Idaho Suicide Prevention Hotline

Analysis of Options for Decision Making

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CHAPTER 1
INTRODUCTION

Hotline Options Report

Acknowledging that suicide is a significant public health concern for Idaho, the State entered into a contract with the Institute of Rural Health at Idaho State University (ISU–IRH) in August 2009 to prepare a report identifying how a hotline could be established and maintained. The goal was to study the benefits of a suicide prevention hotline; examine infrastructure needs; prepare guidance for operator training; and evaluate accreditation standards, operation policies and procedures, sustainability, and marketing. Significant research was required to ascertain the components of a successful hotline, including the collection of new data. Little written data are available regarding Idaho's former hotline, which closed in 2007. Some data used in this report are available from the National Suicide Prevention Lifeline (Lifeline) which has, as a professional courtesy, answered Idaho's calls since the Idaho hotline's closure. While Idaho benefits from the Lifeline services, they are insufficient because national operators report difficulty in identifying resources and referrals for Idaho callers.

National operators report difficulty in identifying resources for Idaho callers

ISU–IRH prepared this *Hotline Options* report to assist Idaho decision makers in understanding why Idaho needs a hotline and in developing a suicide prevention hotline for the state. Funding for this work was provided by the Legislature under the Community Collaboration Grant program with additional support from the Awareness to Action Youth Suicide Prevention Project, Substance Abuse and Mental Health Services Administration. The project is endorsed by the Region IV Mental Health Board and project members worked closely with the Governor's Council on Suicide Prevention, the Suicide Prevention Action Network of Idaho (SPAN Idaho) and the Idaho Department of Health and Welfare Bureau of Vital Records and Health Statistics (IDHW–BVRHS). An Advisory Partnership was created for the project and focused its work with ISU–IRH on sustainability and other future funding issues as well as developing a hotline marketing plan. This *Hotline Options* report addresses potential choices for accredita-

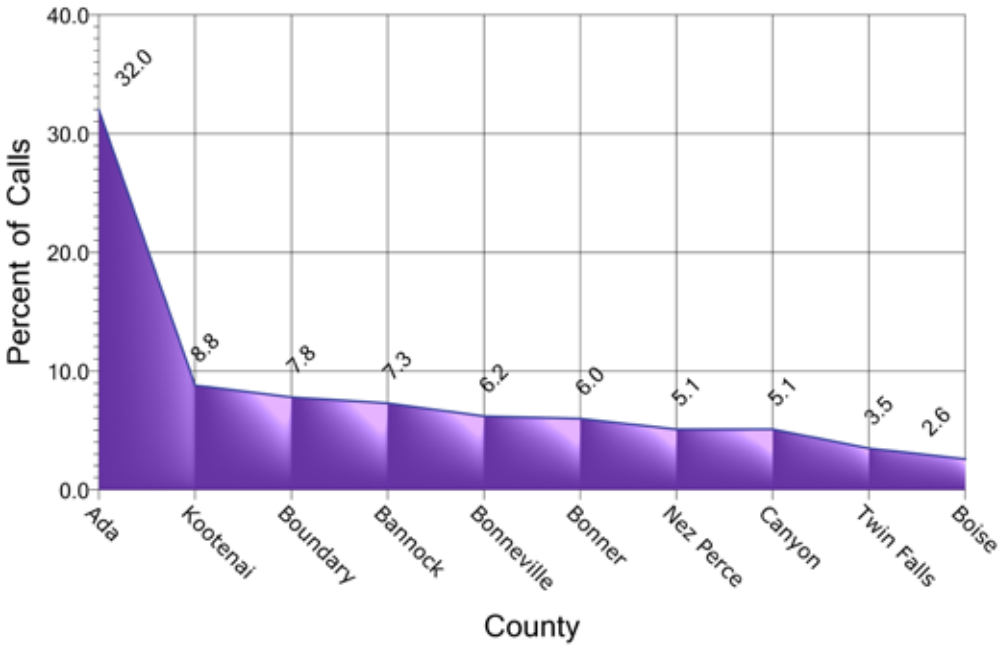
tion/certification, policies, operator training, and locations options for an Idaho hotline. A final chapter provides findings and recommendations for a hotline.

Background

Idaho is the only state in the Nation without its own nationally certified suicide prevention hotline. Small hotlines for domestic violence and other concerns do operate in some Idaho communities, but their operators are not specifically trained in suicide crisis intervention. In addition, there is one small local suicide hotline functioning in Idaho that serves the Wood River Valley. While they offer valuable life-saving services to their communities, the Hailey operation is not part of a national network nor is it accredited, and the hotline is targeted, in large measure, to Southeast and South Central Idaho.

State hotline membership in a national network and national accreditation are indicators that a hotline has met rigid standards of hotline operations such as training and policies. A number of accrediting agencies exist and it is the task of a hotline board to find the accreditation service that best fits its needs. Crucial to the efficient and successful operation of state hotlines is Lifeline, which provides participating members backup for overflow calls, instructions on best practices, risk assessment, and funding resources. As mentioned above, Idaho is the only state in the Nation that is not part of Lifeline. After the closure of Idaho's hotline, Lifeline agreed as

Figure 1: Percent of Idaho Lifeline Calls for Top 10 Counties, 2009



a professional courtesy and at its own expense to accept all of Idaho's calls through its national network of crisis centers. But the Idaho call volume to the Lifeline 1-800 number appears to be increasing. Of the 3,633 calls in 2009, 37% came from Ada and Canyon Counties and another 24% came from Kootenai, Boundary, and Bannock Counties (Lifeline, 2010). Figure 1 shows Lifeline's call volume for the top ten Idaho counties in 2009.

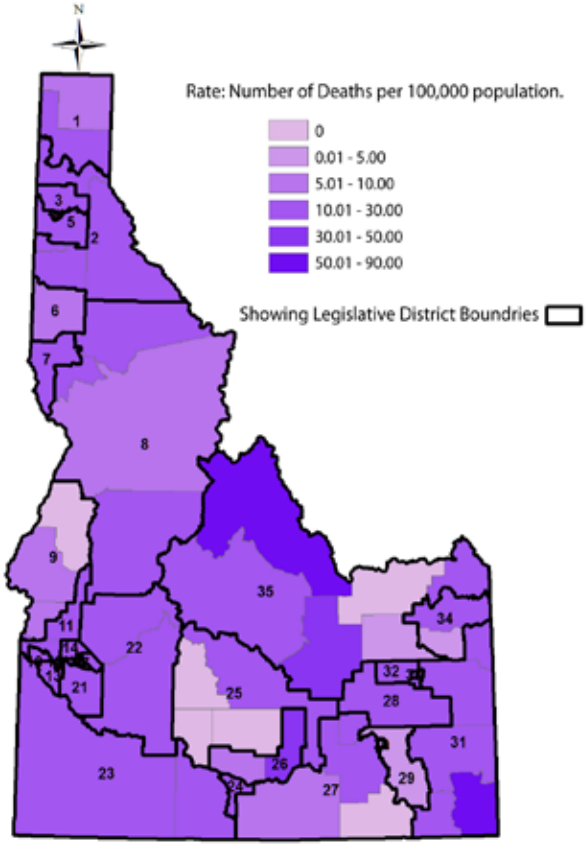
The need for an Idaho hotline has been recognized for many years. In 2007, Idaho's previous hotline was terminated in part due to lack of funding. It utilized local volunteer hours with uncovered time rolling over to Lifeline. Secure and ongoing sources of funding did not materialize, making network membership and accreditation impossible. Since closure of the Idaho line, Lifeline and accrediting bodies have adopted more stringent requirements for network participation, making it more difficult than in 2007 to be nationally certified and accredited.

Idaho's Suicide Rate

Idaho's suicide rates are consistently high

Idaho's suicide rate consistently ranks among states with the highest suicide rates (Idaho Department of Health and Welfare, Bureau of Vital Records and Health Statistics [IDHW–BVRHS], 2006). Nationally, the suicide rate is 11.5 suicides per 100,000 people; Idaho's rate in 2008 was 16.5 per 100,000 people, up from 14.9 in 2007 (Center for Disease Control, National Center for Injury Prevention and Control [CDC-NCIPC], 2010; Suicide Prevention Action Network Idaho [SPAN Idaho], 2010a). This increase could change Idaho's national ranking from 11 to 8 respectively once national rankings for 2008 are completed. The number of suicides in Idaho rose from 258 in 2008 to a preliminary figure of 305 in 2009, a 19 percent increase (K. Anderson, personal communication, 24 February 2010; K. Anderson, personal communication, 8 April 2010). Several Idaho counties have rates far higher than the Nation's average, hitting more than 30 per 100,000 in some areas (IDHW–BVRHS, 2010). Because the population in rural Idaho is low, the total number of suicides also is low. However, suicide rates when compared nationally are very high in rural areas of Idaho. In these rural areas, access to care is limited, especially with recent cuts in spending. The availability of a suicide prevention hotline may be the only mental health service available. Mental illness is the largest risk factor for suicide. Four studies demonstrate that among youth who die by suicide, 82–94 percent had a diagnosable mental illness and/or substance abuse disorder at the time of death (Apter et al., 1993; Shaffer et al., 1996; Marttunen, Aro, Henriksson, & Lönnqvist, 1991; Brent, 1999). Data show that calls pertaining to suicide and substance abuse are frequently made to suicide prevention hotlines as are those involving domestic violence. The following Idaho map illustrates suicide deaths by county in 2008. Superimposed on the map in Figure 2 are numbers designating legislative districts.

Figure 2: Idaho Resident Suicide Deaths by County, 2008



The impact of suicide on economic conditions cannot be understated. The recent national recession has been particularly devastating in Idaho, making the Idaho population more vulnerable to mental illness, substance abuse, domestic violence, and suicide. Some estimates indicate that people who are unemployed are three times more likely to die by suicide than their employed counterparts (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). The national Lifeline data support these conclusions, showing that calls linked to financial concerns increased substantially in 2008, with between 20 to 30 percent of Lifeline calls specifically linked to economic distress. Further, Lifeline reports a total of 51,160 answered calls in April, 2009, (corresponding with the height of the national economic crisis) representing the highest number of answered calls in Lifeline's history. Lifeline likely experienced 727 to 1,090 Idaho suicide calls relating to the economy although no definitive data are available at this time.

In terms of occupation, two important at-risk populations in Idaho are members of the military and farmers/ranchers. In 2007, the most recent year for which data are available, 48 current or former members of the U.S. Armed Forces in Idaho died by suicide, about 22% of Idaho's suicides that year (Idaho Suicide Prevention Research Project [ISPRP], 2009a).

Those involved in farming, forestry, and fishing accounted for 14 suicides in 2007 or 6% (ISPRP, 2009b). Forty-six suicides (21%) in 2007 were by people claiming occupations in precision production, craft, and repair (ISPRP, 2009b). The remaining 40 people, 18% of those who died by suicide, worked in managerial and professional specialty occupations (ISPRP, 2009b).

The Creation of the *Hotline Options* Report

In this report, ISU–IRH recognizes that many conditions are unique and any hotline in Idaho will be required to challenge and overcome them. The Advisory Partnership (members listed below) created as part of this project provided valuable insights into the nature of suicide in Idaho, how to disseminate information about a hotline, and where organizers should look for funding. Additionally, numerous Idaho organizations and agencies supported the ISU–IRH suicide prevention hotline project. These include survivors, mental health consumers, Regional Idaho Mental Health Boards, 2-1-1 Idaho CareLine, Ada County Sheriff, Boise Police Department, the National Alliance on Mental Illness (NAMI) Idaho and NAMI Boise, the Federation of Families, Disability Rights IDAHO, Council on Developmental Disabilities, State Independent Living Council, Council on Suicide Prevention, Suicide Prevention Action Network of Idaho (SPAN Idaho) and Chapters, Idaho Planning Council on Mental Health members, IDHW regional substance abuse/mental health services, Youth Suicide Prevention Advisory Group, IDHW Injury Prevention Program, health educators, Idaho Academy of Family Physicians, Health District Directors, physicians, hospitals, and the Region IV core grant planning group (St. Alphonsus, United Way of Treasure Valley, Office of Consumer Affairs, SPAN Idaho, Veteran's Administration Suicide Prevention coordinator, former hotline director Peter Wollheim, Council on Suicide Prevention, IDHW mental health Region IV, and CareLine).

Idaho conditions are challenging and require unique approaches

Chapter Summaries

Beyond, this "Introduction," the report is divided into nine additional chapters discussing major issues that need to be addressed before a hotline can become operational.

Chapter 2: Background. Provides background on issues pertaining to a hotline in Idaho.

Chapter 3: Data. Reviews the various methods for data collection employed during the creation of this report, along with the results from each of the studies that were conducted.

Chapter 4: Accreditation & Certification. Explores various types of accreditation and the costs/benefits of each. Options for membership in the Lifeline network also are examined.

Chapter 5: Sample Policies. Offers some sample policies and procedures that could guide the management of a hotline and provide operators with steps to follow for each call. This chapter provides information that could form the basis of an Idaho hotline manual.

Chapter 6: Training. Expands on training options for operators. Accredited hotlines that are part of the Lifeline network must provide sufficient training for operators to ensure no harm to callers. The number of hours and nature of the training varies nationwide. This chapter reports on training methods and makes recommendations on the content of any training program in Idaho

Chapter 7: Call Volume & Cost Estimates. Asks a key question regarding where an Idaho hotline could be located. This chapter examines various options and reports on the costs/benefits of each. It also provides the result of an in-state and a national survey of hotline directors to ascertain best practices for operating a hotline and identifies costs of doing so.

Hotline Options explores costs & benefits of various hotline configurations

Chapter 8: Sustainability. Utilizes the feedback of a statewide Advisory Partnership of Idahoans, formed as part of this project, to advise on sustainable funding for an Idaho hotline. This chapter also explores possible long-term funding sources.

Chapter 9: Marketing Plan. Introduces the Advisory Partnership's marketing plan for an Idaho hotline. This chapter explores which groups in Idaho need knowledge about the hotline and the most effective ways to reach them.

Chapter 10: Conclusions and Recommendations. Summarizes the report and offers recommendations on options for pursuing an Idaho hotline and maintaining it in future years.

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CHAPTER 2
BACKGROUND

Because of their unique accessibility, suicide prevention hotlines (from this point forward a suicide prevention hotline will be referred to as a hotline) allow operators to intervene with individuals at various points along the pathway to suicidal behavior, including the moments or hours prior to tragic decisions. The national Substance Abuse and Mental Health Services Administration (SAMHSA) recently sponsored evaluations of crisis hotline processes and outcomes that involved monitoring hotlines and follow-up with callers. These, and other studies examined below, review Idaho's suicide statistics and costs of suicide, current research in hotline effectiveness in meeting the needs of various types of callers, and a hotline's fit in the continuum of mental health and substance abuse care.

Of Idaho's 251 suicides in 2008, 66% involved firearms

Suicide in Idaho

Idaho consistently ranks near the top of states for its rate of suicide (IDHW–BVRHS, 2006). Idaho's suicide rate, at 11th in the nation in 2007, has increased from 14.9 per 100,000 population to 16.5 in 2008 (CDC-NCIPC, 2010; SPAN Idaho, 2010a), which would change Idaho's ranking from 11th to 8th. State by state national rankings have not yet been completed for 2008. However, not only is it important to look at the overall suicide data for the state, but also to review the different populations involved and the methods (means) of suicide. Hotline operators use an assessment of the risk of imminent suicide and access to means in evaluating potential lethality. In Idaho, of the 251 suicides reported in 2008, 66 percent were completed using firearms (SPAN Idaho, 2010a). The next two methods most often used were suffocation and poisoning; together they accounted for another 29.8 percent of Idaho suicides in 2008 (SPAN Idaho, 2010a).

Suicide by Population

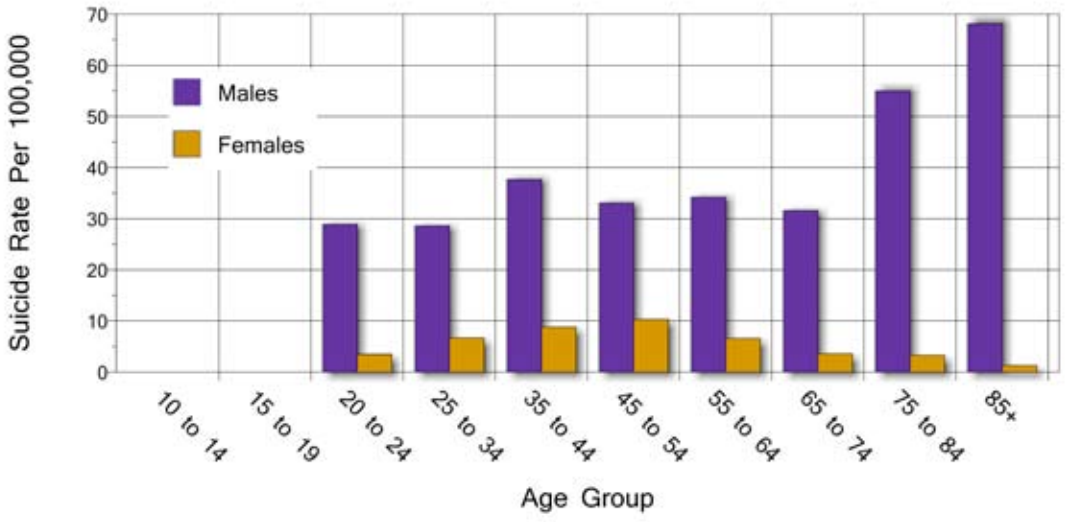
The IDHW–BVRHS reports that suicide is the second leading cause of death among Idaho's 15–34 year olds and third among 10–14 year olds. Among 35–54 year olds it drops to fourth. In calculating rates of suicide in Idaho, non-Native American elderly males have the highest rate. Rates for Native Americans and Alaska Natives are highest among male teens. Suicide is not a single-person risk. Based on 2007–2008 calls to the Institute of Rural Health at Idaho State University (ISU–IRH) Awareness to Action Youth Suicide Prevention Project (AAYSP), multiple suicides ("suicide clusters") have occurred in Idaho communities.

By gender, roughly 84 percent of those who completed suicide in Idaho, 2004–2008, were male and approximately 16 percent were female. Females, however, are believed to have a higher attempt rate. The highest suicide rates are among elderly males 75 and older (81.2 per 100,000). For working age males, age 18–64, the rate is 25.8, and 22.5 for teen males. Among Native American and Alaska Native male teens, age 15–17, the rate is 115 per 100,000, and for age 18–24 it is 88 per 100,000(1992–2001) (SPAN Idaho, 2010b). The overall national rate across populations was 11.5 suicides per 100,000 in 2007 (CDC-NCIPC, 2010).

Rural and Urban Populations

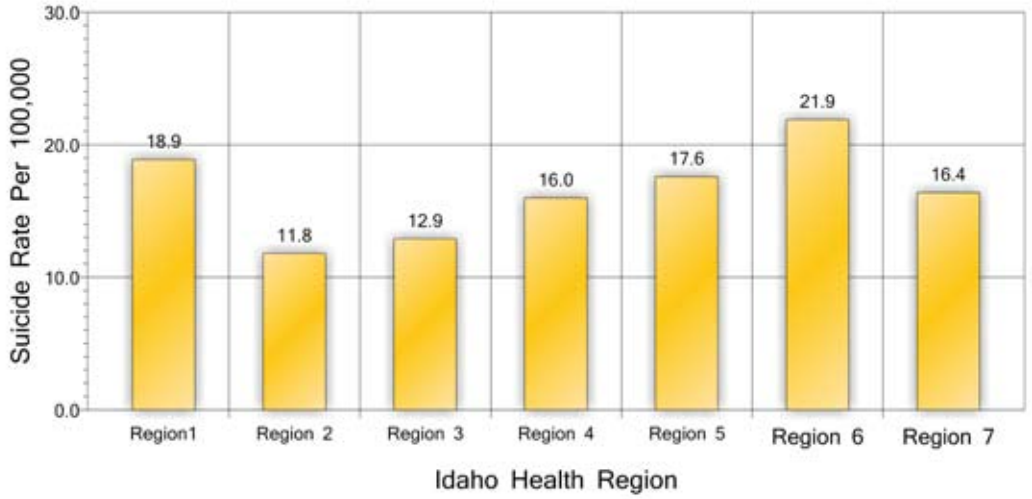
Suicide affects urban and rural Idahoans. Thirty-five of Idaho's 44 counties are designated health professional shortage areas, most of which are rural, with limited healthcare service providers, especially mental health. A health professional shortage area "means any of the following which the Secretary [of the U.S. Department of Health and Human Services] determines has a shortage of health professional(s): (1) An urban or rural

Figure 3: Idaho Suicide Rates by Age and Gender, 2003-2007



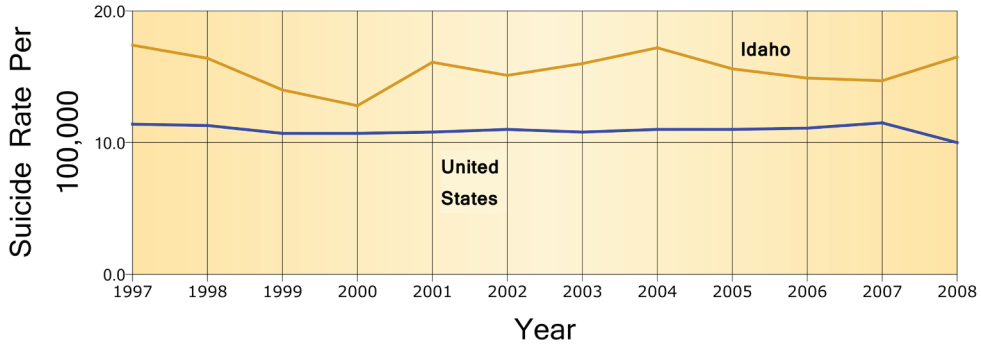
area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility" (U.S. Department of Health and Human Services, 1992). However, access problems exist in urban areas too. The largest number of suicide attempts and completions occur in our urban communities while rates of suicide are highest in rural areas. Counties with the highest average number of suicides from 2004–2008 were the more populated, Ada, Bonneville, Canyon, and Kootenai counties (SPAN Idaho, 2010a). From 2004 through 2008 the counties with the highest average suicide rates were the rural counties of

Figure 4: Idaho Suicide Rate by Region, 2008



Lemhi, Minidoka, Caribou, Custer, Valley, Bonner, Boundary, and Butte (SPAN Idaho, 2010a). According to this report, the largely rural IDHW Regions I and II had Idaho's highest suicide rates in 2004–2008, further illustrating the need for a hotline to provide crisis intervention services to small towns and rural locations. The Figure "Idaho Suicide Rate by Region, 2008," shows the rate of suicides for Idaho and its seven regions/health districts. The suicide rate demonstrates the incidence of suicide in a specific population over a certain time period, in this case the 2008 calendar year, and is shown in terms of number of suicides per a population of 100,000. There are three regions with suicide rates above Idaho's overall rate, representing areas around Coeur d'Alene, Bannock County, and Twin Falls. Another two districts have rates very close to Idaho's overall rate. These are represented in the areas around Bonneville County and Boise (SPAN Idaho, 2010a). As mentioned earlier, all are above the national rate of 11.5 per 100,000 (CDC-NCIPC, 2010). In 2008, Idaho's overall suicide rate was at 16.5 per 100,000 (SPAN Idaho, 2010a).

Figure 5: Suicide Rate per 100,000, US & Idaho 1997-2008



Teens and Suicide

A survey administered by school districts in cooperation with the Idaho Department of Education (IDOE) involves 9th through 12th graders in Idaho schools. The "2009 Idaho Youth Risk Behavior Survey (YRBS): A Healthy Look at Idaho Youth" is based on a survey of 2,164 teens in 53 public high schools across the state (2009). Some survey findings are below.

- Of the high school students reporting about the previous twelve months, 28.5% said that almost every day for two weeks or more they felt so sad or hopeless that they stopped doing some usual activities.
- One in seven high school students and one in four 9th grade females reported seriously considering suicide in the previous 12 months
- During the previous year, 13.3% of high school students reported having actually made a plan about how they would attempt suicide.
- In the previous 12 months, 8.2% of high school females and 5.4% of high school males attempted suicide one or more times.

Farmers experience high stress associated with suicide risk

Suicides by Occupation: Farmers/Ranchers

Due to a variety of factors, farmers and ranchers experience an increased risk of suicide; in fact, male farmers' suicide rates are higher than that of the general population (Benchmark Research & Safety, Inc., 2009). Suicide risk within the farming population does vary by age with older farmers disproportionately more likely to complete suicide than younger farmers (2009). Part of what leads to a higher risk of suicide for farmers is that they are shown to have more serious stressors than the general population (2009). Stressors can include financial problems, immense pressure over losing family farms, social isolation, long hours, high time demands during the growing season, and easy access to various suicide methods (2009). Firearms are the most common method for farmers who die by suicide

(2009). It is important to note the risk factors involved for farmers, as they also have an effect on ranchers. In addition, ranchers tend to report higher stress levels than farmers, which also can play a role in suicide risk (2009).

Suicide Attempts

Information regarding suicide completions provides us with only part of the picture. Information about suicide attempts also is relevant. Research America states that "1.8 million Americans attempt suicide each year" (n.d.). In 2005, there were a total of 174, 861 hospitalized attempts, which means in the United States there were 479 hospitalized attempts every day (Suicide Prevention Resource Center [SPRC], 2008b). Obviously, not all suicide attempts require hospitalization or are brought to the attention of medical personnel. However, of the hospitalized attempts, 60% were females and 40% were males (SPRC, 2008b). Teens are also demonstrating an inclination towards suicide attempts. In the 2009 YRBS, nearly 7 percent of ninth through 12th graders reported attempting suicide in the past year. Of them, two percent reported an attempt that required medical attention (IDE, 2009). The SPRC reports 865 Idahoans were hospitalized due to suicide attempts in Idaho in 2005, averaging 2.4 per day (2008a).

