

Lifeline Suicide Safety Policy (2024): Supplemental Guide

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Section 1: Definitions of Key Terms

Active engagement: Intentional behaviors undertaken by crisis counselors to effectively establish a connection with the individual seeking support from the 988 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.

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* 5 minutes or 5-7 messages into the conversation for chat and text). The timing recommended is a general recommendation; ultimately, the goal is to introduce the prompt questions early enough in the conversation to identify any emergent or immediate risks to safety (i.e., attempts in progress) that should be addressed before continuing the crisis conversation.

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 contact 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 contact center staff must actively engage in increasing immediate safety before any emergency service intervention is initiated.]

First responder: A law enforcement officer, firefighter, or emergency medical services provider. *(This term does not include providers of behavioral health related crisis intervention services, such as a co-responder mobile crisis team.)*

Emergency service intervention: Any intervention that involves the request for first responder dispatch.

Imminent risk: An individual is determined to be at imminent risk of suicide (“imminent risk”) if the crisis contact center staff responding to the crisis conversation contact believe, based on information gathered, that there is a close temporal connection (i.e., 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 contact 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 emergency service intervention. This specifically refers to actions taken when an individual is unwilling or unable to collaborate on securing their own safety and crisis contact 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 above). Crisis contact center staff should clearly document efforts to engage the individual in collaborating on a plan for safety before any involuntary 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 contact 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 contact center staff must consider all available alternative resources before requesting the dispatch of emergency services.

Mobile Crisis Response: the provision of behavioral health related crisis intervention services in real time within the community. This could include multidisciplinary response teams (MDRT), co-responder teams, and/or mobile crisis response (MCR).

Psychiatric or Mental Health Advance Directive (PAD): A legal tool that allows a person with mental illness to state their preferences for treatment in advance of a crisis. They can serve as a way to protect a person's autonomy and ability to self-direct care. They are similar to living wills and other medical advance planning documents used in palliative care.

Safety Assessment Model: A framework that brings together the elements of assessment with a focus on conversation flow. This model reinforces the need to ask all individuals about suicide and to assess immediate risk, while remaining firmly committed to the Four Core Principles of Suicide – 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 individual FOLLOW-UP as needed.

Safety Plan: an active and collaborative discussion between a crisis counselor and an individual contacting the 988 Lifeline that aims to provide the individual with a specific set of strategies and resources to use in order to decrease the risk of suicide after the conversation is over and in a future potential crisis. Ideally the completed safety plan is a written document that includes several "key" areas or "elements," including warning signs, coping strategies, distractions, personal supports, professional supports, and a safe environment. When planning for safety, it is essential to work with the individual to identify key areas of the safety plan that are specific to the safety assessment risk elements identified during the crisis conversation.

Supervisor: Crisis contact center staff that regularly act in a managerial or training capacity, who have knowledge of the crisis contact center's most current policies and procedures related to helping contacts at imminent risk of suicide. Such personnel might include crisis contact 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 conversations: 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.

Voluntary emergency service intervention: Action undertaken by crisis contact 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 agreed to the emergency service intervention. In order to be considered voluntary, individuals must have directly requested an emergency service intervention or freely collaborated with crisis contact center staff regarding available interventions, without coercion. In these situations, a crisis contact 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 for attempt in progress). Crisis contact center staff should clearly document efforts to engage the individual in collaborating on a plan for safety before any voluntary intervention is initiated.

Section 2: Ask About Suicide

Lifeline requires that crisis contact center staff ask about suicide and establish immediate safety with ALL individuals. 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?***

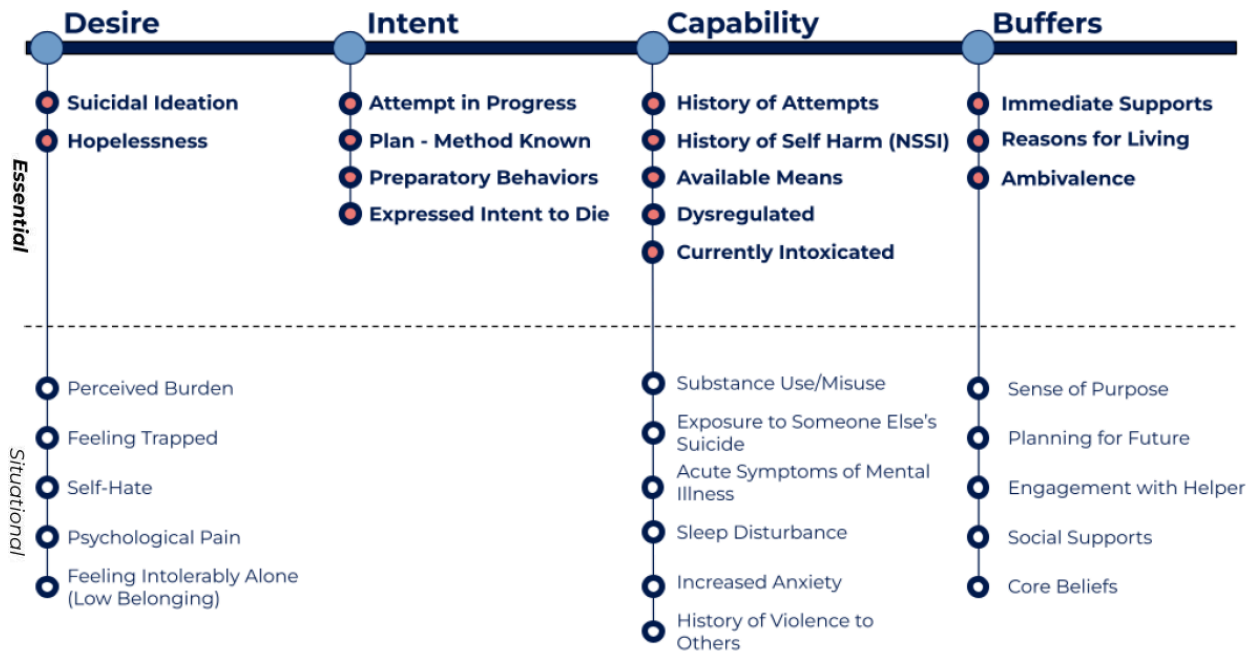
ABOUT THESE QUESTIONS:

