asked if they could follow-up in 1–2 weeks with the caller. Follow-up calls were made by independent research interviewers.	Seriously suicidal individuals reached out to telephone crisis services. Significant decreases in suicidality were found during the course of the telephone session, with continuing decreases in hopelessness and psychological pain in the following weeks. A caller's intent to die at the end of the call was the most potent predictor of subsequent suicidality.
Kalafat, Gould, Munfakh, and Kleinman, 2007	Counselors at eight crisis centers conducted standardized assessments at the beginning and end of calls, and also asked if they could follow up in 1–2 weeks with the caller. Follow-up calls were made by independent research interviewers.	Significant decreases in callers' crisis states and hopelessness were found during the course of the telephone session, with continuing decreases in crisis states and hopelessness in the following weeks. A majority of callers were provided with referrals and/or plans of action for their concerns, and approximately one-third of those provided with mental health referrals had followed up with the referral by the time of the follow-up assessment. While crisis service staff coded these callers as nonsuicidal, at follow-up nearly 12 percent of them reported having suicidal thoughts either during or since their call to the center.
Ho, Chen, Ho, Lee, Chen, and Chou, 2011	The evaluation uses a pre-test/post-test design to evaluate the effectiveness of a center's programs, using monthly Bureau of Health data to track suicide rate changes since the center's opening in 2006.	From 2005 to 2008, suicide rates decreased, Kaohsiung Suicide Prevention Center (KSPC) crisis line calls increased, the number of KSPC telephone counseling sessions increased, and suicide attempt reporting increased.
Gould, Munfakh, Kleinman, and Lake, 2012	Lifeline callers who had received a mental or behavioral health care referral were interviewed two weeks after their call to assess depression, referral follow-through, and barriers to utilization both in suicidal callers and non-suicidal crisis callers.	Decreases in callers' mental state and suicidal ideation occurred from the beginning to the end of the call; a decrease in calls rated to be at "imminent risk" and an increase in those rated as "no suicide urgency" were also observed.
Knox, Kemp, McKeon, and Katz, 2012	Administrative data on calls to the Veteran's Crisis Line, which was established in July 2007, are reviewed.	Since the inception of the Department of Veterans Affairs' (VA) suicide hotline, the percentage of veterans self-identifying as veterans has increased from 30 percent to just over 60 percent, as of September 30, 2010; the volume of calls as of this time was 171,000. Seventy percent of callers were male veterans, and those who disclosed their age were between 40 and 69 years old. Approximately 4,000 referrals were made to the VA's suicide prevention coordinators as of 2008; there were 16,000 referrals at the end of September 2010.
Gould, Cross, Pisani, Munfakh, and Kleinman, 2013	Trained observers listened to and coded calls in real time across 17 call centers nationwide. Centers were offered staggered ASIST training, and analyses used hierarchical regression to evaluate relevant outcomes (counselors' interventions, callers' behavior change, the relation between the two, and effects over time) on the basis of whether centers had or had not received ASIST training.	Call counselors trained in ASIST had significantly positive intervention behaviors on six of 23 metrics, including longer calls and four of seven behavior changes (less suicidal, depressed, and overwhelmed; more hopeful). No relationship between time since training and outcomes. All behaviors that ASIST significantly impacted were associated with improved caller outcomes.

Interrater Reliability for N = 18 Calls

Gender	Percent Agreement: 100
Call content	Percent Agreement: 61–94
Current suicidal ideation	Percent Agreement: 80
Past suicidal ideation	Percent Agreement: 89
Past suicide attempt	Percent Agreement: 94
Counselor response	Intraclass correlations (ICCs): Discussed feelings = 0.00, Reflected back feelings = 0.53, Reflected back situation = 0.37, Connected with caller = 0.60, Was sensitive/receptive = 0.58, Was respectful = 0.37, Showed empathy/validation = 0.56
Caller distress—beginning	ICC: 0.92
Caller distress—end	ICC: 0.79
Overall rating: rapport	Percent Agreement: 50, or ICC = 0.49
Overall rating: collaborative problem solving	Percent Agreement: 72, or ICC = 0.46
Overall rating: referrals	Percent Agreement: 94, or ICC = 0.89
Challenging situation	ICC: 0.44
Challenging caller	ICC: 0.78
Caller satisfaction	ICC: 0.65

