

988 Suicide and Crisis Lifeline Suicide Safety Policy

PROGRAM: National Suicide Prevention Lifeline

EFFECTIVE DATE:12/27/2022

REVIEW TERM: 12 months

LAST REVISION DATE: 12/27/2022

NEXT REVIEW DUE: 12/27/2023

POLICY

NOTE: The Lifeline Suicide Safety Policy (2022) serves to replace the Lifeline Risk Assessment Standards (2007) and the Policy for Helping Callers at Imminent Risk of Suicide (2011).

All Lifeline crisis centers shall have a written policy that specifically addresses actions to be undertaken by crisis counselors in working with those at risk of suicide that is consistent with the Lifeline Suicide Safety Policy. These requirements are as follows:

1. Assessment and Intervention

Crisis centers shall have documented policies requiring that:

- 1.1. Crisis counselors practice **active engagement** (as defined in [Appendix A](#)) with all Lifeline callers/chatters/texters (“contacts”), specifically those determined to be at risk of suicide, attempting suicide, or at **imminent risk of suicide** (as defined in [Appendix A](#)).
- 1.2. In all Lifeline contacts, crisis counselors must **ask about suicide** (see [Appendix B](#)).
 - 1.2.1. If an affirmative response is received to *Have you had any thoughts of suicide in the past few days, including today?*, crisis counselors must complete a assessment of safety that includes the elements outlined in the Lifeline **Four Core Principles of Suicide Assessment 2.0** (FCP) ([Appendix C](#)), AND is consistent with the Lifeline **Safety Assessment Model** (see [Appendix D](#)). This requires that:
 - 1.2.1.1. Crisis centers maintain a safety assessment tool that includes all elements of the FCP
 - 1.2.1.2. A safety assessment requires that all elements noted as essential elements of the FCP are explored
 - 1.2.1.3. Elements noted as situationally specific of the FCP are explored when clinically relevant
 - 1.2.1.4. Crisis centers maintain a safety planning tool consistent with the Lifeline Safety Assessment Model
 - 1.2.2. If an affirmative response is received to *Have you taken any action to harm yourself today?*, crisis counselors must **assess immediate safety** and determine if there is an **attempt in progress** (as defined in [Appendix A](#)) then proceed to follow the requirements in 1.3.

- 1.3. If a contact is determined to be at **imminent risk of suicide** (as defined in [Appendix A](#)) following a full assessment of safety, OR an **attempt in progress** is identified (as defined in [Appendix A](#)), crisis counselors must:
 - 1.3.1. Work to promote the contact's participation in securing their own safety through actively engaging the individual in efforts to increase safety.
 - 1.3.2. Work with the contact to implement the **least invasive intervention** (as defined in [Appendix A](#)) that can secure the safety of the individual.
 - 1.3.3. Initiate an **involuntary emergency service intervention** (as defined in [Appendix A](#)) only as a last resort and only if, despite attempts to de-escalate and collaborate on less invasive alternatives, the individual at **imminent risk** remains unwilling and/or unable to take action to secure their own safety or there is already an **attempt in progress**. In these cases, the request to dispatch an emergency service intervention must be undertaken with or without the caller/chatting/texter's consent.
- 1.4. Crisis counselors must work with **third-party contacts** (as defined in [Appendix A](#) and guidance provided in [Appendix G](#)) using the least invasive and most collaborative actions to best ensure the safety of an individual believed to be at imminent risk of suicide. Crisis center policy must include direction to make efforts to connect to the individual at risk directly.
- 1.5. In all interventions that have resulted in the request of emergency services, crisis counselors must **confirm emergency service contact** (see [Appendix H](#)). Crisis center guidelines must provide crisis counselors with information on how best to confirm emergency service contact has occurred. The policy must include actions to be taken when emergency services are requested but are unable to make contact with the individual. The policy must also require documentation of actions taken by crisis center staff for instances in which emergency service contact could not be confirmed despite the crisis center's best efforts (see also 3.2).