- ***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 988 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).

Section 3: Lifeline Four Core Principles of Suicide Assessment



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

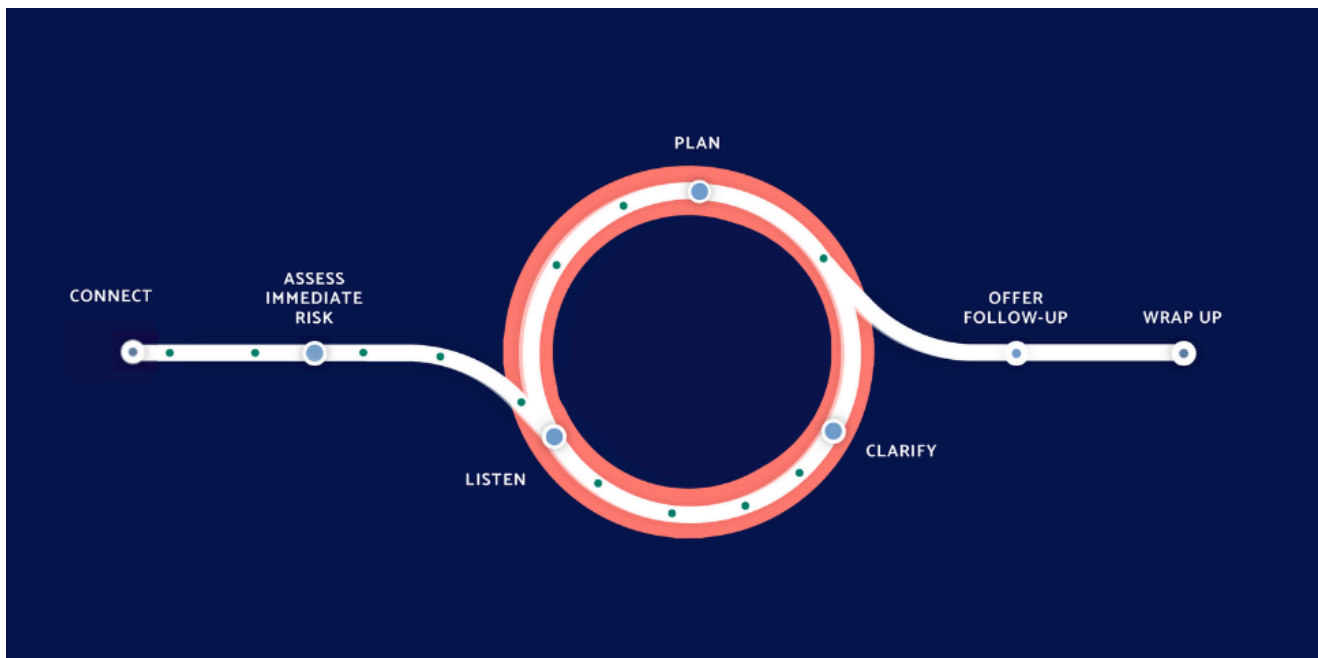
Elements deemed essential by the Lifeline to understanding the degree of risk that is present for a contact are bolded and listed above the dashed line. It is important in any assessment of suicide that crisis counselors address these areas.

Situationally Specific Elements

Situationally specific elements impact suicide risk when present. Though these elements may not be relevant to every conversation, 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.

Section 4: 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 Model 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 understanding of 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.

Section 5: Emergency Service Intervention: Supervisory Review

Supervisory Review Form Template

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 after the interaction has occurred. 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: _____
Record Number/Interaction ID: _____

Start Time of Interaction: _____ AM/PM

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 (*explore the presence of a psychiatric advance directive*)
- 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.

Section 6: Strategies for Outreach and Education to Private and Public Entities

When alternatives to PSAP-related emergency service interventions are unavailable in a Lifeline crisis contact center's community, crisis contact 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 contact 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 contact 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 contact 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 contact centers can provide documentation that these activities have taken place, such as email exchanges, event flyers, community training outlines, copies of legislative communications, etc.

Section 7: 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 contact 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 contact 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 contact 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 contact 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 threeway 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 contact center staff to evaluate the person at risk within a time frame that—in the best judgment of crisis contact 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.

Section 8: 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 contact center staff;
- Contacting local public safety answering points (or 911 call centers) to determine the pickup/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 contact center's best efforts, crisis contact 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 contact 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).

Section 9: 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
- Bureau of Indian Affairs
- Mobile crisis/psychiatric outreach teams
- Hospital emergency departments
- Public safety answering points (PSAPs) or 911 centers
- Emergency medical services (e.g., ambulance/transport services)

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

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

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