SILENT MONITORING PROTOCOL FOR ASSESSING SUICIDE CRISIS LINE CALL CONTENT AND QUALITY

Silent Monitor's (SM) Initials: _____ **Center Code#:** _____01_____

Line (caller called): _____ **Date of Call:** _____

Call Start Time: _____(AM/PM) **Call End Time:** _____(AM/PM) **Call Duration:** _____(minutes)

SECTION A: CALL CHARACTERISTICS

1. Technical/other problems resulted in abrupt termination of call? _____ Yes _____ No
(if yes, select all that apply)

		Check
1a.	Counselor/caller unable to hear each other (i.e., static, noise)	_____
1b.	Caller had to hang up (i.e., someone walked in, told to get off telephone, "have to go now")	_____
1c.	Cell or portable telephone problems (no battery charge left/losing service)	_____
1d.	Other (specify):	_____

2. Were there difficulties in hearing the call (connection problems, accent, etc.)? _____ Yes _____ No

3. Caller put on hold so that Call Responder (CR) could answer another call?
_____ Yes If "yes," how many times? _____
_____ No
_____ Don't know (including if not knowing why the telephone counselor placed call on hold)

4. Caller's gender?
_____ Male
_____ Female
_____ Don't Know

5. Was call selected for silent monitoring (not type 6–11 below)? _____ Yes _____ No

Type of call (if known)		Check
6.	Lacked the capacity to give consent (e.g., in midst of psychotic episode or exhibiting dementia or so intoxicated/high that it interfered with communication) – DO NOT LISTEN	_____
7.	Did not provide consent—asked that the call not be monitored for quality or research purposes – DO NOT LISTEN	_____
8.	Minor (less than 18 years of age) – DO NOT LISTEN	_____
9.	Counselor not eligible to be silent monitored – DO NOT LISTEN	_____
10.	Non-English speaking caller – DO NOT LISTEN (which language, if known):	_____
11.	Obscene / prank caller – DO NOT LISTEN	_____
12.	Continuation of a previous call with SAME COUNSELOR, SAME DAY, but SM did not hear first call	_____
13.	Repeat caller – call center has a particular response plan such as time limit or standard message for caller	_____
14.	Repeat caller – call center does not have a particular plan but the CR is familiar with this caller (not a continuation within the same day)	_____
15.	Repeat caller –caller is 'checking in' with the center as requested on an earlier call or as part of a treatment plan	_____
16.	Other (specify):	

Brief Summary of Call: _____

_____

_____

Section B instructions:

- A third party is someone who is calling about someone else who they are worried about. The person who the third party is worried about is referred to as "someone else (person in need)" throughout the silent monitoring assessment. Thus, the CALLER is the first person who made the call; SOMEONE ELSE is the person in need (in the case of a third-party call), even if that person ends up ultimately talking to the CR.
- These questions are used to describe content of calls. Check all that apply, and do not worry about overlap.

SECTION B: CALL CONTENT

Which of the following were problems/issues for the caller or person in need?
(check all that apply)

	Problem for Caller	Problem for Someone Else (person in need)
1. Relationship problems (e.g., partner)	_____	_____
2. Family conflict problems (not partner)	_____	_____
3. Concern about a family member	_____	_____
4. Concern about a friend	_____	_____
5. Work problems (e.g., unemployment, issues at work)	_____	_____
6. Financial problems (e.g., no money, needs money, pension problems, disability stopped)	_____	_____
7. Suicidal thoughts/intent (including current, past, or worry about potential of future thoughts or intent)	_____	_____
8. Exposure to violence or trauma (or fear of)	_____	_____
9. Loss of family member/friend (e.g., grief)	_____	_____
10. Homelessness (or fear of)	_____	_____
11. Alcohol/drug use problems (current)	_____	_____
12. Sexual orientation problems	_____	_____
13. Illness/injury/disability problems (physical health)	_____	_____
14. Chronic pain (from illness or injury)	_____	_____
15. Depression/anxiety/PTSD/other mental health problem (e.g., states concern about experiencing symptoms [sleeplessness, memory loss, hearing voices, confusion])	_____	_____
16. Veteran/military issues (including getting help from VA)	_____	_____
17. Other (specify):	_____	_____