2. Supervisory Support and Training

Crisis centers shall have documented policies requiring that:

- 2.1. **Supervisory access** ("supervisor" defined in [Appendix A](#)) is available during all hours of the crisis center's operations for timely consultation from crisis counselors when needing assistance in determining the most appropriate intervention for an individual at imminent risk of suicide. This is of particular importance when an involuntary Emergency service intervention is required. Each crisis center's individual policy must clearly outline procedures for accessing supervisory consultation and when crisis counselors are required to do so. (Ideally crisis center procedures would direct crisis counselors to seek approval from a supervisor before requesting dispatch of an emergency service intervention.)

- 2.2. All interventions that have resulted in requesting a PSAP to dispatch an emergency service intervention, either voluntary or involuntary, must undergo a **supervisory review** (see [Appendix E](#)). This must occur in a timely manner (ideally within 72 hours) and include both crisis counselor and supervisor involved in the request.
- 2.3. All crisis counselors must complete the Lifeline Core Trainings, which include information on the **Lifeline Safety Assessment Model**. [Lifeline assumes responsibility for the provision of this training.]
- 2.4. All crisis center staff must receive **training on the use of involuntary emergency service interventions**. [Lifeline assumes responsibility for the provision of this training.]

3. Community Engagement

In support of the requirement to provide the least invasive, most collaborative intervention, the requirement to confirm emergency service contact, and the requirement to use involuntary emergency service interventions as a last resort, Lifeline crisis centers are required to:

- 3.1. **Investigate alternatives to emergency service interventions** within the community. Crisis centers must collect information on all available local resources that could be used as alternate interventions to requesting dispatch of an emergency service intervention from a PSAP (such as mobile crisis teams), and educate crisis counselors on how to access such services. To the extent that no such alternatives exist in their coverage area, crisis centers must document strategies for outreach/education efforts to public/private entities to address this need (see [Appendix F](#)).
 - 3.1.1. Should a mobile crisis team (or similar community outreach team) exist and/or serve the crisis center's designated service territory, an MOU must be developed between the crisis center and any such entities that articulates the goal of the collaboration, the roles and responsibilities of each collaborator (or agency), and the specific protocols for intervention and/or support for crisis center contacts. (If an MOU cannot be put into place, the crisis center must provide documentation of efforts to secure an agreement.)
- 3.2. **Establish collaborative relationships with emergency service providers** in the community. This should include, at a minimum, establishing a formal relationship with the closest local public safety answering point (PSAPs/911 centers) to establish cooperative relationships and protocols for working together. (If a formal relationship cannot be put into place, the crisis center must provide documentation of efforts to secure such an arrangement.) Crisis centers should also work to establish formal or informal collaborative relationships to the extent possible with all PSAPs in the crisis center's service territory, as well as with other local emergency services providers. Lifeline centers must submit proof of the formal collaborative relationship with their local PSAP (see [Appendix I](#)).

Appendix A: Definitions of Key Terms

Active engagement: Intentional behaviors undertaken by crisis counselors to effectively establish a connection with the individual seeking support from the Lifeline. “Engagement” refers to the building of an alliance that facilitates connection and makes it possible to collaborate with, and empower, the individual to secure their own safety, or the safety of the person they are reaching out about. The word “active” reinforces the need to focus on engagement in phone- or text-based crisis counseling, consciously and intentionally. Active engagement is necessary for both a comprehensive accurate assessment of an individual’s suicide risk/safety and for collaborating on a plan to maintain their safety.

Imminent risk: An individual is determined to be at imminent risk of suicide (“imminent risk”) if the crisis center staff responding to the contact believe, based on information gathered, that there is a close temporal connection (very short time frame) between the person’s current risk status and actions that could lead to their 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 individual’s risk; that is, if no actions are taken, the individual is likely to seriously harm or kill themselves in the very near future. Imminent risk may be determined if an individual states (or is reported to have stated by a third party) both a desire and intent to die and has the capability of carrying through on this intent.