7% of 9th through 12th graders say they attempted suicide in 2009

Suicide and the Economy

The SPRC notes that "widespread increases in unemployment, usually in the context of unstable or declining economic opportunity, are strongly linked with increases in suicide rates" (2008c). General economic circumstances alone are not sufficient to cause a suicide, but the link to unemployment is clear (SPRC, 2008c). The latest published data on U.S. suicide rates pre-dates the current recession, making it impossible to describe a clear correlation between the economy and suicide. However, SPRC concludes that "unemployment is associated with an array of poor health outcomes, including death by nearly all causes" and this includes suicides (2008c).

The link between unemployment and suicide is further examined by the American Association of Suicidology (AAS). According to AAS, there is a clear and direct relationship between rates of unemployment and suicide. The peak rate of suicide in 1933 occurred one year after the total U.S. unemployment rate reached 25% of the labor force (AAS, n.d. a). Similar findings have been documented internationally. At the individual level, unemployed individuals experience between two and four times the suicide rate of the employed. As well, economic strain and personal financial crises have been well documented as some of the multiplicity of risk factors precipitating events in individual deaths by suicide. AAS indicates that stressful life events, financial problems, and other economic factors have a significant impact on individuals vulnerable to suicide where typical coping mechanisms are compromised by the effects of mental disorder,

substance use, acute psychiatric symptoms, and a host of other risk factors associated with suicide. AAS leadership points to the present-day, high rate of home foreclosures as an area of concern as noted below.

> "More than a million people recently have lost their homes, about as many as did in the Great Depression when the population was about half what it is today. For most Americans, our homes are our primary investment and the locus of our identities and social support systems. When combined with the loss of job, home loss has been found to be one of the most common economic strains associated with suicides. In contrast to many other developed nations, the U.S. provides little cushion to buffer these strains—unemployment benefits are generally limited in duration and are considerably less than full pay levels, there is no national health insurance." (AAS, n.d. a)

Economic Costs of Suicide

Costs of suicide have an impact on how communities grow and develop

An Idaho hotline can address not only the human tragedy of suicide but can ease the financial costs of a death as well as offering treatment to suicide attempters. A review of suicide costs was prepared for this report by Neill F. Piland, DrPH. The Centers for Disease Control and Prevention (CDC) report that nationally the average cost per case of suicide is $1 million in lost productivity and $2,596 in medical costs (CDC, 2007). The average cost for a non-fatal self-inflicted injury was $9,726 in lost productivity and $7,234 in medical costs per year. CDC reports that suicide attempters also are more likely to experience a broad range of mental and physical health problems not calculated in the estimates. In Idaho, a state with a relatively small population and many small counties and communities, the economic burden resulting from suicide fatalities and non-fatal attempts is dramatic. It is important to understand that both the medical and foregone productivity costs of suicide continue to accrue over a very long period of time and have an impact on the State's and individual communities' ability to grow and develop. An ongoing economic analysis of suicide in Idaho undertaken by the ISU-IRH estimates that the total annual lifetime medical cost of all suicide fatalities in 2008 was approximately $861,432 and lost productivity costs were $343,595,908 for a total annual lifetime cost of $344,457,340. Non-Fatal attempts added another $52,788,379 to the aggregate medical and lost productivity costs of suicide. Administrative costs (insurance, coroner, funeral, legal, court, etc.) are estimated to add approximately 10.3% more to these figures. Clearly, the economic cost of a suicide and suicide attempts not only negatively impact those people immediately involved, but also the community at large. These costs also illustrate the importance of suicide prevention. Preventing just one suicide avoids approximately $1,372,402 in annual lifetime medical and productivity loss costs alone. Reduction of the long-term economic

burden of suicide through prevention clearly needs to be a major priority and a component of Idaho's economic development as well as its public health planning.

Suicide Protective and Risk Factors

There are various factors involved when looking at a person's risk for suicide. Protective factors may help to reduce an individual's probability of completing suicide while risk factors are those things associated with increased risk of suicide. Protective factors include relationships with family and friends and close ties to a network of community support, such as school or church. One important risk factor is a history of mental health or substance abuse issues. "Multiple studies from the U.S. and Europe show that over 90 percent of people who complete suicide had a pre-existing diagnosable mental health or substance abuse disorder, especially depression" (IDHW, 2007). Other risk factors include a person's exposure to suicide, whether it be one's own attempts, a family member who died by suicide, or media coverage of suicide (IDHW, 2007). An important finding is the role a past suicide attempt plays in the likelihood of the person attempting suicide again, especially when it involves teens. "If a male teen has attempted suicide in the past, he is more than thirty times more likely to complete suicide, while a female with a past attempt has about three times the risk" (IDHW, 2007). Another noticeable risk factor among teens is impulsive or aggressive behavior, "Youth who exhibit impulsive and aggressive behavior are more likely to attempt or complete" a suicide (IDHW, 2007). While not an observable personal factor, the accessibility and availability of firearms also plays a role in a person's ability to complete suicide (IDHW, 2007). The presence of risk factors does not mean that someone will attempt suicide. However, it is important to know these factors as they play a critical role in assessing an individual's suicide risk, especially for hotline operators.

Assessing for risk factors is critical for operators

Hotline Effectiveness and Benefits

A suicide prevention hotline has the potential to mitigate some of the tragedy of suicide. The national studies cited in this section confirm that hotlines are effective in reducing death rates among callers. A number of studies of in-call and post-call measures indicate that interventions reduce suicidal intentions and encourage callers to prepare an action plan for the future. The efficacy of hotlines has been established in several studies. Most people who are suicidal do not want to die, but report being hopeless, in psychological pain, and unable to see other options (AAS, n.d. b; Gould, Kalafat, Munfakh, & Kleinman, 2007). In one study, a significant portion of callers became less distressed, confused, helpless, depressed, and anxious and more hopeful and confident post call (Kalafat, Gould, Munfakh, & Kleinman, 2007; Mishara et al., 2007). Even after some time had passed, callers continued to experience less psychological pain and hopelessness (Gould et al., 2007). Another important part of a call to a hotline is the

process of referrals and the creation of plans of action to guard against future suicidality. Kalafat and colleagues noted that of those callers who created a plan of positive action during their call, 71.8% were working on or had completed their plan on follow up (2007). When Gould and colleagues looked into suicidal caller referrals they found that 35% had followed up on the referral they received from the hotline operator (2007).

The national studies cited above conclude that hotlines are effective in reducing death rates among callers. Around the country, people who call hotlines may be experiencing a number of complicating conditions, including substance abuse, domestic violence, or unemployment, in addition to suicide risk. Because of the lack of Idaho-specific data, national figures were gathered to anticipate what Idaho can expect once a hotline is operating. These data were gathered to offer insight into expected call volumes, the demands on operators, the flow of calls over a 24-hour period, and the ratio of suicide crises and information/referral calls. Idaho and national data were collected and, when not available, statistical models were designed to provide guidance to decision makers. Interviews were conducted with hotline directors from the National Suicide Prevention Lifeline (Lifeline) to provide information on what an Idaho hotline could expect. The directors of Lifeline are part of a network of hotlines in 49 states that are tied together by a 1-800 number. A national study indicates most hotline calls are not from people at risk for suicide but need informational/referral to service. Seven per cent are imminent suicide crises, and 17% are suicidal ideation (Lifeline, 2006). Substance abuse and domestic violence, many with an underlying suicide issue, form major categories for callers. Some data indicate a significant number of domestic violence calls were taken by Idaho's hotline in 2006 (P. Wollheim, personal communication, 2 July, 2008). In other words, a hotline can help to directly save lives but it also serves a much broader range of services and people.

Anonymity for callers lessens stigma

Further benefits include anonymity for callers, the inexpensive nature of phone calls, cultural sensitivity about suicide in the calling area, and protection against the shame and stigma of seeking mental health treatment. These conditions are especially acute in rural areas where access to a free telephone number provides anonymity. Because suicide and mental health conditions remain stigmatized, an anonymous call to a hotline creates an environment where greater self-revelation is possible, including openness of thoughts and feelings (Lester, 2002a). Currently, national hotline operators may not understand cultural issues, such as the rural and frontier nature of Idaho and minority and ethnic groups within the state (Mishara & Daigle as cited in Lester, 2002b). When effective hotline services are not offered, "the individual may proceed to further deterioration and the development of symptomatic behavior such as withdrawal or engaging in destructive behavior such as violence, suicide, or substance abuse" (Williams & Douds, 2002). Access to low-cost telephone service, such as 1-800 numbers, increases use of a hotline, especially for elders, people who have

physical or psychological disabilities, or even for those who leave town periodically but continue to require access (Lester, 2002a). Hotlines can be access points especially for adolescents, people who are isolated, people who are desperate, and those who call one time while in crisis (Williams & Douds, 2002). "Crisis services which operate on a 24-hour basis also permit immediacy and many therapists suggest that their clients use crisis services between therapy sessions should crises occur" (Lester, 2002a).

Hotlines and the Continuum of Care

Because of their unique accessibility, hotlines are available to callers ranging from a person concerned about a loved one to an actively suicidal individual. No matter where a person is located on the continuum of care, a hotline can offer appropriate interventions to avert a suicide attempt. Recently completed SAMHSA-sponsored evaluations of crisis hotline processes and outcomes were used to monitor hotlines and follow-up of callers to hotlines. These evaluations provided overall evidence in support of hotlines' roles in responding to crisis and suicidal callers. A study by Mishara et al., silently monitored 2,611 calls to 14 centers within the Lifeline network. The conclusions were that people in need (crisis and suicide) call the network number; people appear to be helped in a significant number of calls; some lives may have been saved as a result of calling; and specific operator qualities, styles, and behaviors are related to better outcomes (2007). Two independent studies by Gould et al., (2007) and Kalafat et al., (2007) appear to support these findings. Respectively, 1,081 suicidal calls and 1,613 crisis calls were monitored and the callers were contacted three weeks later. The studies found that seriously suicidal individuals do call hotlines, by the end of the call, callers showed a significant reduction on all measures of emotional distress and suicidality, callers experienced continuing significant reductions on all emotional distress (but not all suicidal) symptom indices upon follow-up and during follow-up calls, and approximately 12% of suicidal callers spontaneously reported the call to be lifesaving (Gould et al., 2007). These studies found that specific advantages of a hotline included

Callers have less emotional distress after calls

- Twenty-four-hour access to trained operators (anytime/anywhere, toll-free).
- Anonymity, which helps callers avoid stigma around help-seeking.
- Information and referrals to link callers to help before a suicidal crisis occurs.
- Links to emergency services for an individual at imminent risk that might not otherwise dial 911.
- Local hubs are formed for facilitating ongoing community suicide prevention education and training activities.

Improved Access to Mental Health and Substance Abuse Services

According to a study concerning crisis interventions by phone, key aspects of hotlines make them cost-effective and efficient means of mental health, substance abuse, as well as suicide crisis intervention (Lester, 2002a). A hotline can improve access to mental health and substance abuse services by linking callers to needed care. In 2003, 40% of the calls to the then-existing Idaho hotline were related to substance abuse and domestic violence (P. Wollheim, personal communication, 2 July, 2008). Additionally, a 2006, Lifeline call log report from Idaho's Boys and Girls Town, which handled many of Idaho's calls at that time, noted that 38% of callers reported a history of mental health/substance abuse treatment (23% were unsure and 23% did not answer) (Lifeline, 2006). In a more detailed analysis, Lifeline found that callers reported that mental health/illness prompted their calls 31% of the time and substance abuse 5.6% (Lifeline, 2006). An Idaho hotline could fill a significant gap in the Idaho mental health system, providing immediate response to suicidal individuals who may not seek alternative forms of care for reasons such as remoteness, stigma, or lack of immediate access to mental health care.

Lifeline's Benefits to State Hotlines

Membership in Lifeline provides other important but tangential benefits for state hotlines. Lifeline is an invaluable resource, in particular providing the infrastructure to assist states with overflow calls. Thus Lifeline offers additional operators and is essential to the creation of a failsafe option for Idaho callers. Idaho is the only state without its own Lifeline-affiliated hotline. Although Lifeline-affiliated hotlines have taken over the Idaho calls since the closure of Idaho's hotline in 2007, the number of calls from Idaho is surpassing previous years. Lifeline has expressed the need for Idaho to establish an evidence-informed hotline and officially join the network of operators. One reason for this is that Lifeline indicates that a barrier exists in regard to their ability to properly handle Idaho's calls, which often require referrals to mental health or substance abuse treatment services, local services unfamiliar to out-of-state operators. In addition, network membership brings with it access to federal funds for hotline research, development, and operations. For example, in January 2010, Lifeline received supplemental funding from SAMHSA to offer $26,000–$50,000 stipends to member hotlines experiencing significant strain because of economic conditions (SAMHSA, 2010a).

A hotline can improve access to mental health and substance use care

A Hotline's Role in a Statewide Mental Health System

Suicide hotlines can have a variety of structures including local or county level, statewide, national, or university-based organization, but little is known about the structural demands of each setting. A report by the West-

ern Interstate Commission on Higher Education (WICHE) to the Idaho Legislature in 2008 addressed various issues relating to suicide hotlines. First, WICHE recommended revising statutory requirements for evaluations in instances of involuntary commitment. This was intended to ensure that the necessary services are provided at a local level. Comments from Lifeline indicate that they support this model (L. Bernik, personal communication, 11 February 2010). Second, WICHE recommended that a statewide regional system should allow a services package to be offered within each region. Michigan, for example, has an overall system that specifically includes "24-hour, 7-day per week, crisis emergency service that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions" (WICHE, 2008). An Idaho hotline could provide a similar services package of support for minimal cost. WICHE also addressed inpatient hospitalization and the cost of community care. Crisis hotlines can significantly reduce costs by decreasing unnecessary hospitalizations and linking individuals in need to appropriate, community-based services (L. Bernik, personal communication, 11 February 2010).

Conclusion

Nationally, hotlines have been shown to effectively reduce a caller's probability of committing suicide. In fact approximately 12% of the callers in one study spontaneously said that their call to the hotline stopped them from attempting suicide (Gould et al., 2007). Hotlines can also be an important tool for assisting callers in finding resources to assist them in overcoming those factors that first led them to think about suicide. Many people in Idaho already recognize the benefit that hotlines can have in preventing suicide as demonstrated by the fact that 3,633 calls were made to Lifeline from Idaho residents in 2009 (Lifeline, 2010). The creation of local hotline would help to further assist Idaho callers by providing them with access to local knowledge and referrals which is harder for Lifeline to provide.

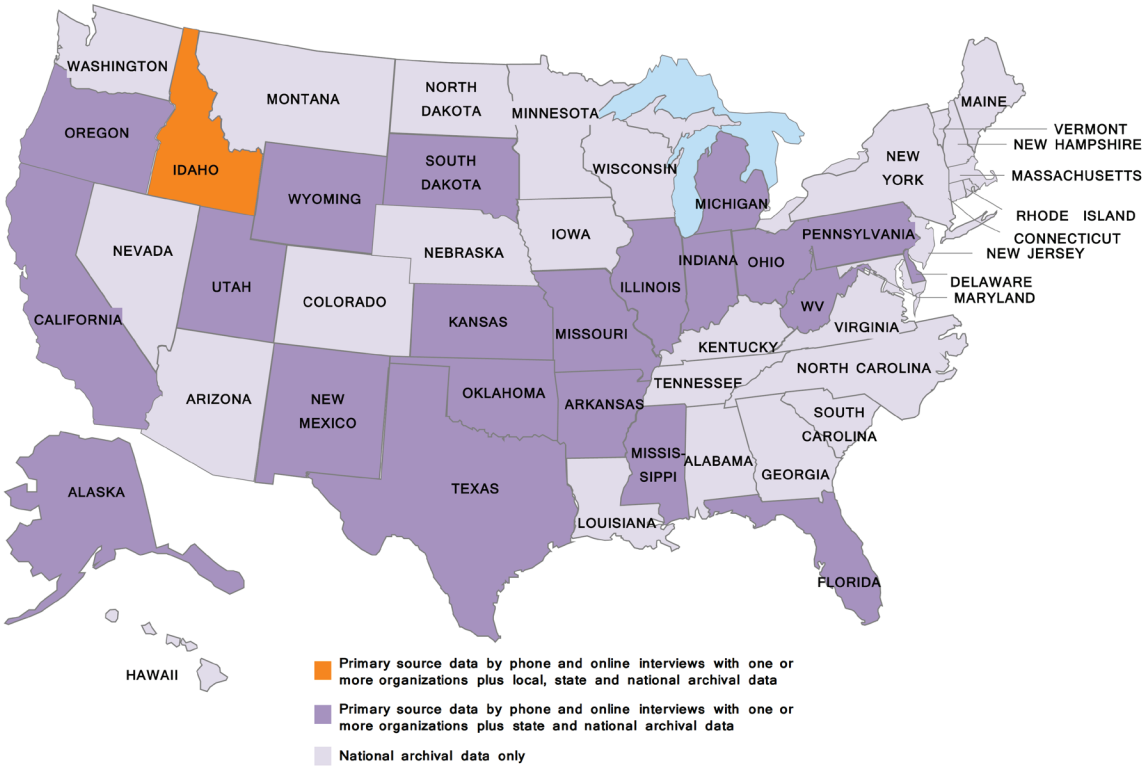
The statistics discussed in this chapter demonstrate the suicide continues to be an important issue in Idaho. Suicide prevention has no "one size fits all" solution therefore it is necessary to use a variety of different methods in the effort to lower both suicide numbers and rates. Projects like gatekeeper trainings and student screenings for suicide demonstrate some of the methods that can be used, and this report focuses on yet another method that will assist in the prevention of suicide. The implementation of a statewide hotline would provide another resource for those who are thinking about attempting suicide and for those concerned about someone they think may attempt suicide.

CHAPTER 3
DATA

Introduction

This chapter contains information about the thirteen separate studies that were conducted to complete this *Hotline Options* report. These studies include key informant interviews, archival data collection, epidemiology work, and training simulations. Data were collected in Idaho as well as across the nation. The map below shows the locations and types of data collected.

Figure 6: Types of Data Collected by Location



Organization of Chapter

In this chapter each study is presented separately. In some cases, such as the analysis of accreditation options, the study is only briefly reviewed here because it is presented in detail in a specific chapter. In other cases the majority of information is contained in this chapter and mentioned in other chapters as the results applied. For example, data collected about types of calls made to hotlines is presented here and in the training chapter.

For ease of use, each study is presented using the same outline format. The summary of key findings is presented at the beginning of each study and is followed by more detailed information. This is the format used:

1. Title of Study
2. Purpose of study including the question of interest
3. Summary of Key Findings
4. Procedures
    a. Data collection
    b. Data analysis
5. Results and discussion

Summary of Studies and Data Sources

Summary of Studies Conducted

Thirteen separate studies were conducted in the course of completing this report. The studies used key informant interviews, survey methods, policy analysis, content analysis, and economic analysis. Table 1 provides an orientation to the studies conducted. They are presented in the order of use for the larger project. The table provides study titles, an overview of the types of data used in the study and a cross reference to the chapters where the study figures prominently.

Data Sources

Multiple types of data were collected. Archival and primary data were used. Some data were collected using surveys and key informant interviews specifically for this project (primary data). Other data were collected from archival sources, such as U. S. Census Bureau data, to be used for this project. Table 2 gives the name of the data set, the type of data (primary or archival), location and coverage area where the data are reflected and, as best as possible, a web address for the data. In many cases the data were drawn from the particular location and combined with other data to create the databases on which the analyses were conducted.

Table 1: Studies by Name and Type of Data

Study Number	Study Name	Abbreviated Study Name	Type of Data Collection	Other Chapters
1	Highest 15 State Suicide Rates Per 100,000 People in the United States	Highest 15	Archival	
2	Analysis of Accreditation Criteria for Suicide Prevention Hotlines in the United States	Accreditation Analysis	Archival and primary phone and online	Chapter 4
3	Review of Policies For Suicide Prevention Hotlines	Policy Review	Archival and primary phone and online	Chapter 5
4	Analysis of Training Curricula for Suicide Prevention Hotline Operators	Curricula Analysis	Archival and primary phone and online	Chapter 6
5	The Use of Scripted Mock Phone Calls in the Quality of Training for Suicide Prevention Hotline Operators	Training Simulation	Primary Face-to-Face Simulations	Chapter 6
6	Key Informant Interviews with Key Decision Makers About Housing a Suicide Prevention Hotline in Idaho	Instate Key Informants	Primary phone and online	Chapter 7
7	National 2-1-1 Directors Phone-based Key Informant Interviews	2-1-1 Study	Primary Source Phone	Chapter 7
8	National Survey of Directors of Accredited Suicide Prevention Hotlines in the United States	Director Study	Primary Source Online	Chapter 6 & 7
9	Interpolation and Extrapolation of Call Volume for an Idaho Suicide Prevention Hotline	Call Volume Estimate Study	Epidemiological and Demographic Archival Data	Chapter 7
10	Estimating Costs for an Idaho Suicide Prevention Hotline	Cost Estimation Study	Epidemiological and Demographic Archival Data, primary phone and online	Chapter 7
11	The Economic Cost of Suicide in Idaho and the United States	Economics Study	Epidemiological and Demographic Archival Data	Chapter 2
12	Review of a Suicide Prevention Hotline Sustainability Sources	Sustainability Review	Advisory Partners, Key Informant Interviews, Archival Data	Chapter 8
13	A Marketing Plan for an Idaho Suicide Prevention Hotline	Marketing Review	Advisory Partners, Key Informant Interviews, Archival Data	Chapter 9

STUDY 1: Highest 15 State Suicide Rates Per 100,000 People in the United States

Study Purpose

The purpose of this study was to compare Idaho to all other states and to other states with similar suicide rates. The question of interest was whether there was a relationship between state population size and a variety of economic and demographic issues. A key question was whether or not the state infrastructure that could address suicide prevention was related to suicide rates. The most recent data for state-by-state comparisons is 2007. Idaho's suicide rate in 2008 was 16.5, up from 14.9 in 2007, where comparisons to other states can be made. (SPAN Idaho, 2010a; CDC-NCIPC, 2010) In 2007, the year that state-by-state comparison data are availble for, Idaho had 223 deaths. In-state data show that 251 deaths occured in 2008. Eighteen more people committed suicide in 2008 than 2007.

Table 2: Summary of Data Sources in Alphabetical Order			
Data Sources	**Type of Data**	**Data Coverage**	**URL**
Boise City Police Department	Archival	Local	http://idahosuicide.info
Center for Disease Prevention and Control Web-based Injury Statistics Query and Reporting System (CDC WISQRS)	Archival	Idaho and National	www.cdc.gov/injury/wisqars/
Department of Health and Welfare Bureau of Vital Records and Health Statistics	Fact sheets	Idaho	www.healthandwelfare.idaho.gov
Existing help/hotline/emergency lines in Idaho	Phone interviews, email	Idaho	n/a
Healthcare Utilization Project (HCUP), Agency for Health Research and Quality	Archival	National	www.ahrq.gov/data/hcup
Hotline Executive Directors	Online survey	National	n/a
Idaho Suicide Prevention Research Project	Archival	Idaho	http://idahosuicide.info
Idaho Youth Suicide Prevention Awareness to Action Project (AAYSP)	Project evaluation data	Idaho	www.isu.edu/irh/projects/ysp
MACRO, International National, Garret Lee Smith Memorial Act Program	Cross-site evaluation data	Idaho and National	www.macrointernational.com
Medical Expenditure Panel Survey (MEPS) Agency for Health Care Research and Quality	Archival	National	www.meps.ahrq.gov/mepsweb
National Suicide Prevention Lifeline (Lifeline)	Personal Communication	National	www.suicidepreventionlifeline.org
RTI, International	Archival	National	www.rti.org
Scientific Literature Review	Archival	National	www.ncbi.nlm.nih.gov/pubmed, www.apa.org/psycinfo and others
SPAN Idaho	Fact Sheets	Idaho	www.spanidaho.org/docs/factsheet.pdf
Suicide Prevention Resource Center	Personal Communication	National	www.sprc.org
Training Simulations	Primary Research Data	Idaho	
U.S. Census Bureau	Archival	National	www.census.gov
Web Literature Review	Archival	National	various

Summary of Key Findings

Idaho's suicide rate is among the highest in the nation. In 2008, it was 16.5, up from 14.9 in 2007.

1. Only 4 states ranked worse than Idaho on a national index of suicide and depression.
2. Ten of the states with the 15 highest suicide rates are in the western United States.
3. The states with the 15 highest suicide rates are largely rural. Larger metropolitan populations are related to lower suicide rates.
4. The total number of deaths by suicide is qualitatively different for states based on their population regardless of their suicide rate. Smaller population states may have higher rates of suicide but fewer overall deaths. A larger number of deaths by suicide can seem like a greater problem from the perspective of gathering attention to suicide prevention.

5. States with higher per capita income have lower suicide rates.
6. Larger overall per capita state spending is not related to suicide deaths but it is unclear how spending on suicide-related infrastructure is related to suicide rates. There is insufficient data to draw any conclusions.

Procedures

Data Collection

Data were collected from archives at the U.S. Census Bureau and the Kaiser State Health Facts and databases (Kaiser State Health Facts, 2009a; Kaiser State Health Facts 2009b; McIntosh, 2010; U.S. Census Bureau, 2009). The data were combined into a single database. Calculations to equilibrate the data across states were done (e.g., ranks and per capita measures were created from totals). The variables included rural/urban status, total state spending, per capita income, unemployment, poverty, and additional information was drawn from a report commissioned by Mental Health of America that created a national index of suicide and depression combined (Mark, Shern, Bagalman & Cao, 2007).