Section C instructions:

- CALLER is the first person who made the call; SOMEONE ELSE is the person in need (in the case of a third-party call), even if that person ends up ultimately talking to the CR.

SECTION C: SUICIDE RISK ASSESSMENT

Please indicate the risk status on 1–3 and 5–7 and how the information came out on the call.

		Status	CR asked?	Caller offered?	If status is yes, CR explored?
1.	Is **caller** currently (i.e., now or today) thinking about suicide**?**	_____ Yes _____ No _____ Don't know _____ Not discussed	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
2.	Has **caller** thought about suicide in the past?	_____ Yes _____ No _____ Don't know _____ Not discussed	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
2a.	If "Yes", when last had thoughts?	_____ Within 2 months _____ > 2 months _____ Don't know _____ Not discussed	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
3.	Has **caller** attempted suicide in the past?	_____ Yes _____ No _____ Don't know _____ Not discussed	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No

If "Yes" to either "CR asked" or "caller offered"

- "Explored" means at least one follow-up question from CR.

If "Don't Know"

- Use for situations where the caller doesn't know or doesn't answer clearly, same for next two items.

For item #2:

- Rate as "Yes" only if explicitly discussed—not just if there was a past suicide attempt.

4. Did caller take action to kill or harm self while calling or right before calling the crisis hotline?

_____ No
_____ Yes – Preparatory behavior without imminent risk (i.e., obtained method but not ready to use it)
_____ Yes – Preparatory behavior WITH imminent risk (e.g., standing on bridge and ready to jump)
_____ Yes – Attempt or self-harm in progress, without dire consequences (e.g., superficial cut)
_____ Yes – Attempt or self-harm in progress causing serious harm (e.g., took pills)

		Status	CR asked?	Caller offered?	If status is yes, CR explored?
5.	Is **someone else** currently thinking about suicide**?**	_____ Yes _____ No _____ Don't know _____ Not discussed	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
6.	Has **someone else** thought about suicide in the past?	_____ Yes _____ No _____ Don't know _____ Not discussed	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
6a.	If "Yes", when last had thoughts?	_____ Within 2 months _____ > 2 months _____ Don't know _____ Not discussed	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
7.	Has **someone else** attempted suicide in the past?	_____ Yes _____ No _____ Don't know _____ Not discussed	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No

If "Yes" to either "CR asked" or "caller offered"

- "Explored" means at least one follow-up question from CR.

8. Did someone else take action to kill or harm self while calling or right before calling the crisis hotline?

_____ No
_____ Yes – Preparatory behavior without imminent risk (i.e., obtained method but not ready to use it)
_____ Yes – Preparatory behavior WITH imminent risk (e.g., standing on bridge and ready to jump)
_____ Yes – Attempt in progress, without dire consequences (e.g., superficial cut)
_____ Yes – Attempt in progress causing serious harm (e.g., took pills)

Section C, continued

- Fill in this section even if there is no suicide risk indicated in the section above.