Involuntary emergency service intervention: Action undertaken by crisis center staff that is intended to address imminent risk of suicide and assure the safety of an individual at imminent risk in which the individual has not agreed (or is medically unable to agree) to the intervention. This specifically refers to actions taken when an individual is unwilling or unable to collaborate on securing their own safety and crisis center staff believe that, without this intervention, the individual is likely to sustain a life-threatening injury or there is an attempt in progress (see definition below). Crisis center staff should clearly document efforts to engage the individual in collaborating on a plan for safety before any involuntary intervention is initiated.

Assess immediate safety: The requirement to assess immediate safety refers to asking contacts about suicide early in the contact in order to determine if it is safe to continue assessment and referral. It is recommended that individuals are asked about suicide early in the conversation, i.e., within roughly the first five minutes of the contact.

Attempt in progress: Any action that an individual has already taken with the purpose of killing themselves OR that has the potential effect of causing lethal self-harm. [In many circumstances an attempt in progress is clear (e.g., an individual discloses that they have already taken pills that they believe could kill them); in other circumstances it may be more complex and judgment on the part of crisis center staff is necessary before any emergency service intervention is initiated, particularly if that intervention is involuntary. An individual may be at imminent risk and have “taken action” towards suicide (e.g., is sitting on the ledge of a building, holding a gun, standing on a bridge) but an opportunity exists to reduce that risk. As in all cases where imminent risk is present, crisis center staff must actively engage in increasing immediate safety before any emergency service intervention is initiated.]

Least invasive intervention: This refers to the use of approaches that emphasize collaboration over coercion with contacts at imminent risk, with the use of involuntary methods as a last resort. Through

actively engaging the individual, crisis center staff must seek to collaborate with the person and include the individual's wishes, plans, needs, and capacities towards acting on their own behalf to reduce their risk of suicide, wherever possible. Crisis center staff must consider all available alternative resources before requesting the dispatch of emergency services.

Supervisor: Crisis center staff that regularly act in a managerial or training capacity, who have knowledge of the crisis center's most current policies and procedures related to helping contacts at imminent risk of suicide. Such personnel might include crisis center directors, training coordinators/supervisors, shift supervisors, or some other title consistent with the spirit of this definition. Peers (colleagues with no other official designation or routine role as staff supervisor or trainer) acting as consultants are not alone sufficient to meet this definition.

Third-party contact: This refers to conversations with an individual concerned about a person in crisis. These conversations consist of the individual reaching out (the third party) and the crisis counselor.

Appendix B: Ask About Suicide

Lifeline requires that crisis center staff ask about suicide and establish immediate safety with ALL contacts. The following two PROMPT questions are required:

- ***Have you had any thoughts of suicide in the past few days, including today?***
 - ***Have you taken any action to harm yourself today?***
-

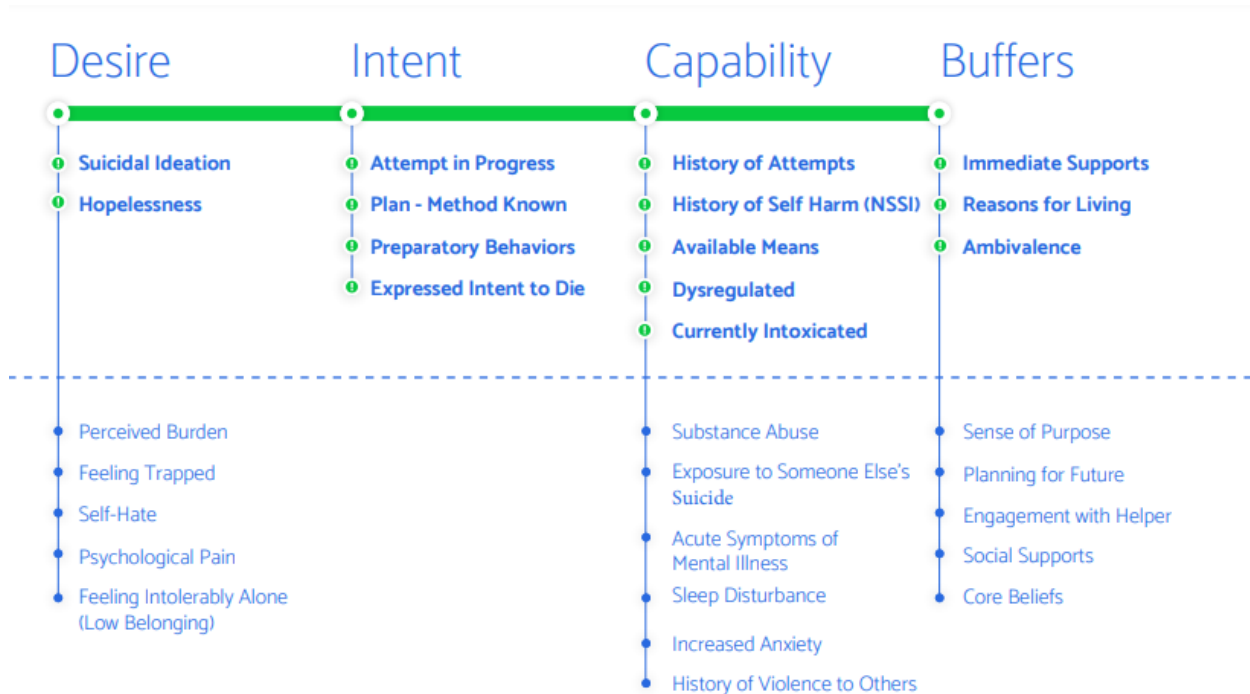
ABOUT THESE QUESTIONS:

- ***Have you had any thoughts of suicide in the past few days, including today?***
 - The individual contacted a service whose mission is suicide prevention. For that reason alone, it is the responsibility of crisis counselors to ask directly about suicide and inquire as to whether they are having thoughts of suicide. What is happening in this person's life today that motivated them to reach out to the Lifeline now?
 - Inquiring about recent suicidal ideation (in the past few days) can allow the individual to talk about suicide more broadly, acknowledging previous thoughts/behaviors, if they are not yet ready to address immediate needs. Discussing previous suicidal desire and/or attempts can increase rapport and trust, leading to disclosure of current suicidal desire if present.
- ***Have you taken any action to harm yourself today?***
 - It is essential to determine if it is safe to even continue the conversation or if immediate intervention is needed.
 - Intervention can refer to any action taken to immediately address and reduce risk—it may not always require emergency intervention and an involuntary emergency service intervention must always be considered a last resort.

NOTE:

- a. It is important to remember that the above questions are PROMPTS in order to begin to explore suicide risk. Acknowledging any thoughts of suicide requires a safety assessment that can then address previous attempts and all additional factors associated with increased risk for suicide.
- b. Crisis counselors do not have to ask the above prompt questions verbatim, but they must ask them in such a way that elicits the same information. The initial determination of an individual's risk for suicide **MUST** include recent past (few days), current (while in contact), and whether the individual has already made an attempt (which may require immediate action).

Appendix C: Lifeline Four Core Principles of Suicide Assessment 2.0



All the elements listed in the *Lifeline Four Core Principles Table* above were included due to their demonstrated influence on suicidal ideation throughout the literature as well as their endorsement as significant by experts in the field of suicide prevention (STPC). They are each relevant to the overall assessment of suicide risk but may not need to be addressed with every individual.