Data Analysis

Data were analyzed using Pearson product-moment correlation coefficient (r correlation), linear regressing, and mapping. The depression and suicide index from Mark and colleagues (2007) is an index created using a combination of a state's suicide rates as well as that state's depression rate .

10 of the top states for suicide rates are in the West

Results

There are 16 states ranked in the top 15 for suicide rates. Utah and Vermont are both ranked at 15 having equal suicide rates per 100,000 people. Idaho consistently ranks in the top 15, often in the top 10, suicide rates nationally. In the most recent suicide rate information, 2007, Idaho is ranked the 11th in highest suicide rate in the nation. Idaho's suicide rate has increased from 2007 to 2008 from 14.9 to 16.5 which could change Idaho's rank from 11th to 8th.

Four of Idaho's five neighboring states, Wyoming, Utah, Montana, and Oregon are also in the top 15 for rates of suicide. Washington is ranked at the 23rd highest rate of suicide.

When ranked on a suicide and depression index (Mark, et al, 2007), Idaho was the 4th worst state in the nation. Idaho ranked at the bottom of the nation at 46th place. As with the suicide rate, some states were tied in their rank. The 4 bottom ranks included 5 states. Only Alaska, Nevada, New Mexico, Montana, and Wyoming fared worse than Idaho.

Geographic Variables and Suicide Rates

Location, overall population and rural/urban distribution were examined in relation to suicide deaths, rates per 100,000 and ranks (see also Figure 7 and Figure 8). States with larger metropolitan populations had lower suicide rates per 100,000 ($r = -.56$; $p < .001$). The states in the top 15 suicide rates are largely rural states and have higher suicide rates.

Perception of the Seriousness of Suicide as a Problem

Death by suicide is a low incidence but high impact health concern. Because the total number of people who die by suicide can be quite small, it may be difficult to convey the seriousness of the problem. When the total number of people who die by suicide is small, the problem can be perceived as small. It is not. Research has indicated that there are approximately 6 survivors for every suicide (AAS, 2009). Firm numbers of suicide attempts are not available.

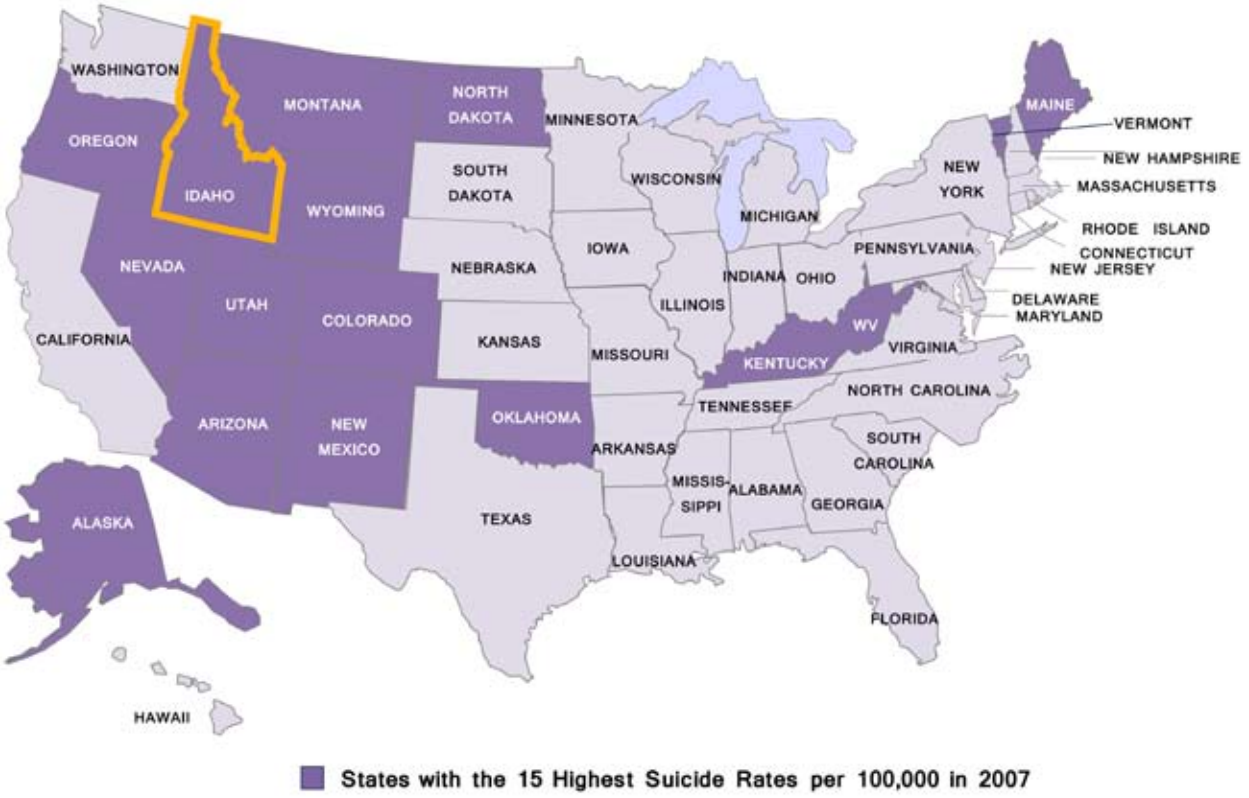
The raw count of people who die by suicide is not typically examined. Yet, there is an important point that should be seen. Larger numbers of suicide may not mean higher rates of suicide. For example, in Wyoming in 2007, 101 people died of suicide. Wyoming has the 4th highest rate of suicide in

Table 3: States with the Highest Ranks for Death by Suicide per 100,000 People and Lowest Ranks on an Index of Suicide and Depression Based on the Most Current State-by-State Comparison Data (2007)

State	Highest Suicide Rank	Poorest Rank on Suicide and Depression Index
Alaska	1st	51st
Montana	2nd	48th
New Mexico	3rd	49th
Wyoming	4th	47th
Nevada	5th	50th
Colorado	6th	44th
West Virginia	7th	42nd
Arizona	8th	43rd
Oregon	9th	41st
Kentucky	10th	34th
Idaho[1]	11th	46th
North Dakota	12th	20th
Oklahoma	13th	39th
Maine	14th	31st
Utah	15th	45th
Vermont	15th	38th

[1]Idaho's suicide rate has increased from 2007 to 2008 from 14.9 to 16.5, which could change Idaho's rank from 11th to 8th.

Figure 7: Map of the States in the Top Fifteen Ranks for Death by Suicide per 100,000 People



the nation but it has a small population. Two thousand four hundred and thirty three (2,433) people died in Texas in that same year. Texas' suicide rate is one of the lowest in the nation ranked at 41st. Texas has a large population.

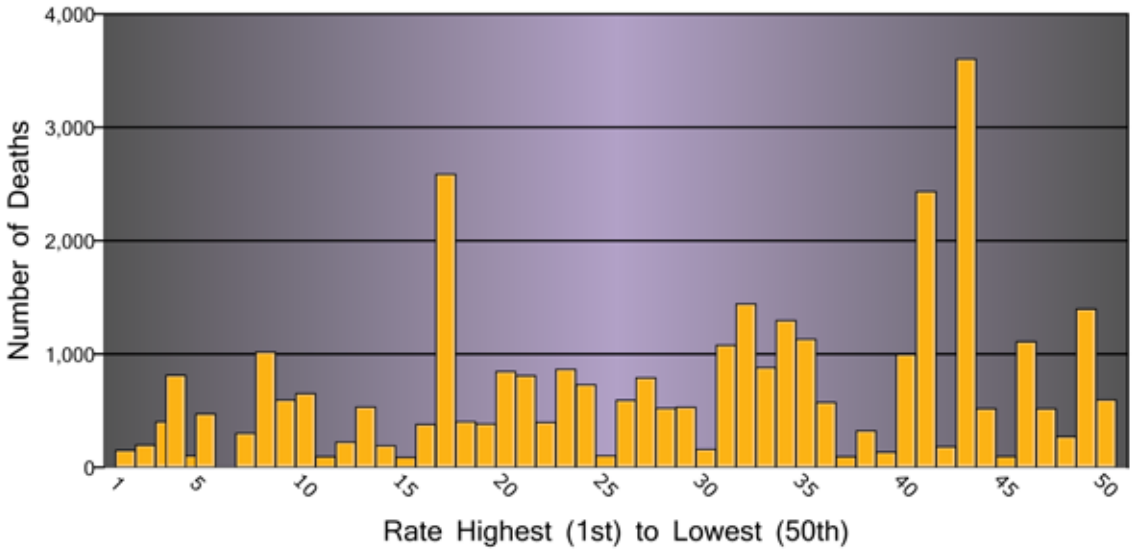
Larger numbers of overall suicide deaths, even if the death rate per 100,000 is smaller may make the problem appear differently in the public perception. The graphic below illustrates the relative positions of total deaths and the suicide rate.

Correlations Between the Demographic Variables of Income and State Per Capita Spending

Significant correlations also were observed between suicide rate and individual per capita income. States with higher per capita incomes had lower suicide rates ($r = -.535$; $p<.001$, $n=51$).

The states with the highest suicide rates also are smaller, less wealthy states. Individual income relates to state budgets because much of the income for state budgets is generated from taxes on citizenry. To examine this, and explore whether state infrastructure was in some way related to suicide rates, research was conducted to identify comparable data across states by category of spending. Very little data were available to address this question.

Figure 8: Total Deaths per State by Suicide Compared to Suicide Rank



Two variables were considered, first, the overall state spending per capita. The second variable considered was the state per capita spending on State Mental Health Programs (SMHP). Neither was related to suicide rate. This is not sufficient to answer the question. More specific data are needed but are not available. For example, total state spending is available divided into types of comparative categories, such as by education, public assistance, Medicaid, corrections, and transportation. However, in this comparison states are instructed not to include administrative costs in their estimates (Kaiser State Health Facts, 2008).

STUDY 2: Analysis of Accreditation Criteria for Suicide Prevention Hotlines in the United States

Study Purpose

The purpose of this study was to identify potential accreditation organizations, compare their requirements, and identify two options that could best work for Idaho.

Summary of Key Findings

1. Accreditation is a voluntary process of standardization verifying that a suicide prevention hotline has met the field's agreed upon standards of care and best practices.
2. Accredititation is granted by an agency recognized and maintained by peer professionals.
3. Accreditation is conducted by site reviewers and through site visits. Meeting these examiners requests takes time and resources on the part of the agency seeking accreditation.

4. Two accreditation options are the AAS and Contact USA (CUSA).
5. Accredited suicide prevention hotlines can belong to Lifeline, which provides back-up for 24/7 coverage and coverage of special needs such as language translation and disability access, in addition to acces to grants.

Procedures

Data Collection

Data were collected directly from the accrediting bodies. Data were also collected from discussions with organizations that do accreditation and those that have been through the process of accreditation.

Data Analysis

Data were analyzed using qualitative and policy analytic techniques.

Results

The results of this study are reported extensively in *Chapter 4: Accreditation.* The summary of the accreditation options is also provided here.

STUDY 3: Review of Policies for Suicide Prevention Hotlines

Study Purpose

The purpose of this study was to identify policy issues that should be addressed by any hotline policy protocol. The secondary purpose was to identify various operating hotlines' responses to policy issues.

Summary of Key Findings

1. Having specific, well laid-out policy provides a framework for training.
2. Clear policy should reduce liability.
3. Clear policy helps operators and other staff feel more confident in knowing what they can do and what is expected of them.
4. There are several instances where policy choices are not clear. Organizations must select an option and clearly state the option the organization has chosen.
5. The views and perspectives on confidentiality often drive the entire policy for an organization.

Table 4: Suicide Demographics by State in Alphabetical Order

State	Suicide Rank 2007	Deaths by Suicide Per Year 2007	Suicide Rate Per 100 Thousand 2007	%Metro-politan 2008	% Non Metro-politan 2008	Total State Spending in Millions 2008	Per Capita State Spending 2008	Per Capita State Spending Rank 2008	SMHA Per Capita Spending 2008	SMHA Per Capita Spending Rank 2008	Per Capita Income 2007	Per Capita Income Rank 2007	Unemploy-ment Rate 2010	Poverty Rate 2007-2008
Alabama	25	592	12.8	73%	27%	$40,159	$8,586	6	$64	39	$32,404	42	11.0%	14.3%
Alaska	1	149	21.8	69%	31%	$12,322	$17,907	1	$279	3	$40,352	15	8.6%	8.2%
Arizona	8	1,016	16	88%	12%	$24,721	$3,804	42	$157	8	$33,029	40	9.6%	18.0%
Arkansas	17	402	14.2	64%	36%	$16,899	$5,893	16	$39	48	$30,060	48	7.8%	15.3%
California	43	3,602	9.9	98%	2%	$194,276	$5,311	24	$123	16	$41,571	7	12.6%	14.6%
Colorado	6	811	16.7	87%	13%	$25,129	$5,092	27	$72	35	$41,042	10	7.9%	11.0%
Connecticut	48	271	7.7	95%	5%	$24,536	$7,004	9	$170	7	$54,117	1	9.2%	8.1%
Delaware	36	95	11	79%	21%	$8,621	$9,839	3	$104	21	$40,608	12	9.2%	9.6%
Dist. of Columbia	51		6.1	100%	0%	n/a	$8,295	51	$394	1	$61,092	(1)	11.6%	16.5%
Florida	17	2,587	14.2	95%	5%	$64,379	$3,494	49	$38	49	$38,444	20	12.3%	13.1%
Georgia	39	997	10.4	86%	14%	$36,762	$3,791	44	$61	41	$33,457	38	10.6%	15.5%
Hawaii	39	133	10.4	71%	29%	$11,160	$8,668	5	$136	13	$39,239	18	6.9%	9.9%
Idaho	11	223	14.9	63%	37%	$5,930	$3,882	41	$46	47	$31,197	44	9.4%	12.2%
Illinois	46	1,108	8.6	89%	11%	$46,877	$3,650	45	$83	30	$40,322	16	11.5%	12.3%
Indiana	27	790	12.5	72%	28%	$24,239	$3,794	43	$88	28	$33,616	37	9.9%	14.3%
Iowa	38	322	10.8	58%	42%	$16,129	$5,387	22	$101	23	$35,023	27	6.8%	9.5%
Kansas	19	382	13.8	64%	36%	$12,689	$4,536	35	$91	26	$36,768	22	6.5%	12.7%
Kentucky	10	649	15.3	50%	50%	$22,995	$5,363	23	$49	45	$31,111	46	10.7%	17.1%
Louisiana	28	522	12.2	85%	15%	$29,995	$6,738	11	$61	42	$34,756	31	6.9%	18.2%
Maine	14	191	14.5	51%	49%	$7,427	$5,628	17	$354	2	$33,722	35	8.2%	12.0%
Maryland	44	518	9.2	96%	4%	$29,798	$5,266	26	$145	10	$46,021	5	7.7%	8.7%
Massachusetts	47	516	8	98%	2%	$44,146	$6,746	10	$112	18	$49,082	3	9.3%	11.3%
Michigan	35	1,131	11.2	85%	15%	$43,982	$4,397	38	$100	24	$35,086	26	14.1%	13.0%
Minnesota	36	572	11	72%	28%	$28,446	$5,438	21	$140	12	$41,034	11	7.4%	9.9%
Mississippi	22	396	13.6	42%	58%	$15,599	$5,305	25	$110	19	$28,845	50	11.5%	18.1%
Missouri	20	808	13.7	77%	23%	$21,179	$3,556	47	$75	32	$34,389	32	9.5%	13.3%

Table 4: Suicide Demographics by State in Alphabetical Order, cont.

State	Suicide Rank 2007	Deaths by Suicide Per Year 2007	Suicide Rate Per 100 Thousand 2007	% Metro-politan 2008	% Non Metro-politan 2008	Total State Spending in Millions 2008	Per Capita State Spending 2008	Per Capita State Spending Rank 2008	SMHA Per Capita Spending 2008	SMHA Per Capita Spending Rank 2008	Per Capita Income 2007	Per Capita Income Rank 2007	Unemploy-ment Rate 2010	Poverty Rate 2007-2008
Montana	2	196	20.5	33%	67%	$4,477	$4,625	32	$146	9	$32,458	41	7.1%	12.9%
Nebraska	41	181	10.2	62%	38%	$8,712	$4,889	29	$62	40	$36,471	24	5.0%	10.6%
Nevada	5	471	18.4	90%	10%	$9,240	$3,532	48	$61	43	$40,480	13	13.4%	10.8%
New Hampshire	29	158	12	62%	38%	$4,806	$3,636	46	$127	14	$41,512	8	7.0%	7.0%
New Jersey	50	596	6.9	100%	0%	$48,704	$5,622	18	$143	11	$49,194	2	9.8%	9.2%
New Mexico	3	401	20.4	68%	32%	$14,790	$7,444	8	$26	51	$31,474	43	8.8%	19.3%
New York	49	1,396	7.2	91%	9%	$116,056	$5,961	15	$213	4	$47,385	4	8.6%	14.2%
North Carolina	31	1,077	11.9	66%	34%	$41,587	$4,497	37	$126	15	$33,636	36	11.1%	13.9%
North Dakota	11	95	14.9	48%	52%	$3,597	$5,608	19	$72	34	$34,846	29	4.0%	11.8%
Ohio	34	1,295	11.3	77%	23%	$56,763	$4,924	28	$68	37	$34,874	28	11.0%	13.7%
Oklahoma	13	531	14.7	68%	32%	$19,962	$5,478	20	$49	46	$34,153	33	6.6%	13.6%
Oregon	9	594	15.9	75%	25%	$22,644	$5,986	14	$117	17	$34,784	30	10.6%	10.6%
Pennsylvania	32	1,441	11.6	82%	18%	$58,696	$4,671	31	$209	5	$38,788	19	9.0%	11.0%
Rhode Island	45	96	9.1	100%	0%	$7,097	$6,737	12	$102	22	$39,463	17	12.6%	12.7%
South Carolina	29	530	12	67%	33%	$20,787	$4,616	33	$66	38	$31,013	47	12.2%	14.0%
South Dakota	25	102	12.8	50%	50%	$3,150	$3,915	40	$74	33	$33,905	34	4.8%	13.1%
Tennessee	20	844	13.7	75%	25%	$26,324	$4,218	39	$88	29	$33,280	39	10.6%	15.0%
Texas	41	2,433	10.2	89%	11%	$82,156	$3,380	50	$35	50	$37,187	21	8.2%	15.9%
Utah	15	378	14.3	78%	22%	$12,420	$4,554	34	$58	44	$31,189	45	7.2%	7.6%
Vermont	15	89	14.3	31%	69%	$5,308	$8,547	7	$198	6	$36,670	23	6.5%	9.0%
Virginia	33	880	11.4	85%	15%	$35,330	$4,532	36	$82	31	$41,347	9	7.4%	10.3%
Washington	23	865	13.4	92%	8%	$31,732	$4,833	30	$99	25	$38,414	14	9.5%	10.4%
West Virginia	7	300	16.6	57%	43%	$18,710	$10,309	2	$71	36	$29,537	49	9.5%	14.5%
Wisconsin	24	729	13	76%	24%	$36,091	$6,413	13	$108	20	$36,047	25	8.8%	9.8%
Wyoming	4	101	19.3	30%	70%	$4,958	$9,302	4	$89	27	$43,226	6	7.3%	10.1%

Table 5: Suicide Demographics by State in Rank Order Highest to Lowest Suicide Rates

State	Suicide Rank 2007	Deaths by Suicide Per Year 2007	Suicide Rate Per 100 Thousand 2007	% Metro-politan 2008	% Non Metro-politan 2008	Total State Spending in Millions 2008	Per Capita State Spending 2008	Per Capita State Spending Rank 2008	SMHA Per Capita Spending 2008	SMHA Per Capita Spending Rank 2008	Per Capita Income 2007	Per Capita Income Rank 2007	Unemploy-ment Rate 2010	Poverty Rate 2007-2008
Alaska	1	149	21.8	69%	31%	$12,322	$17,907	1	$279	3	$40,352	15	8.6%	8.2%
Montana	2	196	20.5	33%	67%	$4,477	$4,625	32	$146	9	$32,458	41	7.1%	12.9%
New Mexico	3	401	20.4	68%	32%	$14,790	$7,444	8	$26	51	$31,474	43	8.8%	19.3%
Wyoming	4	101	19.3	30%	70%	$4,958	$9,302	4	$89	27	$43,226	6	7.3%	10.1%
Nevada	5	471	18.4	90%	10%	$9,240	$3,532	48	$61	43	$40,480	13	13.4%	10.8%
Colorado	6	811	16.7	87%	13%	$25,129	$5,092	27	$72	35	$41,042	10	7.9%	11.0%
West Virginia	7	300	16.6	57%	43%	$18,710	$10,309	2	$71	36	$29,537	49	9.5%	14.5%
Arizona	8	1,016	16	88%	12%	$24,721	$3,804	42	$157	8	$33,029	40	9.6%	18.0%
Oregon	9	594	15.9	75%	25%	$22,644	$5,986	14	$117	17	$34,784	30	10.6%	10.6%
Kentucky	10	649	15.3	50%	50%	$22,995	$5,363	23	$49	45	$31,111	46	10.7%	17.1%
North Dakota	11	95	14.9	48%	52%	$3,597	$5,608	19	$72	34	$34,846	29	4.0%	11.8%
Idaho	11	223	14.9	63%	37%	$5,930	$3,882	41	$46	47	$31,197	44	9.4%	12.2%
Oklahoma	13	531	14.7	68%	32%	$19,962	$5,478	20	$49	46	$34,153	33	6.6%	13.6%
Maine	14	191	14.5	51%	49%	$7,427	$5,628	17	$354	2	$33,722	35	8.2%	12.0%
Vermont	15	89	14.3	31%	69%	$5,308	$8,547	7	$198	6	$36,670	23	6.5%	9.0%
Utah	15	378	14.3	78%	22%	$12,420	$4,554	34	$58	44	$31,189	45	7.2%	7.6%
Florida	17	2,587	14.2	95%	5%	$64,379	$3,494	49	$38	49	$38,444	20	12.3%	13.1%
Arkansas	17	402	14.2	64%	36%	$16,899	$5,893	16	$39	48	$30,060	48	7.8%	15.3%
Kansas	19	382	13.8	64%	36%	$12,689	$4,536	35	$91	26	$36,768	22	6.5%	12.7%
Tennessee	20	844	13.7	75%	25%	$26,324	$4,218	39	$88	29	$33,280	39	10.6%	15.0%
Missouri	20	808	13.7	77%	23%	$21,179	$3,556	47	$75	32	$34,389	32	9.5%	13.3%
Mississippi	22	396	13.6	42%	58%	$15,599	$5,305	25	$110	19	$28,845	50	11.5%	18.1%
Washington	23	865	13.4	92%	8%	$31,732	$4,833	30	$99	25	$38,414	14	9.5%	10.4%
Wisconsin	24	729	13	76%	24%	$36,091	$6,413	13	$108	20	$36,047	25	8.8%	9.8%
South Dakota	25	102	12.8	50%	50%	$3,150	$3,915	40	$74	33	$33,905	34	4.8%	13.1%
Alabama	25	592	12.8	73%	27%	$40,159	$8,586	6	$64	39	$32,404	42	11.0%	14.3%

Table 5: Suicide Demographics by State in Rank Order Highest to Lowest Suicide Rates, cont.