SECTION C: RISK ASSESSMENT, CONTINUED

	Check if mentioned for caller	Check if mentioned for someone else
9. Suicide Desire		
a. Suicidal Ideation	_____	_____
b. Psychological pain	_____	_____
c. Hopelessness	_____	_____
d. Helplessness	_____	_____
e. Perceived burden on others	_____	_____
f. Feeling trapped	_____	_____
g. Feeling lonely	_____	_____
h. Reasons for dying (linked to wish to die)	_____	_____
10. Suicide Capability		
a. Attempt in progress (now)	_____	_____
b. Plan with known method	_____	_____
c. Preparation for death (e.g., wills, finances)	_____	_____
d. Preparation for suicide (e.g., gathering means)	_____	_____
e. Expressed intent to die	_____	_____
11. Suicide Intent		
a. History of suicide attempts	_____	_____
b. Available means	_____	_____
c. Exposure to death by suicide	_____	_____
d. History of violence toward others	_____	_____
e. Recent acts/threats of aggression to others	_____	_____
f. Current intoxication/substance use (now)	_____	_____
g. History of substance abuse	_____	_____
h. Recent dramatic mood changes	_____	_____
i. Decreased sleep	_____	_____
j. Increased anxiety	_____	_____
k. Out of touch with reality (e.g., hallucinations)	_____	_____
l. Extreme agitation or rage	_____	_____

"Check if mentioned"

- The answer or situation can be "Yes" or "No"—check if MENTIONED.

12. Buffers/Connectedness

a.	Immediate supports (to help now or when feel this way)	_____	_____
b.	Social supports (generally)	_____	_____
c.	Planning for future (e.g., what are your plans, what would you like to do?)	_____	_____
d.	Engagement with helper professional(s)	_____	_____
e.	Ambivalence for living/dying	_____	_____
f.	Core values/beliefs	_____	_____
g.	Sense of Purpose	_____	_____
h.	Reasons for living	_____	_____

Section D instructions:

- "No" means not observed. There doesn't have to be confirmation that there is NOT imminent risk for callers when there are no observed signs of suicidal intent. "No" can also be used for suicidal callers when there is enough information to indicate that the caller is not going to act on their suicidal thoughts or plans imminently
- "Don't know" means that there were signs of suicidal intent on the call, but there wasn't enough information on the call to determine if imminent risk, so you aren't sure.

SECTION D: IMMINENT RISK

1. Was imminent risk <u>for suicide</u> observed <u>for caller</u> at any point during call?

_____ Yes
_____ No *If "No," skip to #2*
_____ Don't know *If "Don't Know," skip to #2*

If YES,	**Yes**	**No**	**Don't know**
1a. Was rescue initiated/facilitated by crisis center?	_____	_____	_____
If yes, was rescue with caller's consent/ cooperation?	_____	_____	_____
If No or Don't Know, was imminent risk reduced enough during the call so that rescue was not needed?	_____	_____	_____

2. Was imminent risk <u>for suicide</u> observed <u>for someone else</u> at any point during call?

_____ Yes
_____ No *If "No," skip to #3*
_____ Don't know *If "Don't Know," skip to #3*

If YES,	**Yes**	**No**	**Don't know**
2a. Was rescue initiated/facilitated by crisis center?	_____	_____	_____
If yes, was rescue with caller's consent/ cooperation?	_____	_____	_____
If No or Don't Know, was imminent risk reduced enough during the call so that rescue was not needed?	_____	_____	_____

Definition: Imminent Risk

- A close temporal connection between current risk status and actions that could lead to caller's suicide. Imminent Risk determined if caller states, both a desire and intent to die NOW or VERY SOON and has capability of carrying through with intent.

3. Was some other imminent risk situation observed at any point during the call (with or without imminent risk for suicide)?

_____ Yes
_____ No *If "No," skip to #4*

If YES, what type of situation?
_____ Imminent threat to harm someone else
_____ Severe impairment and risk of danger to self or others due to substance use
_____ Severe impairment and risk of danger to self or others due to mental health problems
_____ Other (specify: _____)

If YES,	**Yes**	**No**	**Don't know**
3a. Was rescue initiated/facilitated by crisis center?	_____	_____	_____
If yes, was rescue with caller's consent/cooperation?	_____	_____	_____
If No or Don't Know, was imminent risk reduced enough during the call so that rescue was not needed?	_____	_____	_____