Essential Elements

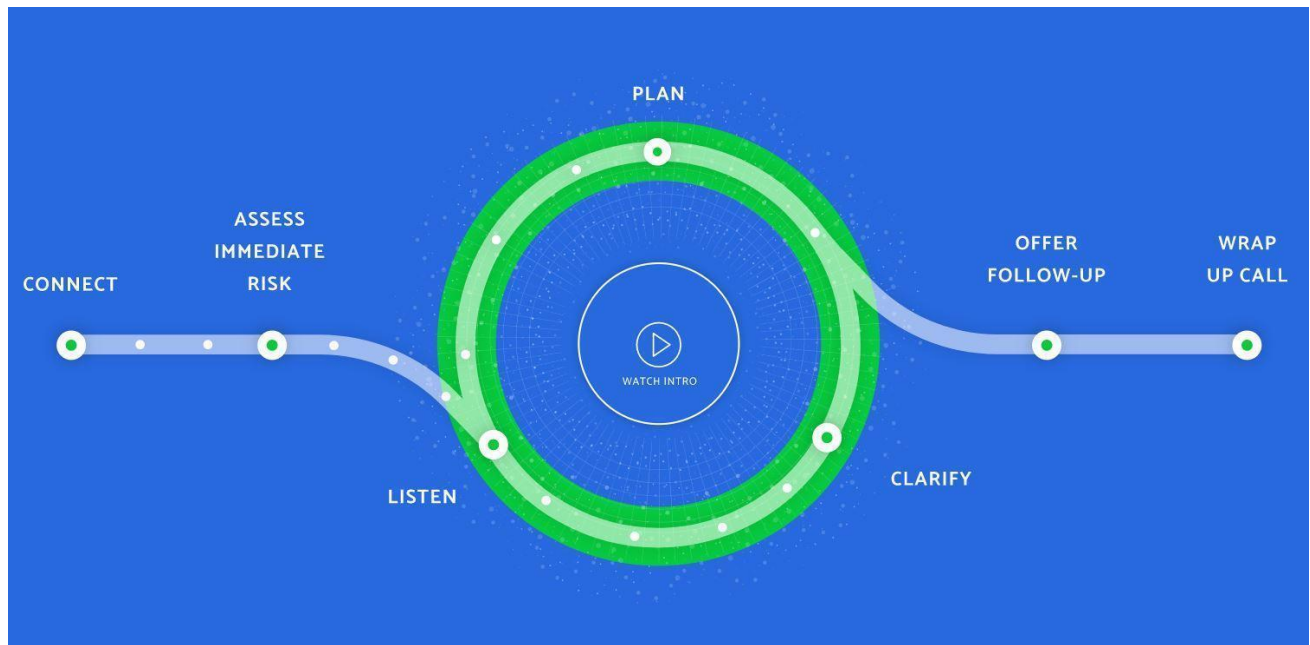
Elements deemed essential by the Lifeline to understanding the degree of risk that is present for a contact are bolded and listed above the dashed line. It is important in any assessment of suicide that crisis counselors address these areas.

Situationally Specific Elements

Situationally specific elements impact suicide risk when present. Though these elements may not be relevant to every contact, crisis counselors should be listening and clarifying for these elements during crisis conversations. When these elements are present, they are a crucial part of a comprehensive Safety Assessment.

For more information on conducting a Safety Assessment and the Four Core Principles, see the Network Resource Center (NRC) for Safety Assessment Guidance and Training.

Appendix D: Lifeline Safety Assessment Model



Following recommendations made by the STPC, Lifeline developed the Safety Assessment Model to provide a framework that could bring together the elements of assessment with a focus on conversation flow. The model reinforces the need to ask all contacts about suicide and to assess immediate risk while remaining firmly committed to the Four Core Principles of Suicide Assessment originally identified in the Lifeline Risk Assessment—Desire, Intent, Capability, and Buffers.

The Safety Assessment is divided into three general phases:

- The FIRST PHASE of the model focuses on CONNECTION and IMMEDIATE SAFETY.
- The SECOND PHASE encourages the crisis counselor to LISTEN to the individual's narrative, CLARIFY any missing pieces of information, and develop a PLAN for safety.
- The THIRD PHASE involves WRAPPING UP the conversation and offering the caller/chatter/texter FOLLOW-UP as needed.

In an effort to guide crisis counselors, the Lifeline developed a [Safety Assessment Site](#) to support the model. This site contains video roleplays demonstrating the model in action, along with text content suggesting ways to explore safety with individuals, strategies you can use to help increase safety, and additional resources you can use to learn more about best practices. A [Safety Assessment Overview](#) was also developed to introduce crisis counselors to the Safety Assessment Model as well as the online Safety Assessment Site.