State	Suicide Rank 2007	Deaths by Suicide Per Year 2007	Suicide Rate Per 100 Thousand 2007	% Metro-politan 2008	% Non Metro-politan 2008	Total State Spending in Millions 2008	Per Capita State Spending 2008	Per Capita State Spending Rank 2008	SMHA Per Capita Spending 2008	SMHA Per Capita Spending Rank 2008	Per Capita Income 2007	Per Capita Income Rank 2007	Unemploy-ment Rate 2010	Poverty Rate 2007-2008
Indiana	27	790	12.5	72%	28%	$24,239	$3,794	43	$88	28	$33,616	37	9.9%	14.3%
Louisiana	28	522	12.2	85%	15%	$29,995	$6,738	11	$61	42	$34,756	31	6.9%	18.2%
South Carolina	29	530	12	67%	33%	$20,787	$4,616	33	$66	38	$31,013	47	12.2%	14.0%
New Hampshire	29	158	12	62%	38%	$4,806	$3,636	46	$127	14	$41,512	8	7.0%	7.0%
North Carolina	31	1,077	11.9	66%	34%	$41,587	$4,497	37	$126	15	$33,636	36	11.1%	13.9%
Pennsylvania	32	1,441	11.6	82%	18%	$58,696	$4,671	31	$209	5	$38,788	19	9.0%	11.0%
Virginia	33	880	11.4	85%	15%	$35,330	$4,532	36	$82	31	$41,347	9	7.4%	10.3%
Ohio	34	1,295	11.3	77%	23%	$56,763	$4,924	28	$68	37	$34,874	28	11.0%	13.7%
Michigan	35	1,131	11.2	85%	15%	$43,982	$4,397	38	$100	24	$35,086	26	14.1%	13.0%
Minnesota	36	572	11	72%	28%	$28,446	$5,438	21	$140	12	$41,034	11	7.4%	9.9%
Delaware	36	95	11	79%	21%	$8,621	$9,839	3	$104	21	$40,608	12	9.2%	9.6%
Iowa	38	322	10.8	58%	42%	$16,129	$5,387	22	$101	23	$35,023	27	6.8%	9.5%
Hawaii	39	133	10.4	71%	29%	$11,160	$8,668	5	$136	13	$39,239	18	6.9%	9.9%
Georgia	39	997	10.4	86%	14%	$36,762	$3,791	44	$61	41	$33,457	38	10.6%	15.5%
Texas	41	2,433	10.2	89%	11%	$82,156	$3,380	50	$35	50	$37,187	21	8.2%	15.9%
Nebraska	41	181	10.2	62%	38%	$8,712	$4,889	29	$62	40	$36,471	24	5.0%	10.6%
California	43	3,602	9.9	98%	2%	$194,276	$5,311	24	$123	16	$41,571	7	12.6%	14.6%
Maryland	44	518	9.2	96%	4%	$29,798	$5,266	26	$145	10	$46,021	5	7.7%	8.7%
Rhode Island	45	96	9.1	100%	0%	$7,097	$6,737	12	$102	22	$39,463	17	12.6%	12.7%
Illinois	46	1,108	8.6	89%	11%	$46,877	$3,650	45	$83	30	$40,322	16	11.5%	12.3%
Massachusetts	47	516	8	98%	2%	$44,146	$6,746	10	$112	18	$49,082	3	9.3%	11.3%
Connecticut	48	271	7.7	95%	5%	$24,536	$7,004	9	$170	7	$54,117	1	9.2%	8.1%
New York	49	1,396	7.2	91%	9%	$116,056	$5,961	15	$213	4	$47,385	4	8.6%	14.2%
New Jersey	50	596	6.9	100%	0%	$48,704	$5,622	18	$143	11	$49,194	2	9.8%	9.2%
Dist. of Columbia	51		6.1	100%	0%	n/a	$8,295	51	$394	1	$61,092	(1)	11.6%	16.5%

Table 6: Summary of Accreditation Analysis		
Item	**AAS**	**CUSA**
Basic Eligibility Criteria:	• Offer crisis intervention services as primary focus or principal component of services offered • Must be an AAS organization member • Must be operational 24/7	• Must have been in operation for at least one full year • Agree to the minimum CUSA operational standards • Must be operational during advertised hours only
Accreditation/ Reaccreditation Cycle:	• First accreditation:3 years • Reaccreditation:5 years	• First accreditation:5 years • Reaccreditation:5 years
Steps to Accreditation:	• Accept accreditation requirements • Complete pre-screening questionnaire • Provide organization documents per accreditation manual • Complete on-site visit and earn a passing score	• Accept accreditation requirements • Complete pre-screening questionnaire • Provide organization documents per accreditation manual • Complete on-site visit and earn a passing score
Time to address problems/ reapply:	No time frame provided	Six (6) months
Accreditation Standard/ Requirements:	• Board of Directors/Bylaws • Salaried Program Director • Designated Office Space • 24/7 Hours of Operation • Operate with generally accepted accounting principles for budget/business records • Follow up all calls • Routine Lethality Assessment • Program Evaluation Capabilities • Confidentiality Policy • General Written Procedures for Rescue Services • Code of Ethics • Detailed Training Program	• Board of Directors/Bylaws • Appropriate legal structure (e.g. – IRS nonprofit status, government agency) • Mission Statement • Sufficient staff with clearly defined duties • Appropriate facilities • Appropriate and up-to-date technology • Accessible to callers during advertised hours • Sufficient revenue for hotline operation • Accurate records • Clearly defined confidentiality policy • Code of Ethics • Detailed training program
Basic Operator Training Standards:	• Minimum requirements: 32 classroom hours 8 apprenticeship hours **40 total training hours** • Training must address AAS Core Competency Requirements • Must adhere to Best Practices Training recommended by AAS • Must include required training components per AAS guidelines	• Minimum requirements: 24 classroom hours 8 apprenticeship hours **32 total training hours** • Training must address CUSA Core Competency Requirements • Provide continuing education opportunities for volunteers/ staff • Training/eval. at least annually including volunteer recruitment
Main Focus of Training:	• Attitudinal Outcomes • Knowledge Outcomes • Skill Outcomes	• Attitudinal Outcomes • Knowledge Outcomes • Skill Outcomes

Procedures

Data Collection

Data were collected from various hotlines nationally. Some data were taken from Internet sources. Other data were collected directly from an existing hotline center. Finally, some data were collected through a combination of these two sources.

Data Analysis

The policy documents were analyzed for common themes and for points of diversion on specific policy issues.

Results

The results of this study are reported extensively in *Chapter 5: Sample Policies*.

One of the cornerstones of policy development is confidentiality. Confidentiality is not always defined in the same way. The most extreme example of this is when an organization chooses to maintain the confidentiality of their callers at all cost vs. an organization that believes it is appropriate to breach confidentiality and contact emergency services to attend to an at-risk caller.

STUDY 4: Analysis of Training Curricula for Suicide Prevention Hotline Operators

Study Purpose

The purpose of this study was to identify training curricula. Three questions were addressed. First, the curricula were analyzed for similarity and differences in content and methods or training. Second, the curricula were reviewed for fit with accreditation requirements. Third, the curricula were analyzed for appropriateness to Idaho.

Summary of Key Findings

1. Most organizations utilize modules from a variety of training curricula.
2. Most training curricula have similar content.
3. Most curricula include the use of stand-alone, evidence-based protocols for at least a portion of their training.

Procedures

Data Collection

Training curricula and portions of training curricula were obtained directly from hotlines nationally. Some data were sent to this project by email. Some data were taken directly from the Internet.

Data Analysis

The policy documents were analyzed to identify the basic training modules as well as the use of standardized stand-alone training modules such as Applied Suicide Intervention Skills Training (ASIST).

Most national hotline training programs have similar content

Results

The results of this study are reported extensively in *Chapter 6: Training*.

In sum, two types of training criteria emerged. The first is "training to criteria" which addresses training designed to meet the criteria of accrediting organizations. The second training type is focused on content that may or may not address specific accreditation criteria.

Additionally a large developmental leap between classroom/lecture style training to role-playing calls was identified. A methodology to address this gap was developed and tested and is reported in Study 5.

STUDY 5: The Use of Scripted Mock Phone Calls in the Quality of Training for Suicide Prevention Hotline Operators

Study Purpose

The purpose of this study was to test a scripted role play for training suicide prevention hotline operators. The question of interest was whether operator trainees would (a) accept and (b) find useful scripted role play in contrast to free role play. Scripted role plays are used in some training situations but typically there are scripts for the patient or person being helped, not for the trainee who is learning how to do something. Scripts written for both participants' roles are less common but have been used (Alden, 1999). In this study, the scripts included a brief instructional statement so future operators not only learned from the scripted conversation but were alerted as to why the statement was made. This is examined in detail in *Chapter 6: Training*.

Summary of Key Findings

1. Scripted role plays can be useful for training operators.

2. Scripted role plays with an instructional commentary for each part of the conversation helps trainees understand why a statement is made.
3. Scripted role plays were viewed as a "safe" way to begin learning how to manage the variety of, and level of difficulty of calls an operator might receive.

Procedures

Data Collection

Data were collected in two rounds of training simulations. There were a total of 8 participants, 4 in each round. There were 6 females and 2 males. The male to female ratio is similar to the customary ratio of male to female hotline volunteers. The participants ranged in age approximately from 20 to 45 years of age. Half of the participants were AmeriCorps members whose community service was health-related. Six of the 8 people were also enrolled in university-level courses, 4 who were in graduate school. Six of the 8 participants had worked full time prior to returning to school. One participant had been the director of training in a human resources department for a corporation.

Participants were recruited through invitations read by professors in classes that included the type of people who might be interested in volunteering to work as a hotline operator. These classes included several health professions. AmeriCorps Idaho Community HealthCorp members were also recruited. The study was reviewed by the Idaho State University Human Subjects Committee Chair and deemed to be quality improvement, not a research design. Nonetheless, participants were given informed consent and offered the opportunity to withdraw or discontinue their participation at any time without loss of any benefits that might have accrued to them. Participants were given a $10 gift card in appreciation for their participation.

Scripted role plays were seen as a safe way to learn

The same procedure was used for the first and second round. Participants discussed and did a role play using the scripts with the researcher. Standard questions were asked and participants were invited to discuss their ideas in a free format. Following the first round of simulations, the information provided by the participants was incorporated into a revised version of the script. The participants in the second round of simulations provided feedback on the revised script.

Data Analysis

Qualitative and quantitative methods were used to analyze the data. Participant recommendations were reviewed for common themes and unique comments. These data were used for revising the scripts. Frequency counts for the standardized quantitative questions were conducted.

Results

All of the participants thought the scripted role play of the mock calls was a good idea and believed that trainees would learn from it. The Round 1 participants found the script confusing in one place. This was addressed by providing further detail for Round 2. All of the Round 2 participants said the explanation was clear.

The participants were enthusiastic about the instructional comments that preceded each scripted statement. One person commented, "This really helps you know what you are trying to do. You can learn a lot this way."

In regard to the scenarios themselves, participants made comments like "they are simple and everything wraps up so neatly. It is almost too neat." Participants recommended that more complicated scenarios also be taught with scripted role plays. Some participants pointed out that having the script "made it safe" so that trainees could learn about handling more difficult calls. Participants suggested that the scripted training sessions be graded from easy to hard so that people could progress in their learning. They all believed that the scripting was a good idea as a precursor to free role-play, mock calls. The table below summarizes the frequency counts on the structured questions.

Participants felt scripts helped prepare for free-flowing mock calls

Table 7: Participant Responses to Queries on Helpfulness of Training Simulation

Question	Yes	No
Liked the role play	8	0
Thought it would be helpful	8	0
Did it seem contrived?	0	8
Did it feel silly or embarrassing?	0	8
Were there places where the script seemed confusing?		
Round 1	4	0
Round 2 with script edits based on round 1 feedback	0	4
Do you think trainees would learn about problem solving?	8	0

STUDY 6: Key Informant Interviews with Key Decision Makers About Housing a Suicide Prevention Hotline in Idaho

Study Purpose

The purpose of this study was to discuss the potential for housing an Idaho suicide prevention hotline with key Idaho decision makers.

Summary of Key Findings

1. Organizational culture differences existed between current business and the business of a suicide prevention hotline.

2. All organizations received at least some government funding.
3. No organization could integrate a hotline without additional resources.
4. With decision maker support, the 2-1-1 CareLine might be able to provide a home for an Idaho suicide crisis hotline.
5. The 9-1-1 system cannot include a hotline without major structural changes to its mission and operation.

Procedures

Data Collection

Data were collected through phone interviews and email correspondence. Phone interviews were conducted using a structured interview. Data from 9-1-1 decision makers was collected via email.

Data Analysis

Data were analyzed qualitatively for common and unique themes. Frequency counts also were conducted.

Results

Three current call-in programs were interviewed, Idaho's 2-1-1 CareLine, Wood River Valley Crisis Hotline and the Eastern Idaho Regional Medical Center Behavioral Health Center (BHC). The questions focused on operational issues. A summary of the data is provided below.

Types of calls Received

All three hotlines received informational, medical or law enforcement crises, crisis suicide, domestic violence, mental health, and substance abuse calls. The 2-1-1 CareLine is primarily a resource and referral line although it receives calls about domestic abuse and child abuse and neglect as well as calls about fraud and childcare. BHC receives calls about hospital admissions and scheduling outpatient appointments.

Service Area

The 2-1-1 CareLine serves the entire state of Idaho. Wood River Valley and BHC serve their regions, although Wood River Valley noted that they received calls from around the state and even calls from outside of the state.

Heaviest Call Volume

Call volumes are somewhat, but not entirely, dependent on operating hours. The Wood River Valley and BHC crisis lines are open 24/7 and the 2-1-1 CareLine is open during regular business hours. All three organi-

zations reported that their heaviest call volume was on weekdays. One reported Monday and one reported Friday as the highest days. The highest call volume time was reported as afternoons. All three hotlines reported their highest seasonal call volume in the winter, while one hotline reported that the summer was a lower call volume for them. Christmas was reported by two hotlines as being the highest holiday period. The 2-1-1 CareLine is not open over Christmas and thus could not respond to call volume during this period.

Response to Suicide Crisis Call

The 2-1-1 CareLine refers suicide crisis calls to 9-1-1. Wood River Valley and BHC managed crisis suicide calls themselves. If their operators feel that a caller is in imminent danger, they call 9-1-1 to send emergency personnel to the scene. Both 2-1-1 CareLine and BHC refer people to the Idaho Department of Health and Welfare (IDHW) in their region. BHC also refers callers to their in-house services. None of the call lines reported sending IDHW regional mental health teams to a scene.

Staffing and Training

All three call lines used a combination of paid and volunteer staff. The Wood River Valley crisis line has the fewest paid staff and the most volunteers. The 2-1-1 CareLine has 4 full-time and 4 part-time operators. Both Wood River Valley and BHC reported their FTE (full-time effort) as just under 2FTEs. All three reported a need to increase staffing should they incorporate a statewide hotline into their organization. They also reported that their operators receive initial training of at least 20 hours as well as ongoing training and they believe they could support the additional training necessary to become an accredited hotline.

Organizations report call volume is high on weekdays

Accreditation

BHC is currently accredited through the Joint Commission (the agency formerly known as JCAHO) and the Center for Medicare and Medicaid Services; the organization also has a childcare license. None of the three centers was accredited by a suicide prevention hotline organization. To accomplish this goal, they all believed that they would need additional funds to pay for accreditation.

Budgetary Issues

All three organizations said that they would need an additional line should they incorporate a statewide hotline into their operation. As previously noted, none of the centers believe that they could afford accreditation without additional funds although they said that they have the capacity to provide any additional operator training necessary for accreditation.

The organizations all reported a mix of funding sources with the sole common source being some type of government funding. Only Wood River Valley reported receiving funds from United Way and only BHC reported receiving funds from third-party payers like insurance companies.

Benefits and Disadvantages for Housing an Idaho Hotline

A benefit of the 2-1-1 CareLine could be its existing role as a central point of contact on a variety of health and human service issues. BHC noted that it would solidify its mission to provide crisis and early intervention for suicide prevention.

BHC felt a disadvantage to that model could be the diversion of staff from providing direct care to patients to addressing suicide prevention calls. The information gathered from 9-1-1 clearly pointed out the differences in a 9-1-1 system and a hotline system. Decision makers for the 9-1-1 system indicated that should a hotline be placed into a 9-1-1 system, it would effectively have to be operated as a separate unit. It is their strong recommendation that the fit is not good.

Existing help lines would need some additional funding for accreditation

STUDY 7: National 2-1-1 Directors Phone-based Key Informant Interviews

Study Purpose

The purpose of this study was to learn what 2-1-1 help line information and referral lines in other states did in regard to suicide prevention hotlines.

Summary of Key Findings

1. Suicide prevention crisis hotlines can be merged successfully with 2-1-1 help lines.
2. Crisis hotlines and help lines have different organizational cultures. Help lines are encouraged to efficiently find information and keep call time short. Crisis operators are encouraged to stay on calls as long as it takes to encourage the caller out of a crisis.
3. Combining crisis and help calls in a 2-1-1 system could improve fundraising and volunteer recruitment because the services are diversified and appeal to a broader range of people than either alone.

Procedures

Data Collection

Nine 2-1-1 help line directors participated in phone key information interviews. A standard interview was used in order to make the interviews comparable. Data were collected from South Dakota, Oklahoma, Florida, California, Michigan, and Ohio to include some states similar to Idaho and some that were considerably larger and more resourced than Idaho.

Data Analysis

Qualitative analysis methods were used. The notes from each call were transcribed. Data were organized by question across sites. Each question was reviewed for key themes. Unique or important points not mentioned by other participants were also included in the analysis results.

Results

Combining crisis and help lines could help with fundraising

Unlike Idaho's CareLine which is a part of state government, most of the 2-1-1 help lines are private nonprofit organizations. According to the interviewees, they do, in large part, rely on state and other government funding. Resources are also obtained from private donations and in some situations, taxes dedicated to the 2-1-1. United Way provides another source of funding. Most 2-1-1 organizations rely on paid staff, although several do have volunteers. As one director put it they use paid staff and rely on volunteers to "fill the holes."

One difference between a 2-1-1 help line and a suicide prevention hotline is the goal for the outcome of the call and thus the manner in which an operator completes a call. Typical 2-1-1 calls for referrals are deemed successful based on how quickly an operator can give the caller the information needed. This addresses customer satisfaction as well as efficiency for the 2-1-1 help line. Suicide prevention hotline calls are the opposite. In some cases the operator's goal is to actually keep the conversation going. Longer calls can be "better" calls. Of the help line directors with whom we spoke, most of the operators are cross-trained to manage short-response (help-line referral calls) and long-response calls (suicide prevention hotline calls). One director was adamant that 2-1-1 specialists should not answer hotline calls except after hours when other options are not available.

All of the 2-1-1 organization directors interviewed reported operating 24/7. The designated service areas and the functional service areas are not the same. Hotlines that are tasked to serve one area, actually serve larger ones, but still are identified with a smaller portion of their service area. The hotlines in South Dakota and Oklahoma serve the entire state. Most hotlines serve several counties unless the county is particularly large (e.g., several hundred thousand people or more).

The annual operating budgets of the 2-1-1 programs ranged from $500,000 to more than $2 million. Two were reported at $550,000 to $700,000. Four were reported at $1 million to $1.7 million and two were over $2 million. Not all calculate the percentage of their budgets by crisis and routine calls. Estimates for the proportion of 2-1-1 organizations' annual budget expended for crisis calls ranged from less than 2% to 88%. Crisis call volume was not directly related to crisis call costs. One center reported less than 2% of their calls and 4% of their operating budget was committed to crisis calls. Another organization reported that nearly 50% of their calls were crisis calls but only 35% of their budget was associated with crisis calls. Two 2-1-1 centers reported spending a considerably larger proportion of their operating budget on crisis calls than the percentage of crisis calls within their overall call volume. Among this group, it seemed that the organizational structure of the 2-1-1 help line strongly affects their crisis calls received and budget allocations for crisis suicide prevention calls.

The 2-1-1 centers reported they had faced budget cuts because of the economy. They also reported having to deal with "political" issues from their funding sources, particularly in regard to government funding.

When asked about the advantages and disadvantages of combining a 2-1-1 help line and crisis hotline, the directors generally saw benefits and drawbacks. The benefits mentioned included efficiencies in staffing and streamlined administration compared to separate organizations. One director pointed out that suicide prevention "tugs at the heartstrings" and makes it easier overall to fundraise. On the negative side, directors mentioned the "cultural differences" between a referral line and a crisis line. Directors also pointed out that there are issues in regard to how calls are prioritized. One director noted that the 2-1-1 number is associated more with a help line and that 9-1-1 is more associated with crisis.

Crisis and help lines have different organizational expectations

When asked for advice regarding the potential of blending a 2-1-1 help line and suicide crisis hotline in Idaho, one director likened the merge to a diversified business. She noted that it is easier to manage volunteer recruitment and fundraising when people can identify with either a help line or a crisis line.

STUDY 8: National Survey of Directors of Accredited Suicide Prevention Hotlines in the United States

Study Purpose

The purpose of this study was to find out about the types and numbers of calls, training, staffing, and various practices of suicide prevention hotlines across the United States.

Summary of Key Findings

1. Seventy eight percent (78%) of hotlines were freestanding, non-profit suicide hotlines.
2. The number of suicide crisis calls can vary, but was most often reported as being less than 10% of the total number of calls.
3. Few callers to hotlines needed medical attention.
4. Most hotlines use a combination of paid and volunteer staffing. The most common mix is 25% or fewer volunteers with 75% or more paid staff.
5. Seventy-seven (77%) of hotlines reported being accredited.
6. Half of organizations report some government funding within their top source of funding.
7. The most common funding source is state government.

Procedures

Data Collection

Data were collected from 23 hotline directors nationally. Responses were received from one or more hotlines in seventeen (n=17) states.

Participants were recruited through email invitations sent by list servs members of Lifeline and AAS. The invitation was written by the research team and emailed to the lists by the executive director of Lifeline. While the invitation went out on the larger lists the target audience for the invitation was crisis centers. Across both lists Lifeline estimated that about 150 centers got the invitation.

77% of hotlines contacted report being accredited

The study was reviewed by the Idaho State University Human Subjects Committee Chair and deemed to be quality improvement, not a research design. Nonetheless, participants were given informed consent and offered the opportunity to withdraw or discontinue their participation at any time without loss of any benefits that might have accrued to them. Data were collected anonymously. Participants were invited to provide their name and contact information but were not required to do so. Participants could choose to skip questions.

Data Analysis

The data were collected using an automated online survey. Data were downloaded from the online survey daily and checked for consistency and errors. Data were transferred from the online format to be analyzed using PASW Statistics 18, Release 18 (June 30, 2009).

Results

Organizational Structure

Hotlines exist in multiple configurations. For the purposes of this study, the way that hotlines were structured was viewed in three different ways. First, it was viewed by tax status: for profit, non profit, and government. Second, it was viewed by specific type of organization. Finally, the data were viewed by the type of function of their organization.

Chi square tests were undertaken to determine if there was a relationship between the type of organizational structure and the categorization of the number of calls per year. There were no statistically significant relationships based on tax status, type of organization, or function of organization.

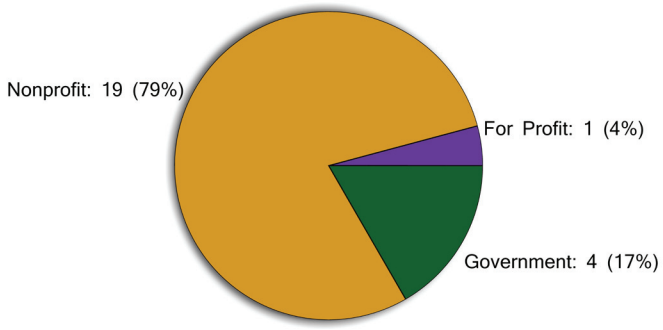
Organizations by Tax Status

One hotline reported being housed within a for profit organization. Typically hotlines housed in for profit organizations are within hospitals or an extension of a practice group. Four (n=4, 17%) hotlines reported being part of a branch of government. The remaining hotlines (n=18, 78%) were nonprofit organizations.

Most hotlines reported being nonprofit organizations

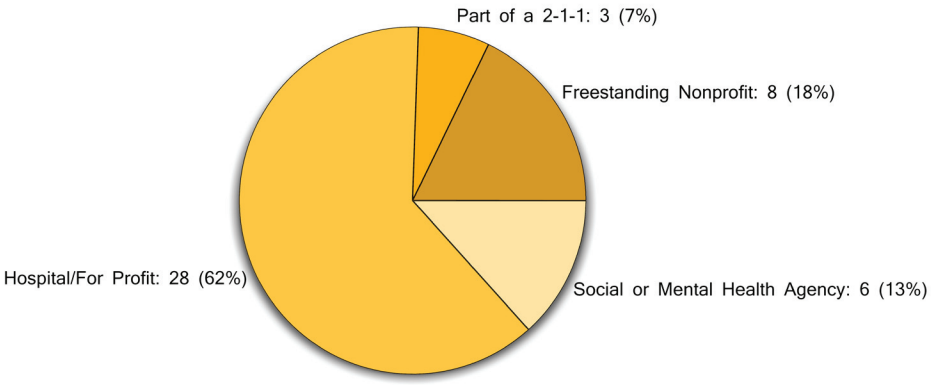
Figure 9: Hotlines by Tax Status

Hotlines by Type of Organization



About one-third (35%, n=8) of the hotlines were free-standing and not affiliated with another organization. About one quarter (n=6, 26%) were part of a hospital or other healthcare organization whether for profit or nonprofit. Another 25% (n=6) were part of a community mental health center or social service office. Three hotlines (13%) were part of a 2-1-1 system. None reported being part of a 9-1-1 system.

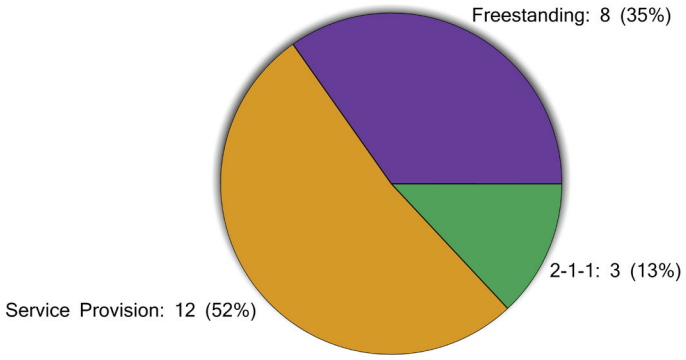
Figure 10: Hotlines by Type of Organization



Hotlines by Function of Organization

In this analysis, hotlines were organized based on the type of function of the company in which they were housed. Half (12=12; 52%) of the hotlines were associated with organizations that provided some type of service provision such as health care, mental health care, or social services. Three (n=3, 13%) were part of a 2-1-1 organization. The remaining hotlines were classified as freestanding organizations whose only job was a suicide prevention hotline (n=8, 35%).

Figure 11: Hotlines by Function of Organization



Number of Calls Received Per Year

A very wide range of numbers of calls were reported. The number of calls ranged from 120 per year to over 120,000 calls. The median and mode number of calls was 16,000. Because the range of the number of calls was so very wide and the number of hotlines represented was small, the num-

ber of calls was grouped into three large approximately equal groups. The divisions for the groups were based on breakpoints in the distribution of the calls. Thirty nine percent (n=9, 39%) received fewer than 10,000 calls per year. Thirty percent (n=7, 30%) received between 10,000 and 25,000 per year and 30% (n=7) received more than 25,000 calls.

Number of Callers Requiring Medical Care

Only 9 of 23 centers responded to the question regarding the number of callers who needed medical care as a result of the situation about which they called. Of the 9 hotlines reporting, one reported that none of their callers needed medical assistance. One hotline reported that a single caller needed medical assistance. Two centers reported about 150 people needed medical care. Two reported about 300 needed medical care and 3 hotlines reported that between 1600 and 2000 callers needed medical care. No further analyses were conducted on this variable because of the very low response rate and wide variability in the responses.

Types of Calls Received

Survey respondents were asked to estimate the percentage of calls they received in 7 categories. Because these were estimates based on the directors' best guesses, the percentages did not sum to 100%. nor were respondents required to have their answers sum to 100%. The results are taken from the average percent response across each of the 7 categories. All of the 23 participants responded but there are a large variety of responses.