4. Did SM initiate contact with Center's Representative for required intervention?

_____ Yes
_____ No *If "No," skip to next section*

If YES,	**Check all that apply**
a. Rescue already being initiated by center	_____
b. SM's call prompted rescue	_____
c. Center unable to rescue, reason:	_____
d. Center said they do not rescue without caller's consent	_____
e. Center chose not to rescue for other reason (specify):	_____

SECTION E: ACTION PLAN TO INCREASE SAFETY/DECREASE DISTRESS IF IMMINENT RISK CALL

1. CHECK: If Question D1, D2, or D3 = YES, Was there imminent risk on this call?

_____ Yes *(continue)*
_____ No *(skip to section F)*

2. Was an action plan developed and/or discussed with the caller/third party to increase safety or decrease distress?

_____ Yes
_____ No *(skip to section F)*
_____ Don't know *(skip to section F)*

Definition: Action Plan
- A suggested course of action to alleviate distress or increase safety.

2a. If Plan developed and/or discussed, within the action plan discussed, indicate whether each of the following was included *(overlap between items is ok)*:	**Yes**	**No**
a. Includes specific plans for self-help *(use past survival skills, identify coping strategies)*	_____	_____
b. Includes specific plans for increasing safety *(get rid of potential means, safe use of drugs/alcohol, make sure not alone)*	_____	_____
c. Includes specific plans for increasing social interactions and support *(talking to friends or family)*	_____	_____

d. Includes specific plans for seeking professional help *(referral to new help or existing helping professionals, includes crisis and non-crisis resources as well as making warm hand-off to mobile services or other emergency service)* _____ _____

e. Includes collaboration and steps to increase likelihood of plan being used *(listing steps, discussing potential barriers, asking permission to follow up)* _____ _____

f. Includes request for permission to follow up later to see how things went _____ _____

3. If plan developed and/or discussed, did the caller/someone else agree to the plan?

_____ No/Don't Know
_____ Yes, agreed to parts of the plan
_____ Yes, agreed to the whole plan

SECTION F: TELEPHONE COUNSELOR RESPONSE

These questions refer to ANYONE the CR spoke with during the call.

During the call, the telephone counselor (check one box in each row):	**0 Not at all or Not Applicable**	**1 A little**	**2 Moderately**	**3 A lot**
1. Allowed caller(s) to talk about his/her feelings/situation?	_____	_____	_____	_____
2. Reflected back caller(s)' feelings?	_____	_____	_____	_____
3. Reflected back caller(s)' situation?	_____	_____	_____	_____
4. Challenged caller(s) (in negative way)	_____	_____	_____	_____
5. Was condescending	_____	_____	_____	_____
6. Connected/established rapport with caller(s)	_____	_____	_____	_____
7. Displayed inappropriate behavior (i.e., fell asleep, laughed at caller[s])	_____	_____	_____	_____
8. Was judgmental	_____	_____	_____	_____
9. Overall, was sensitive/receptive to caller(s)' problems	_____	_____	_____	_____
10. Preached or forced his/her opinions on caller(s)	_____	_____	_____	_____
11. Was respectful	_____	_____	_____	_____
12. Showed empathy/validated caller(s) (e.g., "it must be hard for you")	_____	_____	_____	_____

"Not at all" should be used to capture calls where this didn't happen, even if the counselor had no opportunity to do it (e.g., the caller didn't express feelings, so the telephone counselor had no opportunity to reflect them back).

SECTION G: CHANGES DURING CALL

Specific to caller

Rate the level of distress of the CALLER (check one box in each line):	0 Not at all distressed	1 A little distressed	2 Moderately distressed	3 Extremely distressed
1. At the beginning of the call	_____	_____	_____	_____
2. At the end of the call	_____	_____	_____	_____

Specific to someone else (person in need in the case of a third-party call)

Rate the level of distress of SOMEONE ELSE CR spoke with (check one box in each line):	0 Not at all distressed	1 A little distressed	2 Moderately distressed	3 Extremely distressed
3. At the beginning of the call	_____	_____	_____	_____
4. At the end of the call	_____	_____	_____	_____