Appendix E: Emergency Intervention: Supervisory Review Template

Emergency Service Intervention Supervisory Review

Lifeline's guidance is that in all cases where emergency services were dispatched (**emergency service intervention**) a review of the decision-making process be undertaken. This review should include all team members involved in the decision to dispatch emergency services and a supervisor. The review should include an assessment to discern if any alternative, less invasive, more collaborative approach could have been employed to assure contact safety. The intent of this review is to provide an opportunity to explore clinical decisions within a supportive environment, where staff can debrief on the intervention process. Dispatching emergency services, particularly when involuntary, is a significant undertaking and one that necessitates reflection when the inherent stress of the presenting crisis has resolved. The institution of a formal review process also reinforces the accountability that is essential when an individual's right to choose is taken away. The goal is to learn from every situation where an emergency service intervention has taken place in order to inform both policy and practice going forward.

Date of Interaction: _____

Start Time of Interaction: _____ AM/PM

Record Number/Interaction ID: _____

Staff Involved in Interaction: _____

Active Engagement

- Established rapport
- Engaged the person in crisis in a discussion of suicidal thoughts/behaviors

Safety Assessment

- A thorough Safety Assessment was completed
- The person in crisis was at imminent risk* of suicide or there was a life-threatening attempt in progress
- Interaction is well documented; it accurately reflects the interaction and the communication among center Staff during the decision-making process

Least Invasive Intervention

- Listened to the individual's story and attempted to de-escalate without an emergency intervention
- Assessed the person's willingness/ability to take action in securing their own safety
- Attempted to voluntarily collaborate with the person in crisis to develop a Safety Plan
- Attempted to include the person's wishes
- Exhausted all other intervention options
- Attempted to achieve consent for emergency service intervention

** A person in crisis is determined to be at imminent risk of suicide if the center staff responding believe, based on information gathered, that if no actions are taken, the person in crisis is likely to seriously harm or kill themselves in the very near future. Imminent risk may be determined if an individual states (or is reported to have stated by a third party) both a desire and intent to die with a close temporal connection to their capability of carrying through on their intent.*

Please describe crisis counselor actions with regard to the decision to undertake an emergency service intervention, including supervisory feedback and whether additional training is needed.

Appendix F: Strategies for Outreach and Education to Private and Public Entities

When alternatives to PSAP-related emergency service interventions are unavailable in a Lifeline crisis center's community, crisis centers are required to document strategies for outreach/education efforts to public/private entities to address this need.

Examples of outreach and education for private and public entities to increase access to emergency service intervention alternatives include, but are not limited to:

- Community-based training that includes an overview of the role of your crisis center, areas for collaboration, and opportunities for increasing access to alternatives and increasing access to crisis care continuum services;
- Community-based training or presentations for key stakeholders that participate in decision-making regarding the development of alternatives;
- Culturally sensitive engagement to underrepresented communities; this includes creating and disseminating correspondences in other languages and collaborating to develop/include in crisis center referrals culturally appropriate alternatives to PSAP-related emergency service interventions;
- Participation/organization of panels, webinars, or conferences related to your local service area's crisis care continuum and opportunities to strengthen that continuum;
- Collaborative efforts with state/territory, tribal leadership, community liaisons and cultural brokers to assist with outreach and the development of alternatives for marginalized communities;
- Promotion of the crisis center's work related to its membership in the 988 Lifeline network and the need for alternatives through local media outreach, including newspapers, journals, publications, and radio;
- Legislative and/or municipal meeting requests regarding increased access to alternatives;
- Legislative testimony/education around the need for increased access to alternatives.

Crisis centers can provide documentation that these activities have taken place, such as email exchanges, event flyers, community training outlines, copies of legislative communications, etc.

Appendix G: Third-Party Contact Guidance

In circumstances where a third party is reporting that another individual is at imminent risk of suicide, it is recommended that crisis center staff actively engage the third party to:

- Gather all relevant information available regarding the individual's reported risk status
- Obtain contact information for the person at risk
- Obtain contact information for the third party, as well as information about their relationship to the individual at risk.