Table 8: Types of Calls Received

	Mean	Standard Deviation	Number of Responses
Referral Calls (%)	26.3	21.7	20
Suicide Crisis Calls (%)	18.1	21.0	22
Substance Use (%)	10.9	9.6	20
Domestic violence (%)	3.5	2.8	19
Mental Health (%)	38.0	20.7	22
Child welfare (%)	2.4	1.9	16
Other (%)	16.2	18.6	10

The majority of calls to a suicide prevention hotline are mental health reasons followed closely by calls for referrals. There is likely overlap between these two categories as many callers seek mental health referrals. Substance abuse accounts for 11% of calls, domestic violence 3% and child welfare 2%. Mental health and substance use problems place a person at high risk for suicide.

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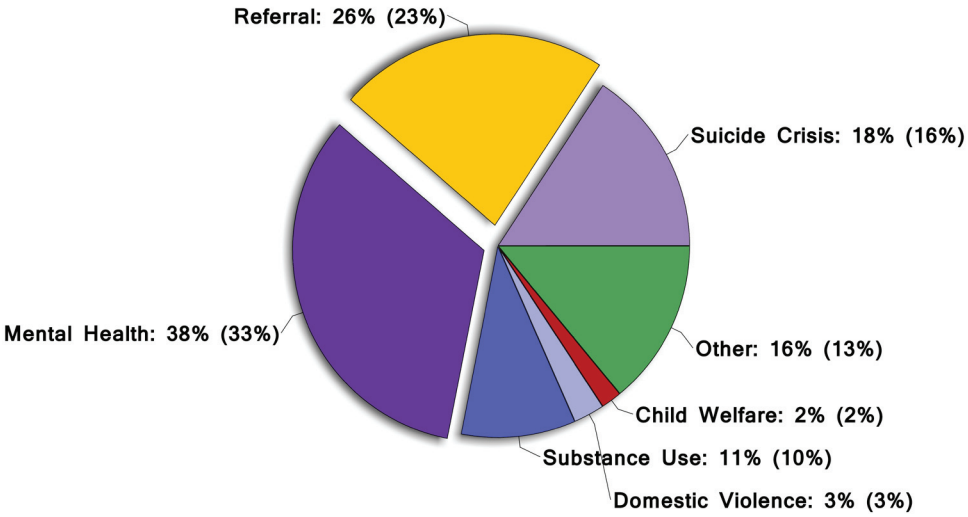
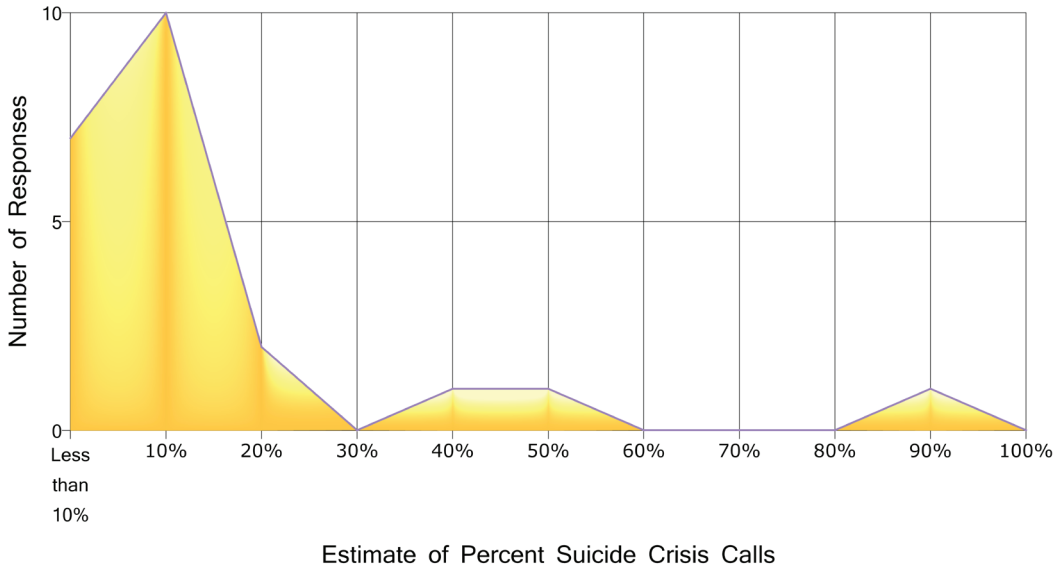
Figure 12: Annual Calls Per Year by Category



Suicide crisis calls accounted for an average of 18% of calls among the 22 hotlines reporting. The range of estimates of percentage of suicide crisis calls varied but was clustered at 10% or less which accounts for 13 of the 22 responses.

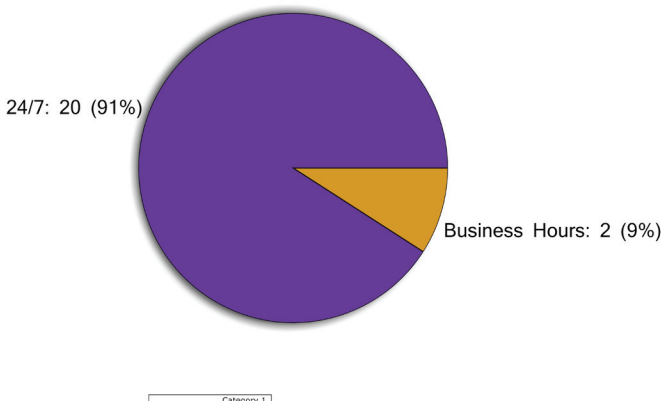
Figure 13: Number of Responses by Percentage of Suicide Crisis Call



Hours of Operation

Twenty of 23 hotlines reported operating 24 hours a day 7 days a week over 365 days per year. One hotline did not indicate hours of operation and two reported operating on a business hour model that does not include nights and weekends.

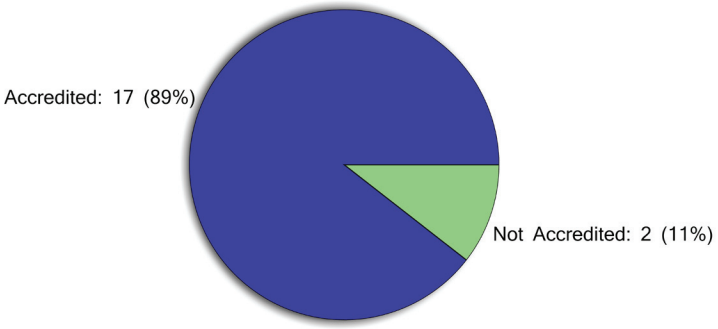
Figure 14: Hours Per Day Operational



Accreditation

Three quarters (n=17, 77%) of hotlines reported being accredited and 23% said they were not accredited. One hotline did not respond.

Figure 15: Accreditation Status



Staffing

Two hotlines reported that it had no paid staff. One hotline reported that it had no volunteers. Most hotlines have a mix of volunteers and paid staff. The most common mix is 25% or fewer volunteers with 75% or more paid staff.

Funding Sources

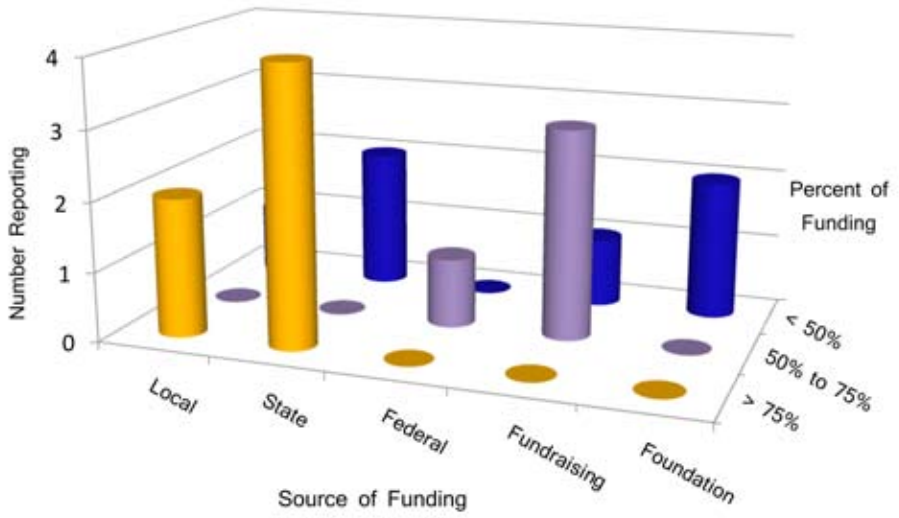
Funding sources varied but state funding was the most common across all centers. Respondents were asked to report on their top three sources of funding. The vast majority (n=19, 83%) of hotlines received at least 50% from their top funding source. Half (n=11, 50%) had at least 80% of their funding from their top source. Only 10 of 23 hotlines reported having a third source of income and of those 80% (n=8) depended on their third source for less than 10% of their funding.

Six hotlines reported funding from state sources with two centers reporting at least 75% of funding from the state. Only one hotline reported federal funding as a top source of funding. Only two hotlines reported having foundation funding and neither of these centers received more than 50% of funding from a foundation. No centers were supported entirely by fund-raising. Two hotlines were funded by a parent organization.

Table 9: Amount of Funding by Source

Amount of Funding	Federal	State	County/Local	Foundation	Fundraising	Parent Organization Budget
50% or less	0	2	1	2	1	0
50% to 75%	1	0	0	0	3	0
75% to 100%	0	4	2	0	0	2

Figure 16: Graphical Representation of Amount of Funding by Source



STUDY 9: Estimating Call Volume for an Idaho Suicide Prevention Hotline

Study Purpose

The purpose of this study was to create a reasonable estimate of the call volume that an Idaho suicide prevention hotline might expect.

Summary of Key Findings

1. Almost no reliable data exist that could be used to make reasonable projections about call volume.
2. Call volume is related to the marketing of the hotline.
3. Call volume is related to the presence and absence of Idaho hotlines. One dedicated suicide prevention hotline was operational until 2007. The hotline struggled with funding but did receive a significant number of calls.

Procedures

Data Collection

Call volume for Idaho data was collected from Lifeline. Call volume for "suicide related" calls was gathered from the Boise City Police Department. Data also were collected from the U.S. Census Bureau.

Data Analysis

The data were analyzed to identify actual data points. There were few data points on which to build. Interpolation and extrapolation techniques were used to fill in the many missing data points. Interpolation is the estimation of data missing from a known series. For example, if real data existed for 2006, 2007 and 2009, data would be interpolated for 2008 based on the real data available. Extrapolation is the estimation of data points outside of the range of the real data. For example, data for all models was extrapolated for the year 2011.

Results

The results of this study are reported in detail in *Chapter 7: Call Volume & Cost Estimates.*

Call-volume increases can be attributed to the marketing of a hotline's number. For example, the call volume for Idaho calls to Lifeline increased sharply in 2008 and continued to grow in 2009. This growth corresponded to heavy marketing of the Lifeline call number through the Awareness to Action Youth Suicide Prevention Project (YSPP). The amount of real data was very small casting doubts on the reliability of the estimated data.

Nonetheless, these data are the best available. To reduce the estimation errors, standardized methods were used to interpolate and extrapolate the missing data.

STUDY 10: Estimating Costs for an Idaho Suicide Prevention Hotline

Study Purpose

This study attempted to estimate real costs that could be associated with different configurations of an Idaho suicide prevention hotline.

Summary of Key Findings

1. Cost estimates were very difficult to estimate because the estimation of the number of calls to a hotline was very poor.
2. Operating a 24/7 hotline requires minimal additional costs when compared to a business hour model. The infrastructure is the same for both models and the increased costs are associated with personnel only.
3. Hotlines with dedicated funding ultimately cost less than hotlines that are funded through grants, contracts and gifts.
4. Accreditation can reduce costs substantially because the hotline can participate in the national Lifeline. This provides overflow coverage, off-hour coverage, language translations, disability adaptive equipment such as TTY and access to an annual stipend or federal grants.

Procedures

Data Collection

Data were collected from businesses that would provide services to a hotline. These included cost estimates from water, sanitation, power and phone companies. Rent was estimated by contacting rental agencies and chambers of commerce in two Idaho towns. Equipment and supply costs were based on real costs drawn from two office supply company catalogs. Personnel costs were based on Idaho-state job descriptions and pay scales. The Idaho Division of Human Resources reviewed and suggested the positions used for this study.

Data Analysis

Data were analyzed based on real costs and estimated configurations and staffing. Accounting methods were used to develop sample budgets.

Results

The results of this study are reported in detail in *Chapter 7: Call Volume & Cost Estimates.*

While costs were estimated based on the best available data, the call volume, which drove the budget samples, is not a reliable number. Therefore, the strength of the sample budgets is modest. Because the infrastructure necessary to run a hotline is a substantial amount of the total budget, a 24/7 hotline is not proportionally more expensive than a business hour model. Hotlines with dedicated funding cost less for two reasons. First, there are fewer personnel hours dedicated to fundraising. Second, a hotline with dedicated funding can be an accredited hotline and can belong to the national Lifeline, fulfilling these criteria make the cost of a hotline less expensive. Even after paying accreditation fees, the costs were lower due to the services available through the national Lifeline.

STUDY 11: The Economic Cost of Suicide in Idaho and the United States

Study Purpose

The economic costs of suicide attempts and completions are fundamental when considering resource allocation to suicide prevention. There is little information nationally and almost none for Idaho. This study sought to generate detailed information regarding the economic costs of suicide attempts and completions based on the best available economic and epidemiological data. A key question was how suicide affects the Years of Potential Life Loss (YPLL). The economic analysis was conducted for this report by Neill F. Piland, DrPH.

Summary of Key Findings

1. The effects of suicide attempts and completions cause health, behavioral, and economic problems that can continue from generation to generation.
2. A very high proportion of suicide attempts and completions attempts take place in younger age groups.
3. Suicide attempts cost Idaho $36 million annually.
4. Suicide completions in Idaho cost $861,432 annually in medical care.

5. When people die from suicide their potential contributions to productivity over their expected lifetime are not made. The total lifetime productivity lost for the people who die from suicide each year in Idaho it is $343 million dollars.
6. Each year, if just 23 deaths by suicide were prevented in Idaho it would save $34 million dollars annually across the victims' lifetimes from loss of productivity.

Procedures

Data Collection

Data were collected from multiple archival sources. The estimates are built upon the work reported in The Incidence and Economic Burden of Injuries in the United States States (Finkelstein, Corso, & Miller, 2006) and data from the Medical Expense Panel Survey (MEPS) as well as the Health Care Cost and Utilization Project (HCUP). Other data were gathered through the National Violent Death Reporting System (NVDRS) the National Hospital and Ambulatory Medical Care Survey, the national Ambulatory Medical Care Survey (NAMCS) and the National Electronic Injury Surveillance System (NEISS). The estimates derived from synthesis of data from all of these sources are very conservative due to the error involved in combining data from different sources and time periods and adjusting to establish levels of comparability.

Data Analysis

These data were gathered into a database from which the study was conducted. Standard metrics and methods were used for the analysis. These are described below.

Years of Potential Life Lost (YPLL)

The YPLL is the numerical difference between a predetermined end point age (usually 75) and the age at death for a death or deaths that occurred prior to that end point age. The potential years of life lost for each death are summed to represent the total years of potential life lost. The YPLL provides a way to calculate the years of lost productivity (National Association for Public Health Statistics and Information Systems, n.d.).

Opportunity Costs

An opportunity cost is the cost associated with passing up an alternative. Economic costs should be understood as *opportunity costs* or alternatives foregone in the consumption of scarce health resources. This means that there are costs associated with any course of action and for non-action as well. For example, the prevention of fatal and non-fatal injuries

resulting from suicide and suicide attempts conserves resources that can be employed in other productive uses. Failure to avert these potentially preventable events results in the consumption of resources that can then no longer be used for alternative purposes. It is a simple concept but one fundamental to understanding the economic valuation of health programs and the resources required to operate them. To derive accurate estimates of cost, direct and indirect costs both must be included. Costs represent, most frequently, a flow or series of uneven recurring expenditures of resources. Therefore, measurement of costs entails inclusion of both short and long-run direct and indirect costs. This is particularly true for the measurement of the economic costs of fatal and non-fatal injuries where long-term physical, emotional and community demographic effects are common and frequently entail very long-term economic burden.

$34 million could be saved each year in Idaho if 23 suicides were averted

Direct Costs

Direct costs are those costs that can be traced directly to, or identified with, a specific event. In this case the event is an attempted or completed suicide. Adequate age- and sex-specific cost data at the national, state, or local level are rarely available. Still, the accounting of direct costs should include as many of the following elements as possible.

1. Medical care services including emergency and pre-hospital services, ambulance, emergency department, EMT paramedic, physician services, other personnel costs
2. Hospital inpatient costs
3. Ambulatory medical care including hospital outpatient services, ambulatory clinic, office-based physician care, and cost of pharmaceuticals
4. Disability and rehabilitation services including physical therapy, occupational therapy, and speech and hearing therapy
5. Long-term care including long-term rehabilitation and custodial care
6. Home healthcare services, including home health nursing, aid, and homemaker services
7. Administrative costs
8. Police, legal, and court costs
9. Welfare and human services costs
10. Public and private counseling program costs for victim and families of victims
11. Morgue, mortuary, and medical examiner costs
12. Funeral costs

Indirect Costs

Indirect costs are costs that are not directly attributable to a specific event. Indirect costs should include a number of cost categories.

1. Foregone production (earnings) due to death, injury, and disability
2. Consumption foregone from reduced long- and short-run income
3. Value of time, production, and consumption foregone by family and other caregivers during care of victims
4. Value of reduced earnings stemming from early termination of education or training to care for the victim

Prevention of suicide and attempts conserves resources that can be used elsewhere

Again most of these costs are not easily attainable or readily available. But since the greatest proportion of costs are lost productivity due to premature death and disability, it is critical to determine the cost of suicide and the economic burden it places on society and develop and apply effective methods of prevention. This is an area where preventive efforts can yield highly cost-effective solutions.

Human Capital

Human capital is the human skills and capabilities generated by investments in education, training, and health.. This research is based upon a human capital approach to valuation. The approach does not estimate the value of such intangibles as pain and suffering or stress and depression. It also undervalues lost productivity since the reporting of suicide-related injuries and suicide intent is incomplete (Drummond, O'Brien, Stoddart, & Torrance, 1997). The estimates derived for this report are based only upon fatalities and self-inflicted injuries that have been treated in inpatient hospital facilities, hospital emergency and outpatient departments, physician offices, and clinics. Such injuries are underreported due to difficulty in determining "intent"; a lack of uniform, complete, and accurate use and recording of E codes; and the lack of inclusion of costs of care given outside medical facilities. Mental health, substance abuse, and psychological services are most frequently not included in cost estimates. Since foregone productivity is by far the largest proportion of the economic cost, this under reporting is a serious concern (Corso, Merey, Simon, Finkelstein, & Miller, 2007). Productivity losses due to partial disability, reduced income and reduced income for family and other non-market caregivers are not included in the estimates if medical treatment did not take place or was not recorded. Therefore, the figures must be viewed as very conservative and they underestimate the cost of suicide and the burden it has on individuals, their families, their communities and the entire society.

Results

National Estimates of Cost and Burden of Suicide

The following discussion presents both national and Idaho-specific estimates of the cost of suicide fatalities and non-fatal suicide attempts. Suicidal behavior is a major cause of death and injury in the United States. The CDC reports suicide as the eleventh leading cause of death and the seventh leading cause of death for males of all ages. However, suicide is the second leading cause of death for males aged 25–34; the third leading cause in ages 15–25; and the fourth leading cause for age groups 10–14, 35–44, and 45-54. It is also the third leading cause of death for females 15–24 and the fourth leading cause for females in the age groups 25–34 and 35–44. In addition, from 2001–2008 the CDC reports that for age group 10-24 intentional self-harm (poisoning, cut/pierce, and other specified, respectively) was the second, fifth, and eighth leading causes of injury (CDC-NCIPC, 2010). These figures illustrate the long-term effect suicide and non-fatal suicide-related injuries concentrate in the potentially most productive and younger age groups. They also show the impact of suicide in younger male age groups whose case fatality rates are much higher than that of females due to the predominant use of firearms. The age and sex structure of suicide has a determining effect on the overall cost of burden of suicide both nationally and regionally.

The most comprehensive study of the costs of intentional and unintentional injuries to date estimated that 324,000 self-inflicted injuries generated $33 billion in medical and lost productivity costs. Approximately 91%, or $30.4 billion, was estimated to be due to suicide. The distribution of these costs is important: About $1 billion was due to medical costs and the remaining $32 billion accrued to productivity losses. The study noted that then as now the self-inflicted injury rate was highest, for males and females, in ages 15–24 (Corso, et al., 2007; Finkelstein, et al., 2006). Data compiled by the Suicide Prevention Resource Center at the Education Development Center (EDC) supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that the medical cost of the average lifetime per suicide case was $3,983 and the work-loss cost was $1,224,322.

Tables 10 and 11 show the relative impact of age and sex on the cost of suicide and non-fatal suicide-related injuries by estimates of the per case cost for suicide fatalities and non-fatal injuries for all ages and for "Youth Suicides" or those ages 10–24. The impact of successful suicide completions, especially for males, in this interval is truly dramatic. Lifetime productivity losses alone for suicide fatalities for males 10–24 are over $750,000 higher than for males of all ages. This also holds true for females, where the lost productivity lifetime costs are more than $500,000 higher for those 10–24 than for all ages.

Table 10: Cost per Case Completed and Attempted Suicides All ages (2008)			
Male and Female - Non-Fatal		**Male and Female - Fatal**	
Medical Care	$5,809	Medical Care	$3,434
Productivity Loss	$7,488	Productivity Loss	$1,368,908
Total	**$13,297**	**Total**	**$1,372,402**
Male - Non-Fatal		**Male - Fatal**	
Medical Care	$6,466	Medical Care	$3,256
Productivity Loss	$11,030	Productivity Loss	$1,468,314
Total	**$17,496**	**Total**	**$1,471,570**
Female - Non-Fatal		**Female - Fatal**	
Medical Care	$5,340	Medical Care	$4,366
Productivity Loss	$4,988	Productivity Loss	$959,021
Total	**$10,328**	**Total**	**$963,387**

Table 11: Cost Per Case of Fatal and Non-Fatal Suicide-Related Injuries Ages 10–24 (2008)			
Male and Female - Non-Fatal		**Male and Female - Fatal**	
Medical Care	$4,137	Medical Care	$3,647
Productivity Loss	$5,821	Productivity Loss	$2,115,818
Total	**$9,958**	**Total**	**$2,119,465**
Male - Non-Fatal		**Male - Fatal**	
Medical Care	$4,935	Medical Care	$3,478
Productivity Loss	$9,2-1-1	Productivity Loss	$2,222,512
Total	**$14,146**	**Total**	**$2,225,990**
Female - Non-Fatal		**Female - Fatal**	
Medical Care	$3,636	Medical Care	$4,662
Productivity Loss	$3,583	Productivity Loss	$1,471,098
Total	**$7,219**	**Total**	**$1,475,750**

Estimates of costs of suicide are conservative due to under reporting and other factors

It is conservatively estimated that the lifetime discounted economic cost of suicide and suicide-related non-fatal injuries is at least $45.5 billion with about $4.8 billion due to medical costs and over $45.6 billion due to productivity losses due to premature death and disability. The non-fatal suicide-related injury costs are based on an estimate of about eleven attempts resulting in medically treated injury for every completed suicide. Again these estimates are very conservative. Estimates of the number of suicide attempts per suicide completion range from 11 to 25 in different studies. In addition these rates vary dramatically by sex and age (Claassen, et al., 2006; Bennett, Vaslef, Shapiro, Brooks, & Scarborough, 2009; Goldsmith, Pell-

mar, Kleinman, & Bunney, 2002). This preventable event is clearly having an impact on health care expenditures and an especially large impact on the economic development potential of communities across the country.

Estimates of the Economic Costs of Suicide in Idaho

Idaho has consistently exhibited suicide rates substantially above national rates. Idaho's 2008 suicide rate (all ages, both sexes) was 16.5 (16.7 age-adjusted) per 100,000 population vs. the national rate of 11.1 (10.9 age-adjusted). Suicide is the eighth leading cause of death in Idaho. But the problem of youth suicides is especially acute in Idaho. It is the second leading cause of death for age groups 15–19, 20–24 and 25–34. And it is the third leading cause of death for ages 10–14 (IDHW-BVRHS, 2010). Although the absolute numbers of suicides may appear to be small, the social and economic impact of suicide and especially youth suicide is very substantial for the state and even more dramatic for individual communities within the state. The relatively small population and large number of small communities make it more difficult to absorb the cost burden resulting from suicide.

Estimates of the number of suicide attempts per completion range from 11 to 25

The CDC estimates, from 2000–2006, the average annual cost of all suicide fatalities to be $144,395,877 in Idaho with $540,810 accruing to medical costs and $143,855,267 to work loss (in 2005 dollars). The average annual costs for age groups 10–24 were estimated to be $35,731,182 with $101,734 in medical costs and $35,629,448 in work-loss. Youth suicides, therefore accounted for nearly 25% of total costs while being less than 16% of total suicide fatalities (CDC-NCIPC, 2010). This is due to the longer period of time over which productivity is lost to the economy and to the higher case fatality rates for younger males as a result of using firearms as the method. In 2008, 39 males and 4 females committed suicide in Idaho. Firearms have not been the favored method of suicide for females at the same rate as that for males.

Total discounted lifetime costs of suicide (all ages and both sexes) for 2008 are estimated to be $344,457,340. Medical costs account for $861,432 and productivity losses $343,595,908. These estimates (expressed in 2008 dollars) reflect higher incidence rates and higher healthcare costs as well as general inflation in labor costs. In addition, non-fatal suicide attempts requiring medical attention added at least $36,713,017. Preliminary estimates of administrative costs (police, court, insurance costs, coroner, funeral, legal, etc.) add about 10.3% to total costs.