SECTION H: OVERALL RATINGS (code based on everyone CR spoke with)

1. Good contact/rapport *(check one item)*

a. _____ Established good contact/rapport (consistently understood and connected)

b. _____ Established good contact/rapport with some weaknesses (had a few times where the counselor did not understand or connect)

c. _____ Did not establish good contact/rapport, or important weaknesses (did not seem to connect or understand, made the caller or someone else upset or shut down)

Items to consider when rating rapport are whether the counselor

- Displayed empathy
- Reflected back caller's feelings
- Paraphrased caller's situation
- Created a caring and safe climate
- Used a warm and genuine tone
- Was non-judgmental
- Was accepting and respectful
- Used patience in matching the client's language and pace
- Did not rush
- Stayed engaged and in the present
- Used questions, reflections or other invitations that deepen the relationship and understanding
- Was authentic and genuine
- Had a natural not scripted use of skills
- Used self-disclosure only when appropriate
- Exhibited trust, competence and confidence
- Did not jump prematurely to problem-solving

2. Problem-solving *(check one item)*

a. _____ Collaborative problem-solving approach used (consistently offered choices and options and asked for input)

b. _____ Collaborative problem-solving approach used with some weaknesses (came up with most ideas for the plan, did not check on all parts of the plan)

c. _____ Did not use collaborative problem-solving approach, or important weaknesses (suggested a plan without input ,did not seem to have caller agreement on plan)

Items to consider when problem solving are whether the counselor

- Helped caller identify and prioritize problems, needs and wants
- Identified the event that precipitated the call
- Explored what the caller has tried to do to solve the problem, to seek support, or to self-soothe
- Avoided taking responsibility to fix the problem / seek support / self-soothe
- Explored (brainstormed) alternatives
- Worked with the caller to create a plan that will work for him/her
- Does not jump prematurely to solutions

3. Referrals *(check one item)*

a. _____ Referrals/resources provided (consistently checked on types of referrals needed or desired and whether referrals were satisfactory)

b. _____ Referrals/resources provided with some weaknesses or incomplete (addressed some but not all problems, did not check on all referrals to see if they were satisfactory)

c. _____ No referrals/resources provided, or important weaknesses (e.g., did not offer referrals or resources at all, or gave information without checking on whether any of it would be helpful or useful)

4. This call can be classified as *(check one box only)*:

(priority should always be given first to urgent, then distress only, and finally no/distress routine)

	Counselor speaks with person in need directly (only)	Counselor speaks with third party about someone else in need (only)	Counselor speaks with both person in need and third party
Urgent: Contains imminent risk considerations for self or other	_____	_____	_____
Distress Only: No imminent risk, person is distressed and wants to talk and/or get support/help	_____	_____	_____
No distress/routine: Request for referral or information	_____	_____	_____

5. If URGENT: How effective was this call in making the caller (or person at risk) safe? *(circle one or leave blank)*

Very ineffective intervention				Very effective intervention
1	2	3	4	5

6. If DISTRESS only: How effective was this call in reducing caller's (or callers') distress? *(circle one or leave blank)*

Very ineffective intervention				Very effective intervention
1	2	3	4	5

7. If ROUTINE: How effective was this call in identifying an appropriate referral and providing referral details? *(circle one or leave blank)*

Very ineffective intervention				Very effective intervention
1	2	3	4	5

8. How challenging was the situation on this call (e.g., urgent or complicated issues)? *(circle one)*

Not at all challenging				Extremely challenging
1	2	3	4	5

9. How challenging was/were caller(s) (e.g., uncooperative, incoherent, belligerent, rejects ideas)? *(circle one)*

Not at all challenging				Extremely challenging
1	2	3	4	5

10. How satisfied was/were caller(s) at the end of the call? *(circle one or leave blank if don't know/unable to judge)*

Not at all satisfied				Extremely satisfied
1	2	3	4	5

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RAND Health

This research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at http://www.rand.org/health.

CalMHSA

The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. Prevention and Early Intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

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