There may be times when a third party asks to remain anonymous. It is recommended that anonymity only be supported when:

- Crisis center staff have reason to believe that revealing the identity of the third party to the person at risk might exacerbate risks to either the third party or the person they are concerned about (e.g., a victim of interpersonal violence); or
- The contact information for the third party is reasonably believed to be less relevant than their report of a clear and present risk to the safety of the person they are concerned about (e.g., a stranger reports a person climbing over the rail of a bridge).

Examples of recommended measures that may be undertaken by crisis center staff when working with third parties include, but are not limited to:

- Facilitating a three-way contact with the third party and the person reported to be at risk so that crisis center staff may assess and intervene with the individual directly;
- Facilitating a three-way contact with the third party and the treatment professional to discuss the current situation and potential safety plans (This would only occur if the person at risk is in treatment, unwilling or unable to inform the treating professional of their risk, and the third party has access to the treating professional's contact information, and they agree to a three-way call.);
- Confirming that the third party is willing and able to take reasonable actions to reduce risk to the person, such as:
 - Removing access to lethal means,
 - Maintaining close watch on the person at risk during a manageable time interval between the call/chat/text and the scheduled time when the person is seen by a treatment professional, or
 - Escorting the person at risk to a treatment professional or to a local urgent care facility (e.g., hospital emergency room)
- Obtaining agreement from the third party to collaborate with a mobile crisis/outreach service facilitated by crisis center staff to evaluate the person at risk within a time frame that—in the best judgment of crisis center staff—is reasonable in that it accounts for current level of risk;
- Using information obtained from the third party to contact another third party or the individual at risk directly, in cases where the third party is either unwilling or unable to help directly with the intervention.

Appendix H: Confirming Emergency Service Contact

Steps that can be taken to confirm that emergency service contact was made include, but are not limited to:

- Staying on the line with the contact until the emergency service provider has arrived and their presence is apparent to the crisis center staff;
- Contacting local public safety answering points (or 911 call centers) to determine the pick-up/transport status of the individual at risk (e.g., by using reference or tracking numbers); in instances where emergency services refuse to confirm contact despite a crisis center's best efforts, crisis centers are required to document their efforts to confirm contacts;
- Contacting the emergency room or mobile crisis/outreach staff to determine the status of their contact with the individual at risk (including giving mobile crisis/outreach staff all information collected by crisis center staff regarding the at-risk individual's status);
- Contacting the professional responsible for the care and treatment of the individual at risk;
- Contacting the individual at risk directly to obtain confirmation that they have made contact with the emergency service provider, and/or conducting an assessment of the individual to verify that they are no longer at imminent risk of suicide; or
- Contacting the support person who took responsibility for the safety of the individual at risk.

Examples of recommended procedures to determine contact safety when emergency service contact did not occur include, but are not limited to:

- Contacting the individual at risk to assess their current risk status and continuing need for service linkages;
- Contacting a support person (e.g., friends or family) believed to have potential access to the individual at risk who is willing and able to conduct a safety check;
- Contacting the treatment professional or case worker of the individual at risk to conduct further evaluation and a safety check;
- Providing the individual's contact and address information—to the extent known—to the appropriate mobile crisis/outreach team for follow-up, if one is available in the individual's area; or
- Informing local law enforcement authorities or other appropriate first responders of the situation and requesting continued safety checks until the safety status of the individual at risk can be confirmed (e.g., arrangements or procedures are in place that allow center staff to be notified of the individual's safety status).

Appendix I: Collaboration with Emergency Service Providers

Examples of emergency service providers for collaboration include, but are not limited to:

- Police departments
- Fire departments
- County sheriff offices
- Mobile crisis/psychiatric outreach teams
- Hospital emergency departments
- Public safety answering points or 911 centers
- Emergency medical services (e.g., ambulance/transport services)

Crisis centers are required to establish and maintain formal relationships with PSAPs and mobile crisis teams. Crisis centers may have informal relationships with other emergency service providers.

Examples of formal relationships include, but are not limited to:

- Cooperative agreements
- Memoranda of understanding
- Relationships officially authorized by a local government entity (e.g., city/county health or mental health department)
- Intra-agency policies for collaboration between a center and an emergency service provider housed within the same parent agency