If the cost burden of suicide in Idaho were evenly distributed over the population (2008) the burden would amount to about $250 for every person living in Idaho. But the burden is not distributed evenly. It falls on individual families and communities as well as the state as a whole. The effect can be and frequently is devastating from both social and economic standpoints. Prevention of just 10% of Idaho suicides annually would result

in saving at least $34 million in lifetime costs stemming from medical care and foregone productivity. This is very clearly an investment with a very high ROI (return on investment) and one that needs to be made in prevention programs and systems that have proved promising and effective. A great deal of research remains to be done on the economic impact of suicide and the cost-effectiveness of alternative programs and methods of prevention. However, the cost of suicide is demonstrably very high and the burden placed on the state is substantial. The need for prevention is critical.

STUDY 12: Review of a Suicide Prevention Hotline Sustainability Sources

Study Purpose

The purpose of this study was to analyze the types of available funding opportunities for sustaining a suicide prevention hotline.

Summary of Key Findings

1. Identifying funding sources for sustaining a suicide prevention hotline requires constant vigilance.
2. Applying for funding sources for sustaining a suicide prevention hotline requires considerable time and other resources. In some cases the types of funding opportunities cost more to apply for than the amount of money that could be awarded.
3. Hotlines with dedicated funding are less expensive than hotlines that are reliant on external funding because there are fewer costs associated with fundraising and with operating costs due to the ability to be accredited. Accredited hotlines can belong to Lifeline, which provides important and expensive services for members.

Procedures

Data Collection

The Suicide Prevention Hotline Advisory Partners assisted with data collection. The Partners initiated the identification of sustainability sources. The project team then followed up on those sources and added others identified through Internet searches, email and phone discussions with experts and expert knowledge from the report team. Those data then were reviewed by the Partners and additions were made.

Data Analysis

A two-step qualitative analysis was used. At the first step potential sources were included only if there was some chance that they would support a suicide prevention hotline. Those sources that were included underwent a variety of sorting. Sources were categorized by

1. Type of support: (a) start-up, (b) ongoing
2. Type of location: national, regional, state and local.
3. Type of funding: grants, cooperative agreements, donations, etc.
4. Length of funding in years
5. Range of funds in dollars
6. Application Due Dates
7. Application Rating 1 to 4 with 1 being less complex and 4 being extensive applications

Hotlines with dedicated revenue are less expensive than those relying on external funding

Results

The results of this study are presented in detail in *Chapter 8: Sustainability.*

There were no funding sources that specifically sustain suicide hotlines. Some funding opportunities were for one-time start-up funds. The smaller grants may or may not have smaller application packages. Larger grants often involve data collection and evaluation. Seeking funding is very labor intensive and the pace does not mix well with other duties of hotline personnel.

STUDY 13: A Marketing Plan for an Idaho Suicide Prevention Hotline

Study Purpose

The purpose of this study was to develop a marketing plan for an Idaho suicide prevention hotline.

Summary of Key Findings

1. Resources are available through Lifeline for developing a marketing campaign.
2. No decisions have been made regarding a phone number for an Idaho suicide prevention hotline. Therefore, it is not possible to create camera materials for a marketing campaign at this time. Materials created for a campain only will require insertion of a phone number and Website address.

The Suicide Prevention Partnership designed the marketing campaign

Procedures

Data Collection

The Suicide Prevention Hotline Partnership participated in the data collection. The Partners worked to establish the message and delivery method for the campaign. The project team followed up by developing materials. Those data were then reviewed by the Partners and additions were made.

Data Analysis

The marketing items and process were established by the Partnership, reviewed, and then approved by them.

Results

The results of this work are presented in detail in *Chapter 9: Marketing Plan.*

The Partnership understood the messages that are important to Idaho and how to reach out to Idahoans. The lack of a hotline phone number made it impossible to complete the camera ready marketing materials in their entirety, although basic designs were completed.

CHAPTER 4
ACCREDITATION AND CERTIFICATION

What is Accreditation and Certification?

Accreditation is a voluntary process of standardization verifying that a suicide prevention hotline has met the field's agreed upon standards of care and best practices. The process is carried out by an accrediting agency recognized and maintained by peer professionals. Accreditation includes on- and off-site consultation time involving organizational examiners and the agency seeking accreditation. It also includes a process of written documentation and on-site evaluation to show that the hotline meets accreditation standards.

In the past, the word certification has been used interchangeably with the term accreditation. All of the major accrediting organizations have now switched to the term accreditation to avoid any confusion. The American Association of Suicidology (AAS) is one such organization. During its standardization process AAS shifted from awarding certification to awarding accreditation. The National Suicide Prevention Lifeline (Lifeline) requires that a hotline or crisis center first be accredited by an external, peer body before Lifeline will accept application to become a Lifeline member.

Peer accreditation addresses professional & ethical standards

Why Should an Idaho Hotline be Accredited?

The accrediting organization CONTACT USA (CUSA) aptly explains why a hotline would seek accreditation: "an organization that serves the public and seeks the support of the community needs to set standards for its operations" (Schoop, 2006). It is imperative to have the community's trust when providing such an important and life-altering service. Peer accreditation helps to establish that trust through the voluntary process of publicly acknowledging that a hotline is maintaining professional standards. Through accreditation by a self-governing entity, a hotline ensures that it is maintaining its integrity, mission, and the field's best practices. In addition, peer review aids in establishing a long-term support network, which allows the hotline access to a ready resource for consultation on new practices and

methodologies. Using the years of knowledge garnered from other member suicide prevention hotlines reduces the chance of making unanticipated mistakes. In sum, accreditation reassures funders and supporters that the hotline follows "national, scientifically proven standards" (CUSA, n.d.).

Further, the most recent study on suicide prevention hotlines, conducted in 2001 and later published, made a number of important findings, including the need for "more quality control and monitoring of crisis workers," and the need for training curricula to include certain skills-building activities (Kalafat, Gould & Munfakh, 2005; AAS, 2006). Following the conclusion of the research, a work group was established including members of the AAS accreditation committee. The work group recommended solid, tangible changes that were made available to all members of AAS. As a member of an accrediting body, the most up-to-date research is made readily available to a hotline, reducing risks in working with high risk populations and improving outcomes. According to CUSA's Web site, "accreditation offers an agency the respect and credibility that comes with knowing that their service has met a nationally recognized set of requirements ensuring high quality and ethical practice" (n.d.). In other words, accreditation ensures that a hotline adheres to national standards of safety. National status also enhances the hotline's ability to access grant funds.

Accreditation offers hotlines respect and credibility

If Idaho determines that accreditation is to the benefit of an Idaho hotline, the decision then becomes whether to apply for Lifeline membership. Lifeline requires accreditation before membership is granted. Lifeline members receive a range of important and useful tools upon membership—from the availability of additional funds to a multi-tiered back-up system for crisis calls. More details about Lifeline follow later in this chapter.

How Does Accreditation Work?

To become accredited, a suicide prevention hotline is required to fulfill a number of standards that vary according to individual accrediting bodies. With some accrediting organizations, membership to the organization is required. All of the organizations list requirements regarding hours of operation, focus of the hotline in relation to the hotline's other functions, and a willingness to maintain the accrediting agency's operational standards. Time frames are established for the length of the first accreditation as well as reaccreditation in subsequent years. Training standards are spelled out along with time frames for resolving any training or accreditation problems.

A hotline must first decide with which accrediting body to affiliate. Once this is determined, the hotline administration will want to confirm that they are following the requirements spelled out by that organization. The next step is to complete an application for accreditation (a sample application can be found at the end of this chapter). After the accrediting body receives the application a time for a site visit is established. Site visits are conducted by members of the accreditation committee designated as peer

reviewers. The site visit generally lasts a day and a half to two days with the cost being covered by the hotline. During the site visit, discussions occur about the hotline's strengths and weaknesses. Requirements that must be completed to achieve accreditation are explained along with the best ways to accomplish them. Suggestions may be made for improvements or modification. At the time all of the requirements of the accrediting body are met, the hotline is awarded accreditation, which would allow the hotline to consider membership in Lifeline.

What Are The Accreditation Options?

Numerous accrediting bodies exist, including Alliance of Information Referral Systems (AIRS), American Association of Suicidology (AAS), the Commission on Accreditation of Rehabilitation Facilities (CARF), Contact USA (CUSA), the Council on Accreditation, and the Joint Commission. Each accrediting body has different strengths and focus. All of these organizations provide national status as a member benefit and many also offer international status.

Site visits are conducted by an accreditation committee

The Alliance of Information Referral Systems

The Alliance of Information Referral Systems or AIRS (www.airs.org) is a professional organization that offers accreditation and certification to its members with a focus on information and referral systems. Most AIRS members are clearinghouses for services and information; the United Way is one of its largest member groups. AIRS is respected on a state, national, and international level as a benchmark for information and referral providers, such as 211 systems. However, although information and referral are components of a suicide prevention hotline, it is not *the* primary component and therefore AIRS may not provide relevant hotline support and standardization possible from other organizations.

American Association of Suicidology

The American Association of Suicidology or AAS (www.suicidology.org) was founded in 1968 and provides accreditation to a narrow group of users, primarily hotlines. They have a strong track record in their areas of expertise, of which accreditation is a major part. As an accredited AAS member, a hotline gains access to up-to-date research and best practices, archived discussions regarding crisis centers, and "criteria for systematic, ongoing-self evaluation" (AAS, n.d. c). During the accreditation process, AAS examiners help tailor the accreditation and consultation to individual programs. Their expertise in crisis centers and suicide makes them prepared to consult and accredit an Idaho suicide prevention hotline.

Commission on Accreditation of Rehabilitation Facilities

The Commission on Accreditation of Rehabilitation Facilities (CARF, www.carf.org) provides accreditation for a broad base of human service provider programs including but not limited to aging services, rehabilitation services, and behavioral health services of which accreditation for suicide prevention hotlines is a part. CARF, like AAS, tailors its accreditation process to fit the needs of each program. According to CARF, callers look for CARF accreditation, expecting strong outcomes achievement through CARF's wide range of program-specific resources. CARF provides a support system that includes knowledgeable staff. Once accredited through CARF, a center or program becomes internationally recognized as maintaining the same standards of excellence as all CARF members. Although CARF has the advantage of experience from multiple sectors of the human services field, it is difficult to say whether it would have the benefit of specializing in issues unique to a suicide prevention hotline.

Contact USA

Contact USA or CUSA (www.contact-usa.org/Accreditation.htm) is a leader in the field of crisis line accreditation, having been in existence since 1967. Today, CUSA's network includes 20 states. It is "one of the only programs in the country devoted to establishing and maintaining standards of service at crisis lines, warm-lines, and reassurance calling programs" (CUSA, n.d.). CUSA accreditation immediately links a hotline to the resources of a larger network of specialists dealing with similar problems. Accreditation is for a five-year period. For an Idaho hotline, CUSA's strength lies in its specific focus on hotlines and crisis intervention.

Council on Accreditation

Contextual Accreditation is a trademarked accrediting process provided by the Council on Accreditation (COA, www.coastandards.org/p_guidelines.php). Contextual Accreditation "focuses on each agency's unique mission, resources and culture, as well as the unique needs and aspirations of the people it serves," tailoring the process to the goals of the organization seeking accreditation (COA, n.d.). Geographically, the closest COA accredited organizations are Consumer Financial Solutions and Idaho Youth Ranch, both in Boise. Local alliances such as these could be useful. The disadvantage to COA is its limited hotline experience.

The Joint Commission

The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations or JCAHO is "dedicated to helping health care organizations prosper by improving quality of care and patient safety" (Joint Commission Resources, n.d.). Joint Commission Resources (JCR) is the arm of JCAHO that provides accreditation. The JCAHO web site includes a list of program types that JRC accredits, hotlines are not included.

The organization's focus appears to be on hospital safety. If an Idaho hotline were housed at a Commission-accredited agency, it would make sense for using this agency's accreditation process.

In sum, an overview of relevant accreditation organizations suggests that Idaho consider either CUSA or AAS accreditation. These are the only accrediting programs experienced solely with crisis centers and hotlines. Although the other accrediting bodies may have tangential experience in crisis call centers, their focus is in other areas.

AAS and CUSA Accreditation

CUSA Accreditation Requirements and Accreditation Process

1. CUSA's main goal in providing accreditation is to strengthen effectiveness of centers and hotlines. The accrediting/reaccrediting process is conducted on a five-year cycle as a way to ensure a hotline's efficacy. Since 2005, membership in CUSA has not been a requirement for accreditation. According to CUSA, "full accreditation is based on the ability of the crisis line program to conform to and follow the established accreditation process and adhere to the minimum operating standards as set forth by the CUSA Accreditation Committee and approved by the CUSA Board of Directors" (CUSA, 2008). A sample of these requirements is listed below. The accreditation-seeking organization accepts the conditions of accreditation as presented in the "Application for Accreditation" (see the sample at the end of this chapter).
2. The accreditation-seeking organization accepts and signs the CUSA "Statement of Values" which states that CUSA "is a network of telephone helpline centers that strives to help callers realize their human potential, self-worth, and inner resources to resolve problems or issues affecting their well-being. CUSA exists to uphold the principles on which it was founded: caring, love, peace, inclusiveness, non-judgmental acceptance of all people, and social justice in serving those communities that call us to serve" (CUSA, n.d.) CUSA values are listed below. (1) We value people. We treat all people with respect and courtesy and create an environment of acceptance that supports the attainment of each individual's personal and professional aspirations. We actively promote respect for the dignity of the caller, confidentiality, and anonymity except in cases of abuse, suicide, or homicide, as required by law. (2) We Value Performance. Contributions by individuals and teams are critical to our success. Such contributions at all levels of the organization are appreciated and recognized. (3) We Value Diversity. We actively promote an atmosphere of mutual respect for each other's differences, recognizing that our diversity creates a breadth of perspectives and strengthens our organization. (4) We Value Teamwork. Team-

CUSA and AAS are involved in hotline accreditation

work is critical to our success. Trust and mutual respect for each other's responsibilities, functions, skills, and experience are essential ingredients of teamwork. (5) We Value Communication. We actively promote open, candid communication flowing in all directions. We believe that listening is the key to good communication. (6) We Value Integrity. We are recognized as an organization of the highest ethical standards and integrity. (CUSA, n.d. a)

3. The accreditation-seeking organization completes the on-site visit and receives a passing score. Scoring is done during a site visit and each accreditation component, as listed on the application, is scored based on four levels from 0 to 4. Zero means noncompliance; 1-minimal compliance, 2-adequate compliance, and 3-exceptional compliance. The scoring is cumulative and progressive. Different levels of compliance are required for each component and the scoring evaluators are required to provide recommendations for improvement. The accreditation-seeking organization is approved for accreditation by the Accreditation Committee of CUSA.
4. The Accreditation Committee reviews all components of the hotline's standards, including governance, fiscal and business, training, service, facilities and equipment, and community and integration standards.

CUSA: We promote the highest ethical standards

Cost for accreditation depends on membership. If the hotline is a CUSA member, accreditation is $500 every five years, plus the cost of the site visit. If the hotline is not a CUSA member accreditation is $1000 every five years plus the cost of the site visit. The site visit consists of all transportation costs, meals and lodging on the day of arrival, meals and lodging for one full day (at least eight hours of onsite time) of evaluation and meetings, meals on departure day. The costs, including transportation are approximately $2500 assuming a site visit team of two people. The annual membership fee to join CUSA before or while seeking accreditation is $500 and the hotline must agree to include CUSA's logo in all hotline publicity materials.

Preparing for a site visit is a lengthy process for both CUSA's evaluation team and the hotline. Significant documentation must be sent to the accreditation team in advance of the site visit. A complete list of the required documents is available in CUSA's accreditation manual, (CUSA, 2008), examples of the documentation include a set of bylaws, a mission statement, training documents, and current budget. The documents should be sent to the team at least six weeks prior to the scheduled site visit.

If elements of the accreditation-seeking organization's process do not meet CUSA standards the organization has six months in which to come into compliance and seek a new review. CUSA prefers the submission of documentation showing the required changes have been made. A new on-site review is not generally required.

AAS Requirements and Accreditation Process

One of the core values of AAS is based on the results of research showing the need for active intervention when working with a client in crisis. Therefore AAS requires, as a fundamental aspect of accreditation, that the hotline provides intervention if it is determined that a client's life is in danger. "Being mindful of the callers/client's confidentiality and, in some cases, anonymity, and the intervention would ideally be done with the client's consent and only after all other options have been exhausted. When that is not possible, the intervention will occur without the client's consent or knowledge" (AAS, 2010). If AAS' core value resonates with the policy of an Idaho hotline, further additional requirements must be fulfilled to seek accreditation.

Crisis intervention must be the primary focus of the hotline. The hotline understands that AAS uses as the basis for the accreditation criteria, the manual *Program Analysis of Service Systems (PASS)* (Wolfensberger & Glenn, 1978). Utilizing the PASS structure, AAS evaluates hotlines on seven basic areas of function, each with separate standards. They are administration and organizational structure; screening, training and monitoring crisis workers; general service delivery system; services in life-threatening crises; ethical standards and practices; community integration; and program evaluation. CUSA uses six areas of standardization and although it is difficult to make direct links across the two organizations' standards of evaluation, within the subcategories of the areas all of the same fundamental standards are considered.

AAS: Intervention without the caller's consent may occur in some cases

Membership with AAS is required, although payment for membership can occur at the same time application is made for accreditation. In addition, the hotline must send a hotline member to the annual AAS convention every year of the three-year accredited period. This is for the first period of accreditation. After the initial three-year period, reaccreditation occurs every five years and hotlines are required to send a representative to the annual conference at least two times out of those five years. A hotline must be already operating at the time of application.

Once the hotline is ready for accreditation, the following documents should be completed and sent to AAS: a complete application (including the three page application and one page prescreening questionnaire, see sample below), a copy of the organization's active intervention policies, and an application fee of $250 and site accreditation/visit fee of $2500. Site visits can last as long as two days for first time accreditation. Additional costs include the expenses of generally two examiners, including transportation, meals, and lodging; the hotline is invoiced directly for these costs. AAS offers subsidies to cover the costs of accreditation in some instances. Should the hotline not qualify for accreditation, AAS provides consultation to help make the necessary changes to seek later accreditation. If accreditation is

awarded, the hotline is required to submit an annual self-survey report during its period of accreditation. AAS offers an appeal process in regard to the denial of accreditation.

Comparison of AAS and CUSA Requirements

Table 6 (seen previously in *Chapter 3: Data*) provides a ready evaluation of the differences between the two organizations in regard to accreditation and for the most part supports the comments above.

Table 12: Comparative Costs of Accreditation with AAS and CUSA

	AAS	CUSA
Accreditation and Membership Costs		
Application Fee	$250	$500
Annual Membership Dues	$250[1]	$500
Accreditation Fee	$2500[2]	

[1] Annual membership required; membership dues are based on annual budget, $250 is for annual budget between $100,000 and 199,999.

[2] Reaccreditation is an additional $1500

Should Idaho's Hotline Choose AAS or CUSA?

Whether to seek accreditation from AAS, CUSA, or another entity will need to be explored by the agency that takes over operation of Idaho's hotline. CUSA accreditation is less costly and less proscriptive--mandating policies and procedures, but not content. CUSA also will accredit a hotline that does not operate 24/7 while AAS will not. This may be a consideration in Idaho, especially as a hotline begins.

The National Suicide Prevention Lifeline Network

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Lifeline is a nationwide network of crisis centers established to be mutually supporting in very tangible ways. As mentioned earlier, should the hotline become accredited, a natural extension of that would be to seek certification with Lifeline. By becoming certified, a number of important benefits may be reaped. According to the Lifeline Web site some of these are:

- An annual stipend to member hotlines
- Frequent monetary support from SAMSHA, including a new award that will be made to six Lifeline centers for $60,000 per hotline or center. For more information, please see the link to the SAMHSA Web site at: www.samhsa.gov/Grants/2010/SM-10-014.aspx
- Weekly and monthly call volume reports
- Multi-tiered back-up system
- Information sharing via blog and conference calls

Table 6: Summary of Accreditation Analysis		
Item	**AAS**	**CUSA**
Basic Eligibility Criteria:	• Offer crisis intervention services as primary focus or principal component of services offered • Must be an AAS organization member • Must be operational 24/7	• Must have been in operation for at least one full year • Agree to the minimum CUSA operational standards • Must be operational during advertised hours only
Accreditation/ Reaccreditation Cycle:	• First accreditation:3 years • Reaccreditation:5 years	• First accreditation:5 years • Reaccreditation:5 years
Steps to Accreditation:	• Accept accreditation requirements • Complete pre-screening questionnaire • Provide organization documents per accreditation manual • Complete on-site visit and earn a passing score	• Accept accreditation requirements • Complete pre-screening questionnaire • Provide organization documents per accreditation manual • Complete on-site visit and earn a passing score
Time to address problems/ reapply:	No time frame provided	Six (6) months
Accreditation Standard/ Requirements:	• Board of Directors/Bylaws • Salaried Program Director • Designated Office Space • 24/7 Hours of Operation • Operate with generally accepted accounting principles for budget/business records • Follow up all calls • Routine Lethality Assessment • Program Evaluation Capabilities • Confidentiality Policy • General Written Procedures for Rescue Services • Code of Ethics • Detailed Training Program	• Board of Directors/Bylaws • Appropriate legal structure (e.g. – IRS nonprofit status, government agency) • Mission Statement • Sufficient staff with clearly defined duties • Appropriate facilities • Appropriate and up-to-date technology • Accessible to callers during advertised hours • Sufficient revenue for hotline operation • Accurate records • Clearly defined confidentiality policy • Code of Ethics • Detailed training program
Basic Operator Training Standards:	• Minimum requirements: 32 classroom hours 8 apprenticeship hours **40 total training hours** • Training must address AAS Core Competency Requirements • Must adhere to Best Practices Training recommended by AAS • Must include required training components per AAS guidelines	• Minimum requirements: 24 classroom hours 8 apprenticeship hours **32 total training hours** • Training must address CUSA Core Competency Requirements • Provide continuing education opportunities for volunteers/ staff • Training/eval. at least annually including volunteer recruitment
Main Focus of Training:	• Attitudinal Outcomes • Knowledge Outcomes • Skill Outcomes	• Attitudinal Outcomes • Knowledge Outcomes • Skill Outcomes

- Comprehensive language services for non-English speakers who phone member hotlines
- Real Time Caller ID
- 911 Locator
- National promotions and free materials
- Credibility
- ASIST (Applied Suicide Intervention Skills Training) training
- Webinars
- Access to best practices

One crucially important asset is that hotline calls "originating from anywhere in the country will be routed, 24 hours a day, to the nearest available crisis center. This call routing is based on crisis center capacity and availability" (Lifeline, n.d.). Lifeline now has 140 center members in 49 states, making this roll-over a strong component of member centers' backup. Idaho is the only state in the nation without a Lifeline-certified hotline. By becoming a Lifeline member, the hotline becomes eligible for additional federal funds. In one instance a competitive bidding process for $20,000 was available for small hotlines to enhance services and provide follow-up contact with high risk suicide callers. Lifeline also provides a $2500 annual stipend for all network centers. This could offset some of the expenses of accreditation.

Lifeline has 140 centers in 49 states

Becoming a member is simple after having gone through the accrediting process. Being accredited by an approved external body is one of Lifeline's requirements. Both AAS and CUSA are approved entities. In addition, since data collection is an important part of Lifeline, certified members must agree to participate in Lifeline's evaluation activities. The hotline must adhere to a set of "written policies or guidelines addressing referral, training and suicide risk assessment" (Lifeline, n.d.). No additional costs are involved in being certified by Lifeline.

Should an Idaho Hotline Choose Certification with Lifeline?

Lifeline membership should be considered an essential part of any hotline due to the unique funding stream and capacity for call backup. If Idaho operators are unable to answer a call, Lifeline will ensure that no call goes unanswered.

Figure 17: Sample AAS Application

APPLICATION FOR AMERICAN ASSOCIATION OF SUICIDOLOGY

AMERICAN ASSOCIATION OF SUICIDOLOGY

5221 Wisconsin Avenue NW, Washington, DC 20015

Application for Accreditation or Re-accreditation

Sample based on Stand Alone Hotline

New: X Renewal:_

I. DATA REGARDING PROGRAM

Name of Program: **[INSERT NAME HERE]**

Contact Person: **[INSTERT NAME HERE]**

Address: **[INSERT ADDRESS HERE]**

City: **[INSERT CITY HERE]** State: **ID** Zip: **[INSERT ZIP CODE HERE]**

Business Telephone Number: **[INSERT PHONE HERE]** Fax: **[INSERT FAX HERE]**

E-mail of Executive Director: **[INSERT EMAIL ADDRESS HERE]**

E-mail Address of Person Completing This Application: **[INSERT EMAIL ADDRESS HERE]**

1) Current Annual Budget: **[INSERT AMOUNT HERE]**

2) Is your organization a member of AAS? Yes **X** No___(If no, you must be a member of AAS to be accredited)

3) List below the name and address of major funding sources

Name	Address	City	State	Zip Code

For a nonprofit list the sources that donate to the crisis line operating budget, and for a governmental organization list your own budget as the source of funding.

II. SERVICES PROVIDED

Check all services provided. Doublecheck those considered major or objectives:

X Suicide Prevention Hotline

_____Teen Hotline

_____Alcoholism Information Service

_____Rape Crisis Counseling

_____Survivors of Suicide Support Group

_____Sexually Transmitted Disease Info

Figure 17: Sample AAS Application, cont.

_____General Victim Services
_____Drop In Center
_____Compassionate Friends
_____Child Abuse Counseling
_____Drug Information Service
_____Sex Information
_____Mental Health I & R
_____Mobile outreach
_____Face to Face Counseling
_____General Grief Support Groups
__X__General Crisis Hotline
_____Teen to Teen Hotline
_____Substance Abuse Counseling
_____Outreach Program
_____Domestic Violence
_____Specify Other:

III. PERSONNEL INFORMATION

Program Director's Name:___**[INSERT NAME HERE]**_____Degree(s): ___**[INSERT HERE]**

Director's Employment Status: ☑Full Time ☐Part Time ☐ Salaried ☐ Volunteer

Total Number of Salaried Employees: _____ Full Time: _____ Part Time:_____

Number of salaried employees with degrees in Mental Health Disciplines (e.g., Ph.D., M.S.W.)

_____**[INSERT NUMBER HERE]**___

Total Number of Volunteers (organizational wide)__**[INSERT NUMBER HERE]**___

IV. AGENCIES/ORGANIZATION TO BE NOTIFIED UPON ACCREDITATION

Please note: if you wish to notify more than 4 agencies, mailing labels are required.

Name Address City State Zip Code

V. MEDIA SOURCES TO RECEIVE NEWS RELEASES

Please note: if you wish to notify more than 4 agencies, mailing labels are required.

Name Address City State Zip Code

Figure 17: Sample AAS Application, cont.

I have included:

__X__ A copy of my organization's (active) intervention policies and procedures.

__X__ A completed Pre-Screening Questionnaire, with explanations of questions answered "no."

In submitting this Application for Accreditation to the American Association of Suicidology, we hereby agree to the following conditions related thereto:

AGREEMENT

1. We agree to prepare and provide copies of any written material that may be requested by the Committee on Accreditation as a part of the evaluation process.
2. We agree to pay the fees required and to maintain an organizational membership in AAS.
3. We agree to attend the AAS annual conference as spelled out in this manual (i.e. once per 3 years or twice for a 5 year accreditation.
4. We agree that the Examiners will not be offered or given any other form of honorarium, stipend, consultation fee or remuneration for any activity or service rendered at the time of the site evaluation.
5. We agree to notify the Chief Accreditation Examiner immediately whenever any change in our program may effect our accreditation status.
6. We agree to notify AAS within 30 days of any changes to our Executive Director, address, phone numbers, email, or URL.
7. We agree to submit the annual self - survey report to AAS by February 1 unless we have been newly accredited or re-accredited in the last 6 months of the year or the first six months of the coming year.

_____

Program Director

_____

Date

Figure 18: Sample CUSA Application

CONTACT USA APPLICATION FOR ACCREDITATION AND SITE VISIT

Submit this registration to:

CONTACT USA

Accreditation Coordinator

1870 Murray Loop

Bosque Farms, NM 87068

Sample based on Stand Alone Hotline

Crisis Line Program to be Accredited: **[INSERT NAME HERE]**

Program Director: **[INSERT NAME HERE]**

Address: **[INSERT ADDRESS HERE]**

City: **[INSERT CITY HERE]** State: **ID** Zip: **[INSERT ZIP CODE HERE]**

Telephone: **[INSERT PHONE HERE]** Fax: **[INSERT FAX HERE]**

Web Site: **[INSERT WEB ADDRESS HERE]** E-mail: **[INSERT EMAIL ADDRESS HERE]**

Agency Name (if different): **[INSERT NAME HERE]**

Name of Executive Director: **[INSERT NAME HERE]**

Address: **[INSERT ADDRESS HERE]**

City: **[INSERT CITY HERE]** State: **ID** Zip: **[INSERT ZIP CODE HERE]**

Telephone: **[INSERT PHONE HERE]** Fax: **[INSERT FAX HERE]**

Web Site: **[INSERT WEB ADDRESS HERE]** E-mail: **[INSERT EMAIL ADDRESS HERE]**

Date Crisis Line Program was established: **[INSERT DATE HERE]**

Budget Information for Current Program Year

Crisis Line Budget: $ **[INSERT AMOUNT HERE]**

Total Agency Budget: $ **[INSERT AMOUNT HERE]**

Major Funding Sources for Crisis Line

For a nonprofit list the sources that donate to the crisis line operating budget, and for a governmental organization list your own budget as the source of funding.

Figure 18: Sample CUSA Application, cont.

Services Provided by Agency

Check ☑ any of the following services provided by your program. Double-check [XX] those considered major purposes or objectives.

☑ Crisis Line
☐ Kidsline
☐ Teen Line
☐ Reassurance Contact
☐ Information and Referral
☑ Suicide Prevention

Other Services (Please specify.)

☐ _____ ☐ _____
☐ _____ ☐ _____

Personnel Information

Agency Staff: _____Full-Time ____Part-Time____Volunteer_____ Total **[INSERT AMOUNTS]**
Crisis Line Staff: _____Full-Time ____Part-Time____Volunteer_____ Total **[INSERT AMOUNTS]**
Crisis Line Staff with Degrees in Mental Health Disciplines:
_____Full-Time ____ Part-Time____Volunteer ____Total **[INSERT AMOUNTS]**

Agency Executive Director:_____**[INSERT NAME HERE**_____
Education/Degree:___**[INSERT NAME HERE]**_____ _____Full-Time ____ Part-Time____Volunteer

Crisis Line Program Staff:

1. Position Title: _____
_____Full-Time ____ Part-Time____Volunteer
2. Position Title: _____
_____Full-Time ____ Part-Time____Volunteer
3. Position Title: _____
_____Full-Time ____ Part-Time____Volunteer
4. Position Title: _____
_____Full-Time ____ Part-Time____Volunteer
5. Position Title: _____
_____Full-Time ____ Part-Time____Volunteer

Figure 18: Sample CUSA Application, cont.

6. Position Title: _____

_____Full-Time ____ Part-Time____Volunteer

7. Position Title: _____

_____Full-Time ____ Part-Time____Volunteer

8. Position Title: _____

_____Full-Time ____ Part-Time____Volunteer

Use additional pages as needed.

Total Crisis Line Specialists: _____Full-Time ____ Part-Time____Volunteer **[INSERT AMOUNTS]**

Application Fee

☐ $500 for CONTACT USA Member Centers

☐ $1,000 for other Crisis Line Programs

☐ Check enclosed

☐ Please charge to (circle one) MasterCard VISA

Name on card: _____

Card Number:_____ Expiration Date: month: _____year: _____

Figure 19: Sample Lifeline Network Application

APPLICATION TO JOIN NATIONAL SUICIDE PREVENTION LIFELINE NETWORK

Sample based on Stand Alone Hotline

Date of Completion: _____

Organizational Information

Name of hotline/call center and organization under which it operates:

[INSERT NAME HERE]

Address:

[INSERT FULL ADDRESS HERE]

Administrative Telephone: **[INSERT PHONE HERE]** Fax: **[INSERT FAX HERE]**

Organizational website URL/address: **[INSERT WEB ADDRESS HERE]**

Name, telephone number and email of person completing this application:

[INSERT NAME, PHONE, AND EMAIL ADDRESS HERE]

CEO/Executive Director: **[INSERT NAME HERE]**

Primary contact person and contact information for hotline/call center:

[INSERT NAME, PHONE, AND EMAIL ADDRESS HERE]

How long has your hotline/call center been operating in your community?

[INSERT AMOUNT HERE]

Number of sites requesting participation in the Lifeline Network (please identify mailing and contact information for each): **[INSERT HERE]**

Has your hotline/call center been part of the national suicide prevention network?

☐ Yes ☑ No

If yes, please note dates of participation: _____

Is your hotline/crisis center participating in a local or statewide hotline network? ☐ Yes ☑ No

If yes, please list here: _____

If your hotline/call center becomes a member of Lifeline Network, will that affect your participation with any other networks in which you are currently involved?

☐ Yes ☑ No

Please note there are no restrictions on the number of local or national networks in which a Lifeline member can participate.

Expires on: **[INSERT DATE HERE]**

Expires on: _____

Figure 19: Sample Lifeline Network Application, cont.

Organizational/Oversight Structure

1. What types of certification(s)/accreditation(s) does your hotline/call center currently have? (check all that apply and include expiration dates)

☑ American Association of Suicidology (AAS)	Expires on: **[INSERT DATE]**
☑ CONTACT USA	Expires on: [**INSERT DATE]**
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)	Expires on: _____
☐ Alliance of Information & Referral Systems	Expires on: _____
☐ The Joint Commission	Expires on: _____
☐ Council on Accreditation	Expires on: _____
☐ Other (please list):	Expires on: _____

2. Is your center licensed/certified by a governmental or affiliated body which routinely audits your agency? ☐ Yes ☑ No
   If so, please check all that apply:
   Office of Health: ☐State ☐County ☐City
   Office of Mental Health: ☐State ☐County ☐City
   Office of Substance Abuse: ☐State ☐County ☐City
   ☐Medicaid
   ☐Medicare
   ☐Other, please specify
3. Which of the following describes your hotline/call center's liability insurance? (check all that apply) **[CHECK TYPES]**
   ☑ It covers directors and officers (D & O)
   ☑ It covers staff and volunteers who respond to crisis calls
   ☑ It covers a minimum of $1,000,000 worth of damages each occurrence
   ☐ It covers a minimum of $3,000,000 worth of damages in aggregate
   ☐ Other (please describe):

Scope of Services

4. Specialized Services
   a. Please note below all language capabilities your center's staff can provide directly to callers. **[INSERT AMOUNTS]**

LANGUAGES	DEDICATED LINE (NOTE HOURS OF OPERATION)	NO DEDICATED LINE (NOTE CAPACITY)
Spanish		
Other(s):		

Figure 19: Sample Lifeline Network Application, cont.

b. Your call center primarily targets which groups?

☑ All ☐ Teens and/or young adults ☐ Adults/parents ☐ Seniors

Do you have dedicated lines/services center for any of the groups below?

[**INSERT AMOUNTS**]

GROUP	DESCRIBE SERVICE	HOURS OF OPERATION
Teens		
Young Adults		
Adults		
Seniors		
Other:		

c. Do you have a TTY line?

☑ Yes ☐ No

If yes, please indicate the number **[INSERT TTY LINE NUMBER HERE]**

Is it a dedicated line?

☐ Yes ☐ No

d. Do you have access to translation services for all languages?

☐ Yes ☑ No

If yes, indicate name of language service [**INSERT LANGUAGE SERVICE NAME HERE]**

e. How many total calls does your center receive monthly, on average?

[INSERT AMOUNT HERE]

Please indicate below what % of these calls concern each of the following?

[INSERT AMOUNTS]

_____% Suicide

_____% Mental health concerns other than suicide

_____% Substance abuse concerns

_____% Social services

_____% Other, please describe: Crisis and referral calls

f. For which geographic area(s) does your center primarily provide services?

Idaho

g. What is the approximate total number of persons residing in the area(s) to which your center provides service?

Idaho's population: 1,523,816

Figure 19: Sample Lifeline Network Application, cont.

Operations

5. Does your hotline/call center operate 24/7?
   ☑ Yes ☐ No
6. Is the hotline/call center a separate and distinct service that is part of a larger organization/agency that provides various other services?
   ☐ Yes ☑ No
   If yes, please note below if the call center has dedicated staff, policies & procedures, supervisory personnel, etc.
7. Follow-up and Linkages with other Agencies/Organizations
   a. What is your relationship with local 911 and law enforcement?
      ☑ Formal (contract and/or Memorandum of Understanding)
      ☐ Informal (knowledge of and ability to refer as a known crisis service)
      ☐ None (do not routinely seek to link callers to 911 or law enforcement)
   b. What is your relationship with local hospital emergency rooms?
      ☐ Formal (contract and/or Memorandum of Understanding)
      ☑ Informal (knowledge of and ability to refer as a known crisis service)
      ☐ None (do not routinely seek to link callers emergency services)
   c. What is your relationship with mobile crisis teams?
      ☐ Formal (contract and/or Memorandum of Understanding)
      ☑ Informal (knowledge of and ability to refer as a known crisis service)
      ☐ None (do not routinely seek to link callers to mobile crisis teams)
      ☐ There is no mobile crisis team currently serving our area(s)
8. Does your hotline/call center have a connection to your local mental health system that allows you to routinely follow up to determine a caller's disposition in those cases where emergency services were dispatched (e.g., liaison at the local emergency room, liaison with mobile crisis services, shared staff)
   ☑ Yes ☐ No
9. Does your center routinely follow up with suicidal callers?
   ☑ Yes ☐ No
   If yes, please describe: **Provide follow up calls one month later for those who provide contact information**
10. Are you a 211 call center?
    ☐ Yes ☑ No
    If no, is there a 211 call center in your area with which you are currently working or with which you are interested in working in the near future?
    ☑ Yes ☐ No

Figure 19: Sample Lifeline Network Application, cont.

Technology, Equipment, and Data Collection

11. Does your hotline/ call center use any of the following to manage incoming calls?
    - ☐ Automated Attendant
    - ☐ Automatic Call Distribution
    - ☐ Answering Machine
    - ☑ None of the above
12. Do you have a dedicated line for the national suicide hotline?
    ☐ Yes ☑ No
    If not, would you consider establishing a dedicated line if the National Suicide Prevention Lifeline provided you with the funds to do so?
    ☑ Yes ☐ No
    If not, please explain why:
13. Do you have caller ID?
    ☑ Yes ☐ No
    If not, is it available in your area?
    ☐ Yes ☐ No
    If it is available, please explain why, if applicable, you would not consider obtaining it for this network:
14. Internet access (check all that apply)
    - ☐ Do not have internet access
    - ☐ Internet is available in our area, but we do not currently have access
    - ☐ Our agency's internet is currently not accessible to direct hotline workers
    - ☑ Hotline staff has internet access and capacity to use web-based applications

    If hotline staff has internet access at your center, please describe any limitations (e.g., shared computers, dial-up connection) below:
    Shared computers
15. What kind of data are you collecting? (check all that apply)
    - ☑ Personal/Demographic
    - ☑ Geographic
    - ☐ Symptoms
    - ☑ Referrals
    - ☑ Other screening/assessment information
16. Would you be willing to share the type of data (de-identified) outlined in Question 15 above with the National Suicide Prevention Lifeline for evaluation purposes?
    ☑ Yes ☐ No

Figure 19: Sample Lifeline Network Application, cont.

17. How does your center currently provide referrals to callers? (check all that apply)
- ☑ We use a computerized, in-house database
- ☐ We use a paper resource/referral directory
- ☑ We use an online database
- ☐ We search the internet
- ☐ We do not routinely provide referrals
- ☐ Other (please describe):

Staffing of Hotline/Call Center

18. a. Suicide hotline telephone workers only (place number of staff in appropriate boxes) **[INSERT AMOUNTS]**

STATUS	NON-MENTAL HEALTH PROFESSIONALS	MENTAL HEALTH PROFESSIONALS (MASTER'S LEVEL OR ABOVE)
Full-time		
Part-time		
Volunteer		

b. Suicide hotline supervisors only (place number of staff in appropriate boxes) [**INSERT AMOUNTS]**

STATUS	NON-MENTAL HEALTH PROFESSIONALS	MENTAL HEALTH PROFESSIONALS (MASTER'S LEVEL OR ABOVE)
Full-time		
Part-time		
Volunteer		

19. On a typical day, what is the ratio of supervisor(s) to telephone workers (including employees and volunteers) (e.g., 1:5 or 1 supervisor to 5 telephone workers)? **[INSERT AMOUNT]**

20. What is the average number of workers for your call center on each shift noted below? [**INSERT AMOUNTS]**

9am-5pm _____ 5pm-11pm _____ 11pm-5am_____
5am-9am _____ Other: _____

Figure 19: Sample Lifeline Network Application, cont.

Quality Assurance

21. Your center has a quality assurance structure (check all that apply):
    - ☑ Checking documentation
    - ☑ Checking compliance with policies and procedures
    - ☐ Silently monitoring calls
    - ☑ Monitoring of staff's responses to callers
22. If your center routinely silently monitors calls, check all that apply:
    - ☐ We do not use a standard assessment form to rate/document worker performance
    - ☑ We utilize a standard assessment form/procedure to rate work performance
    - ☐ We monitor calls daily
    - ☐ We monitor calls weekly
    - ☑ We monitor calls monthly
    - ☐ We monitor calls quarterly or less often
23. If your center does not currently silently monitor calls, would your center be willing to implement silent call monitoring in the future?
    ☑ Yes ☐ No
24. Supervision for call center staff occurs (check all that apply):
    a. Individually, regularly for each worker
    ☐ Weekly ☐ Monthly ☑ Quarterly ☐ Other ☐ As needed (please describe):

    b. In a group led by a professional/supervisor
    ☐ Weekly ☑ Monthly ☐ Quarterly ☐ Other ☐ As needed (please describe):

    c. In a peer group
    ☐ Weekly ☑ Monthly ☐ Quarterly ☐ Other ☐ As needed (please describe):

25. Do you utilize any screening/assessment instruments on the hotline?
    ☑ Yes ☐ No

    If yes, please check all that apply:

    ☐ General symptom severity ☐ Depression ☐ Anxiety
    ☑ suicide risk assessment ☐ Other:

Figure 19: Sample Lifeline Network Application, cont.

Training

26. How many hours of training do new hotline/call center employees and/or volunteers receive in each of the following categories before answering calls (fill in all that apply)?

[INSERT AMOUNTS]

Suicide risk assessment:	_____hours
Emergency service linkages:	_____hours
Listening/engagement	_____hours
Dealing with difficult callers	_____hours
Information and referral/resources	_____hours
Other (please describe below)	_____hours

27. How many hours of in-service (refresher courses) are hotline/call center staff and/or volunteers required to receive each year in each of the following categories? (fill in all that apply)

[INSERT AMOUNTS]

Suicide risk assessment:	_____hours
Emergency service linkages:	_____hours
Listening/engagement	_____hours
Dealing with difficult callers	_____hours
Information and referral/resources	_____hours
Other (please describe below)	_____hours

28. Do you have a person on staff dedicated to overseeing the development and implementation of training for your hotline/call center staff and/or volunteers?

☑ Yes ☐ No

29. Who delivers training to your hotline/call center staff and/or volunteers?

☑ A staff person
☐ A volunteer
☑ An external contractor
☐ Other (please describe)

Please attach a copy of the following to this application:

1. Proof of liability insurance showing the type and amounts of coverage (see question 3)
2. Proof of certification/accreditation/licensure (see questions 1 and 2)
3. Copy of your center's suicide risk assessment instrument, if applicable (see question 25)
4. A copy of your center policies or written guidelines

Return via fax to (212) 964-7302 or mail to:
National Suicide Prevention Lifeline
Link2Health Solutions, Inc.
50 Broadway, 19th Floor
New York, NY 10004

CHAPTER 5
SAMPLE POLICIES

Introduction

Chapter 5 is intended to help anticipate issues for policy development. Note that these are only sample issues, solutions, and suggested policies. Each organization will need to determine the best solutions and policies to fit its situation and environment. Also, this list of issues/policies is not inclusive, as it could never anticipate all the concerns that a hotline might field.

The chapter is divided by common areas of management for a hotline: issues involving suicide prevention hotline calls, issues of confidentiality, and issues involving care of operators and supervisors. The most extensive of these three areas is that of issues involving calls. Policies and procedures provide operators with steps to follow for each call. Each issue or problem begins with a description of the problem and possible solutions followed by a sample policy statement that could be the basis for a hotline's policy manual. Use these suggestions as a starting point for establishing a hotline policy guide and manual.

Issues of Confidentiality

Confidentiality Requirements

Issue or Problem

It is important for the hotline to determine its policy regarding breaking confidentiality to contact emergency services in instances of imminent risk. Some hotlines do trace calls and send emergency services when they believe a caller's life is in imminent danger. Other hotlines choose to make confidentiality their priority. There are procedures for either method but it is important that a clear policy is in place. This is important for two reasons. First, it gives operators and staff clear guidance for what they are

expected to do in a crisis. Second, it is important to have established policy in case there is a negative outcome that comes under review by an outside authority or community stakeholders.

See also the section on Follow-up Calls, High-Risk Calls, Calls Involving Sexual Assault, and Calls Involving Violence.

Sample Policy Statement

The [insert name here] provides a completely confidential service. Discussion of calls is restricted to the [insert name here] call hotline and private [insert name here] meetings. No discussion of calls should occur outside of these two situations. Confidentiality means that no person outside of the [insert name here] has the right to hear the content or a discussion of the content of any call. Operators and staff will not give out any information about previous calls to any caller. No one is allowed on the hotline premises other than [insert name here] staff and volunteers without the specific permission of a supervisor. No information about calls may be removed from the hotline premises under any circumstances.

Established policies help to avoid negative outcomes

There are certain circumstances when a breach of confidentiality is warranted. Only the Professional Director has the authority to make these types of decisions.

Operators shall use only first names when taking calls. Operators do not give out information about themselves or other staff, volunteer or professional. Operators and supervisors shall never intentionally meet in person anyone with whom they have talked on the phone.

If an operator knows or encounters a person that they know they have spoken with, the operator shall not mention this to the person, or to anyone else. If the person who called mentioned the call to the operator, the operator will tell the caller that she or he cannot acknowledge or discuss the call with them.

Issues Involving Hotline Calls

High-Risk or At-Risk Calls

Issue or Problem

It is crucial that a suicide risk assessment be conducted with every caller to ascertain what level of risk a caller may be in. Recent research shows that hotlines have not routinely assessed each call for risk. While the majority of calls that come into a suicide prevention hotline are not from people at imminent risk, there are some calls where the caller may be in danger. Operators should be trained to listen for the suicide potential. If the caller is assessed to be at imminent risk, there are two main options in handling the call.

The key issue in determining the hotline's policy for imminent risk is in regard to confidentiality. Typically the reputation of hotlines of all types, including suicide prevention hotlines, is based on the confidentiality of the caller. It may be this very confidentiality that encourages the caller to actually place the call in the first place.

In preparation for instances of imminent risk of a caller, the hotline must establish a policy to address whether it will break confidentiality to notify public safety officials such as the police and emergency medical services. Because of the difficulties with either path, these policies should be made thoughtfully and typically will be established by a board or committee. If a hotline decides that it will not break confidentiality regardless of the assessed lethality of the caller's mental state, it must articulate in writing its reasons in order to have a clear policy should harm come to a caller. If a hotline decides that it will break confidentiality (e.g. make rescue calls), a clear policy will provide a justification, at the time or after the fact, for its decision to break confidentiality.

While a suicide prevention hotline typically relates to self-harm, a caller may be at risk for harm by others. For example, a victim of family violence may call the hotline at the time of an assault. Regardless of the source of the harm, the call should be treated as high-risk.

A hotline should be aware of, and address, the negative consequences for rescue calls on the operator.

The reputation of a hotline is based on giving confidentiality to the caller

Sample Policy Statement

Does Not Break Confidentiality for Callers Assessed to be at Imminent Risk

It is the policy of [insert name here] not to break confidentiality with its callers under any circumstances, including situations where the caller may be at imminent risk. The hotline is a hotline, not a public safety organization and thus does not assume responsibility for the safety of its callers.

Does Break Confidentiality for Callers Assessed to be at Imminent Risk

It is the policy of [insert name here] that confidentiality of the caller ends when the caller is assessed to be at imminent risk. If imminent risk is determined by the operator, the operator initiates the "rescue call" protocol that includes making all efforts to keep the caller from self-harm during the call, notifying a supervisor, and tracing the call to alert 911 of the caller's imminent risk.

Unconditional Acceptance of the Caller

Issue or Problem

It is typical for suicide prevention hotlines to provide unconditional acceptance for each caller. The policy to provide unconditional acceptance for the caller does not mean that the caller's behaviors and choices are accepted unconditionally. Callers may present a variety of concerns that may or may not be associated with suicide prevention or mental health referrals.

Sample Policy Statement

The [insert name here] advocates unconditional acceptance for each caller.

Structure and Methodology to Be Followed for Calls

Issue or Problem

There are multiple options for structuring calls taken by operators. One such protocol is the R.I.D.E.S. method (Agora Crisis Center, n.d.). At the core of any protocol is establishing boundaries between the caller and the operator. These boundaries protect both the caller and the operator. The caller receives the services that the operator can appropriately provide and the operators can be protected from struggling with any negative consequences from their work. This boundary improves the services that the caller receives, and structures the operator's responses, reducing the risk of a negative impact on the operator. There are two aspects to the need to set boundaries.

Having a clear protocol can protect operators from undue stress

First, callers will receive immediately useful emergency services. While the callers may be sufficiently stressed that they can perceive the call as psychotherapy, the structure will reduce the potential confusion in regard to the services received on the emergency call.

Second, in some cases the call may be very stressful on the operator. Having a clear protocol to follow will assist the operator in managing stress response to the caller and help protect the operator from post-call negative reactions. While any operator may suffer from Compassion Fatigue or even Secondary Traumatic Stress as a result of their work as an operator, providing operators with clear guidance as to their roles and responsibilities will help minimize that risk.

Sample Policy Statement: Use the R.I.D.E.S. Protocol

The [insert name here] policy is to use the R.I.D.E.S. protocol for managing calls. The method is a structured method to assist the caller while maintaining boundaries appropriate to a suicide prevention hotline. Hotlines do not provide therapy and thus must avoid providing therapy services.

All operators will be trained to this protocol.

The R.I.D.E.S. protocol contains five parts, represented by the letters in the acronym.

1. *Establishing and maintaining* ***Rapport***
2. ***Identifying*** *the problem*
3. ***Dealing*** *with feelings*
4. ***Exploring*** *alternatives*
5. ***Summary*** *and closing including establishing a plan of action, exploring possibilities of failure and alternatives, and making referrals.*

Call Back

Issue or Problem

Some hotlines instruct their operators to ask the caller to check back a few days later. The general underlying principle of asking callers to do this is to give them a task that has a future timeframe to it and to support the caller by showing a genuine concern about how they are doing. The typical suggested timeframe for the call back is a few days.

Sample Policy Statement

Operators at [insert name here] will encourage callers to call back in a few days to let the hotline know how the caller is doing.

Some hotlines ask callers to check back in a few days

Follow Up Calls

Issue or Problem

Some hotlines use an operator-initiated follow-up call for callers that the operator determines to be "at risk." At the end of the initial call, the operator procures permission from the caller to call them back to see how they are doing. The typical timeframe for the callback is a few days.

A great deal of research is currently being conducted about follow-up calls. The information about follow-up calls provided in this report is from the Lifeline that currently is researching and developing guidance for crisis hotlines that use follow-up calls with "at risk" callers. To date, the research has shown that there is a significant group of people who will find help during an initial call but may become suicidal again shortly after that call. According to discussions with Lifeline, research finds that approximately 82% of the Lifeline network crisis hotlines are performing some kind of follow-up services for those callers who are assessed as being at risk for suicide during their call to a hotline but did not receive emergency services (L. Bernik, personal communication, 3 March 2010c). The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has demonstrated its

commitment to follow-up practices by funding a Lifeline workgroup to research the use of follow-up services, and announcing a grant that funds six crisis hotlines to develop or expand their follow-up services for callers (L. Bernik, personal communication, 3 March 2010; SAMHSA, 2010c).

When a follow-up call is made it is completed by a hotline operator but may not be the original operator with whom the caller spoke. Most hotlines that are doing calls spend 10 hours or less each month on the follow-up calls.

In order to conduct a follow-up call, the operator must obtain permission from the caller. It is not clear what the exact percentage of people is who agree to a follow-up call, but it does seem to be related to the procedures of different hotlines. Some hotlines have a higher percentage than others.

Procedures for follow-up calls need to be clear for operators

The procedures for asking about follow-up calls need to be clear to the hotline's operators. If the caller does wish to have a follow-up call, the operators should confirm the caller's phone number and call preferences. For example, is it acceptable to the caller for the operator to leave a message on an answering machine? Lifeline recommends that operators not only be trained in protocols to obtain permission for follow-up calls, they should also be trained as to when not to ask about a follow-up call. Lifeline recommends not asking about making a follow-up call when (1) the caller is under 18 years of age, (2) the caller lacks the capacity to give consent, (3) the caller is unable to focus on a discussion related to a follow-up call, or (4) the caller is assessed to be at imminent risk. In the latter case, operators should follow the hotline's policy associated with imminent risk. In addition, Lifeline has provided sample protocols for following up with callers.

Some organizations may not want to establish a policy of follow-up calls for multiple reasons, including the need for increased staffing needs, confidentiality issues, and legal ramifications such as the perception of taking responsibility for the safety of the person. Lifeline reports that the challenges hotlines face are mainly associated with practical barriers such as finding time to complete the necessary organizational tasks, staffing, and finding a confidential tracking system.

Sample Policy Statement

Hotline Does Make Follow-up Calls

[Insert name here] chooses to make follow-up calls. Operators will ask permission from "at risk" callers using the established hotline follow-up call protocol. Callers who do not wish to have a follow-up call will not be contacted. If a caller agrees to a follow-up call, personal information will be stored as confidential data.

Hotline Does not Make Follow-up Calls

It is the policy of [insert name here] not to make follow-up calls.

Sexually Abusive Calls

Issue or Problem

Some callers may become sexually abusive to the operator. This behavior may be the intent of the call or it may be triggered by being on the call. For the safety of the operators, sexually abusive calls should be terminated and reported. Some hotlines may wish to back-trace the call and report it to the police. Other hotlines may choose to simply end the call. In either case, the hotline should be aware of, and address, the negative consequences on the operator.

Sample Policy Statement

The policy of [insert name here] is that operators will terminate a call that is judged to be or suspected to be sexually abusive. Operators will report the call to supervisors who will initiate the hotline's "sexually abusive call" protocol.

Policies should address abusive callers

Regular Callers

Issue or Problem

Some people make frequent calls to a hotline. Sometimes these are identified as "regular callers." Hotlines have various methods for dealing with regular callers. For example, they may choose not to take the call at all. They may limit the number of times a person is allowed to call by the week or the month.

Sample Policy Statement

It is the policy of [insert name here] to limit the number of calls per week that any one person can call. After three calls to the hotline in one week, a caller will be notified that they will be limited to one call per week. At the time that a regular caller is told of a call limit, operators will provide an appropriate referral.

Silent Caller

Issue or Problem

Some people who call hotlines spend a great deal of time silent during a call. It may be that the call starts out silent; when the operator answers the phone the caller may not respond. Silent calls should be considered as real calls. However, there is a limit to how long the caller or the operator can wait for the caller to talk. Typically, hotlines have a limit on the length of a silent call. The limit may be five minutes, for example. If the call reaches

the limit and the caller has still not made any comments, the operator can gently indicate to the caller that they are going to disconnect the call and that the caller can call back when they are ready to talk.

Sample Policy Statement

It is the policy of [insert name here] to take silent calls as seriously as calls where the caller talks. If the caller has not spoken after five minutes, the operator will let the caller know that they are going to disconnect the call. The operator will encourage the caller to call back when he or she is ready to talk.

Third Party Calls

Issue or Problem

In some cases a caller will be calling with concern about another individual and then may ask the hotline operator to contact the person. There are several problems with this request. First, the operator has no way to discern if the third party would consider the caller's concern appropriate. For example, a parent might call with concern about his/her child and the child might not be convinced there is a problem. It is also possible that the caller may have made a judgment about the third party that truly is not accurate. A second dilemma with third-party callers is whether or not the third party wants to talk about his or her problem. It may be that they do not want to talk to a hotline. It may be that they are not ready to talk. Or, it may be that the person is already talking with a helping source of which the caller is unaware. The third and perhaps most important issue with making third-party calls is that the call may violate the confidentiality of the caller or the third party.

Policies can guide operators when callers are relatives or friends

One solution to this dilemma is the use of three-way calls. Some hotlines do allow operators to place a three-way call so that the caller, the third party, and the operator are on the call together.

Sample Policy Statement

Does not allow three-way calls.

The [insert name here]'s policy is not to place third-party calls to individuals whose names and numbers have been given to the hotline by someone else.

Does allow three-way calls.

It is the policy of [insert name here], to allow operators to place a three-way call if the caller is calling with concerns about a third party. In this case, the third party has the option to participate or not.

Calls Involving Sexual Assault

Issue or Problem

Safety is a critical issue when speaking with a caller who has experienced a sexual assault. The caller may use coded language about rape or child abuse or some other way of referring to forced sexual activity. If the crime was recent, the operator's first action should be to determine if the caller is safe. For example, if the person who perpetrated the sexual assault is in the same vicinity of the victim the situation is different than if the perpetrator has left. The operator, to the best of her or his ability, should determine if the danger continues. If the caller is able, the operator should instruct the caller to find a safe place and ask if he or she needs an ambulance or the police.

Once the safety of the caller is established or as a way to establish the caller's safety is found, the operator should encourage the caller to contact the police. Most communities have a special unit for handling sexual assault cases so the operator can assure the victim that the police will understand and not blame him or her. They can also explain that the police can help keep the person safe. Hotline policies should address whether operators are legally mandated to report.

Special policies are needed for victims of sexual assault

Operators should be trained to view historical sexual assault as equally as serious as a recent or current sexual assault. However, the urgency of the call may be different. In either case, the operators can encourage the caller to seek assistance from public safety as both previous and recent sexual assault are crimes.

In the instance of sexual assault, it is important to focus on the needs of the caller, not on the details of the crime. The details of the crime can be established later, if appropriate, because during the period of the call such a discussion could be traumatizing to the caller as well as the operator.

Sample Policy Statement

Does Not Break Confidentiality for Assessed to be at Imminent Risk

When a caller reports sexual assault, it is the policy of [insert name here] to first ascertain as best as possible the caller's immediate safety. The operators will ask the victim if he or she needs an ambulance or the police. The operators will encourage callers to contact the police. The [insert name here] does not break confidentiality with the caller and send emergency services directly to the victim unless requested by the victim.

Does Break Confidentiality for Callers Assessed to be at Imminent Risk

When a caller reports sexual assault, it is the policy of [insert name here] to first ascertain as best as possible the caller's immediate safety. The operators will ask the victim if she or he needs an ambulance or the police. The operators will encourage callers to contact the police. If the operator ascertains to the best of his or her ability that the caller is a current or very recent victim of a sexual assault, the [insert name here] does break confidentiality with the caller and send emergency services directly to the victim.

Calls Involving Violence

When violence is involved, operators should assess for caller safety

Issue or Problem

Callers may report violence, such as hitting, kicking or punching, against them. As with sexual violence, it is important to first ascertain as best as possible the current safety of the person. If the person reports that they are not safe, for example, if the perpetrator is close, ask if the person can get to a place of safety. In some cases this will not be possible. The person should be encouraged to report the violence to the police. For hotlines that break confidentiality for imminent risk, the operator may determine that contacting public safety is necessary. For hotlines that do not break confidentiality, the operator must urge the caller to contact 911. State statute may specify reporting requirments.

Some violence is not individual violence but may be related to community violence such as gang warfare or civil unrest. The same procedures should be followed.

Sample Policy Statement

Does Not Break Confidentiality for Callers Assessed to be at Imminent Risk

When a caller reports violence or assault, it is the policy of [insert name here] to first ascertain as best as possible the caller's immediate safety. The operators will ask the victims if they need an ambulance or the police. The operators will encourage callers to contact 911. The [insert name here] does not break confidentiality with the caller and send emergency services directly to the victim

Does Break Confidentiality for Callers Assessed to be at Imminent Risk

When a caller reports violence or assault, it is the policy of [insert name here] to first ascertain as best as possible the caller's immediate safety. The operators will ask the victim if they need an ambulance or the police. The operators will encourage callers to contact the police. When the operators ascertain to the best of their ability that the caller is a current or very recent victim of violence or assault the [insert name here] does break confidentiality with the caller and send emergency services directly to the victim.

Providing Legal, Medical, Religious Advice

Issue or Problem

It is critical to establish a clear policy that the hotline is available for crisis suicide prevention. While many callers will place a call looking for referrals or perhaps just to talk through a legal, medical, religious belief, operators should respond according to the hotline's established policies to delineate the difference between referrals and advice. Operators should be clearly trained to this protocol.

Sample Policy Statement

The [insert name here] is a crisis helpline. The operator's relationship with the caller is based on the principles of a [insert name here]. Do not give legal, medical, or religious counseling. Do not give advice regarding illegal activities (i.e., drugs, crime, etc.).

Issues Involving the Care of Operators and Supervisors

Caring for Operators and Supervisors

Issue or Problem

Working at a hotline can be very emotionally and physically stressful. Hotlines should recognize that operators and supervisors may experience burnout or even trauma as a result of their work. On the other hand, operators and supervisors may also experience personal satisfaction doing work with callers. The hotline should have existing policies in place to build and support resilience with their workers and to prevent and to respond to the negative aspects of providing care to callers. There are several well-known protocols and trainings that could be useful to hotlines. These include Risking Connection (www.riskingconnection.com), training courses from the Figley Institute (www.figleyinstitute.com), and the Professional Quality of Life information (www.proqol.org).

Hotlines should promote resilience among operators

Sample Policy Statement

The [insert name here] recognizes that working on a hotline may be stressful to the operators and to their supervisors. It is the policy of this hotline to prevent and respond to the negative emotional consequences of working on a hotline and to promote resilience and the positive aspects of working on a hotline.

Reports

Issues or Problems

Gathering systematic information about calls will help a hotline know better how to staff and train their operators. Some data can be collected from call conversations. For example, the caller's gender may be established by a first name, a voice, or other comments such as "since I am a man" or the like. Other information may be requested, but callers should not be pressured into giving that information. By collecting data that can be extracted from the conversation and direct queries, an important databank can be built for the organization and potentially contribute to the understanding of hotlines across the country.

Sample Policy Statement

The [insert name here] has an established call report form. The data from these reports is confidential and will not be reported in such a way that any individual caller could be identified. The data will be stripped of identifiers and the de-identified data will be stored in a secure place. Each operator should complete a call report form for each call. Gathered data from the call is used to complete the call report. When data cannot be discerned, the entry should be "cannot tell" rather than leaving the field blank.

CHAPTER 6
TRAINING

Introduction

There are no universal suicide prevention hotline training protocols. Accreditation organizations have training criteria and optional training manuals, but do not specify a certain training curriculum as a condition of accreditation. However, accreditation organizations do specify competency areas and overall minimum and advanced training hours.

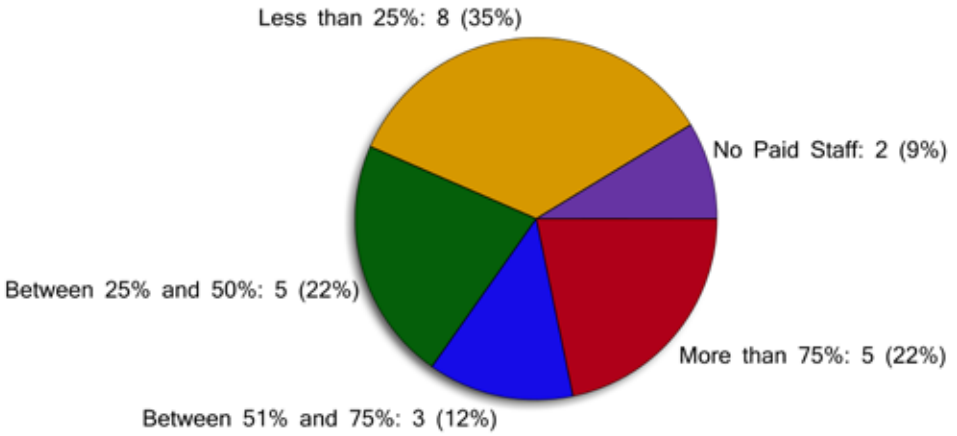
As a means of recommending potential training protocols or curricula, three types of data were collected, all focusing on the improvement of training quality. First, we conducted (1) a content analysis of multiple types of training information including training manuals, accreditation criteria, web-based modules, and discussions with trainers. Second, an (2) online survey regarding hotline effectiveness was conducted (see *Chapter 3: Data* for a full discussion) in which administrators of 23 different hotlines responded. Third, we conducted (3) three rounds of training simulations to assess what to include in an Idaho-specific training module. These data will be used throughout the chapter to illustrate information about training.

Composition of hotline staff impacts training choices

Training Paid and/or Volunteer Staff

The composition of a hotline staff (i.e., all volunteer, all paid, or a combination of both) impacts choices regarding types of training. While rich camaraderie can develop within an organization staffed by paid and volunteer personnel, the same personnel composition can foster strong divisions. Because hotlines are often staffed by both volunteers and professionals, difficult to manage biases and conflicts are not uncommon. Mindful training curricula provide an early opportunity to model respect for the different roles of paid and volunteer staff. About one third of the sites (35%, n=8) reported having 25% or fewer paid staff. Five sites (22%) reported having between 26 and 50% paid staff and three sites (13%) reported having 51% to 75% paid staff. Twenty-two percent of sites reported having over 75%

Figure 20: Percent Paid Staff



paid personnel (n=5). Only two hotlines reported being staffed entirely by paid personnel and one center reported being run entirely by volunteer staff.

One particular divergence in a training program is the model's training perspective. Choosing a training model should take into account the type of staff employed at the hotline--all volunteer, all paid, or a combination of both. Some programs use a general helping model, which is not based on therapy, while others employ a therapy-like counseling model. The general helping model focuses more on helping people solve problems and develop opportunities. The counseling model varies; it may be aimed at a lay or community counselor or a professional counselor. In some cases, profes-

Table 13: Accreditation Training Requirements Comparison Chart

Organization	AAS	CUSA
Basic Operator Training Standards:	• Minimum requirements: 32 classroom hours, 8 apprenticeship hours, 40 total training hours • Training must address AAS Core Competency Requirements • Must adhere to Best Practices Training as recommended by AAS • Must include required training components per AAS guidelines	• Minimum requirements: 24 classroom hours, 8 apprenticeship hours, 32 total training hours • Training must address CUSA Core Competency Requirements • Provide continuing education opportunities for volunteers/staff • Training/evaluation at least annually, including volunteer recruitment
Main Focus of Training	1. Attitudinal Outcomes 2. Knowledge Outcomes 3. Skill Outcomes	1. Attitudinal Outcomes 2. Knowledge Outcomes 3. Skill Outcomes

sional counseling models are used to train volunteer lay counselors to a "counseling-light" model. Those operators trained in professional counseling may find the general helping model too simplistic for their tastes.

Accreditation and Training Protocols

Part of an accreditation process, as discussed in *Chapter 4: Accreditation*, includes meeting the chosen accrediting agency's national training standards. As important as it is, intuitively, to train for success in fielding crisis calls, it is equally important to ensure that the program is mindful of accreditation standards grounded in years of experience and data. To achieve accreditation it is incumbent on hotline management to create a training format that addresses all of the necessary accreditation requirements. Specifically, the training must incorporate and evaluate for attitudinal, knowledge, and skills outcomes. In sum, training programs must ensure accreditation, enable measurement of outcomes, and address content knowledge relevant to the hotline's sociocultural particularities.

Accreditation Requirements

The two major accreditation organizations, Contact USA (CUSA) and the American Association of Suicidology (AAS), discussed in Chapter 4, provide their members training models, but do not require members to use their training programs in order to be accredited. Conversely, AAS and CUSA require that all operators complete a specific number of hours in initial and continuing education as well as training to specific core competencies. Table 13, "Accreditation Training Requirements Comparison Chart," compares AAS's and CUSA's general training standards. The following section lists the two organizations' competencies.

American Association of Suicidology Core Competencies

AAS divides its training criteria into three areas, attitudinal, knowledge, and skills. Table 14 shows the competencies by area.

Contact USA Core Competencies

For each of CUSA's core competencies, the three criteria of knowledge, attitude, and skills are unpacked independently. For example, self-awareness is one core competency. To evaluate self-awareness, trainees should exhibit (1) knowledge of personal values and biases, stress triggers and coping mechanisms, etc. In regard to (2) attitudes, a trainee must, among others, show unconditional positive regard for callers and coworkers. Finally, to show self-awareness (3) skills a trainee must be able to identify personal values and biases as one skill.

Table 14: AAS Training Competency Areas	
Attitudinal	
	1. Acceptance of persons different from oneself, and a non-judgmental response toward sensitive issues (e.g. not discussing suicidal ideation or abortion with a client in terms of its moral rightness or wrongness)
	2. Balanced and realistic attitude toward self in the helper role (e.g. not expecting to save all potential suicides by ones own single effort, or to solve all the problems of the distressed person)
	3. A realistic and humane approach to death, dying, self-destructive behavior and other human issues
	4. Coming to terms with one's own feelings about death and dying insofar as these feelings might deter one from helping others
Knowledge	
	1. Crisis theory and principles of crisis management
	2. Basic suicidology, including suicide assessment (lethality and probability of attempt) and legal issues
	3. Victimology, including assessment of victimization and risk of assaulting others
	4. Legal/Ethical issues
	5. Community resources
	6. Record system and program policies
	7. The consultation process
	8. Voluntary and involuntary hospitalization criteria and procedures
	9. Psychopathology, psychiatric diagnosis, psychotropic medication
Skill	
	1. Techniques of assessment in life-threatening situations, including risk of suicide and/or homicide
	2. Techniques of crisis management
	3. Efficient and effective mobilization of community resources
	4. Efficient record keeping and policy implementation (e.g., recording essential notes in succinct form within same work shift so they are useful to the next worker)
	5. Use of the consultative process, e.g., knowing who to call under what conditions and in fact doing it

To achieve CUSA accreditation, hotline volunteers must show knowledge, attitudinal, and skill competencies in all the following areas.

- Active Listening Skills
- Self-awareness
- Crisis intervention
- Suicide
- Depression
- Mental Illness
- Loneliness
- Frequent Callers
- Grief and Loss
- Addiction and Compulsive Behaviors
- Violence, Neglect, and Exploitation
- Information and Referral
- Apprenticeship

Training Content

An analysis of multiple training manuals and online training models show common content areas as well as some areas that are specific to the population being trained. Different training manuals are focused on different organizational cultures as well as distinctions in race, ethnicity, and socio-

cultural norms. For example, U.S. military uses military language. It trains the operators to the model PRESS (Prepare, Recognize, Engage, Send, Sustain),"prepare, recognize and engage" (U.S. Air Force, n.d.; Air Force Suicide Prevention Program, n.d.; Pflanz, 2008). Most hotline training programs have a model that they use for managing calls. These models vary in specific content but broadly include four stages: an engagement stage, a fact-finding state, an information-giving stage, and a closure stage. There were common training themes across different curricula. Below is a list of the common and less common themes identified through content analysis of the various training programs.

Common Training Themes

1. General suicidology
2. Listening skills of the operator
3. Identification of a crisis, which includes a suicide risk assessment and other danger assessments such as family violence
4. Confidentiality
5. Information and referrals
6. Mental health training, primarily depression
7. Grief and loss training
8. Challenging calls such as violent calls, sexually based calls, regular callers, and other types of non-typical calls

Less Common Training Themes

1. Management of a suicide in process
2. Traumatic stress training including child abuse, family violence, rape, and other traumatic stressors
3. Recordkeeping
4. Phone room operator behaviors and behaviors toward other operators and supervisors
5. Information about hotlines
6. Controversial issues

Multiple suicide prevention training protocols may be used by hotlines. As mentioned earlier, AAS and CUSA have curricula. Other curricula include ASIST (Applied Suicide Intervention Skills Training) and QPR (Question, Persuade, Refer). But typically hotlines use a combination of training: their own specific training and a protocol training such as ASIST or QPR.

Pre-Designed Training Curricula

Programs like ASIST and QPR are used by many hotlines in conjunction with their own training programs. ASIST addresses AAS and CUSA criteria of self-awareness; suicide risk recognition; suicide risk reduction through the practice techniques of creating plans;, and knowledge provision of resources in areas helpful during a hotline call (LivingWorks, 2010).

Another program used by hotlines is QPR and, like ASIST, it can be applied in combination with a hotline's own training program to meet the accreditation requirements of AAS and CUSA. QPR teaches participants about "early recognition of suicide warning signs" and "early intervention and referral," both important parts of a hotline call and part of CUSA and AAS training criteria (QPR Institute, n.d.).

Programs like ASIST and QPR can generally be used successfully by hotlines in conjunction with their own training programs. ASIST addresses AAS and CUSA criteria of self-awareness; suicide risk recognition; suicide risk reduction through the practice techniques of creating plans;, and knowledge provision of resources in areas helpful during a hotline call (LivingWorks, 2010).

Study of Hotline Directors and Curricula Content

In a national survey of hotline directors conducted for this report, directors were asked about multiple types of training. Nearly all hotlines reported designing their own training programs (87%, n = 20). Ten hotlines reported using ASIST (43%). Some hotlines borrowed curricula from other hotlines (17%, n = 4). However, most hotlines reported using a combination of training methods with the most common being a self-designed program in combination with ASIST. Even centers that reported using ASIST and QPR also used programs of their own design. Generalizing from the director survey data and content analysis of the training information, most hotlines use a variety of methods for training.

Standard Phases of Training

Typically, training programs begin their curricula with basic skills training through a (1) lecture-style format. Following this, trainees apply the new knowledge by participating in (2) a classroom setting, working in pairs to free role-play, often described as mock calls. Mock calls form an important part of the training, giving students a way to practice what they are learning in a safe, low-risk environment. However, the potential for problems in the use of mock calls does exist. Next a (3) period of monitored apprenticeship often occurs. Here trainees participate in supervised time that may include observing others taking calls or taking calls with direct supervi-

sion. In some programs, following a monitored apprenticeship, operators begin taking calls on their own; in other instances more supervision with experienced operators may continue for a period.

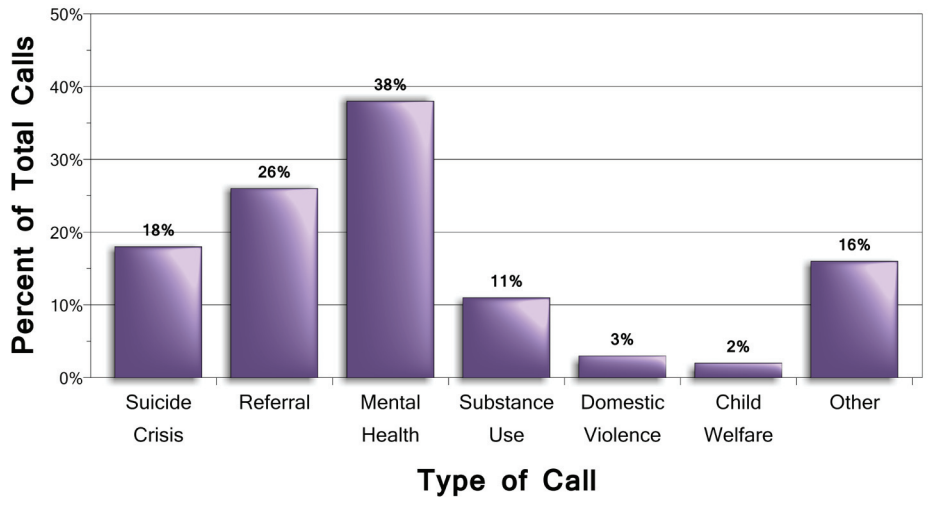
Training to Policies

An important part of the hotline training that cannot be overlooked is training operators to the standards of the organization's policies, including policies regarding call types. This type of training cannot come from pre-designed curricula although the curricula can provide guidelines; policies must be geared to the unique needs of an individual hotline. Some of this is not intuitive, as might be anticipated. Often policies of an organization emerge from the positive and negative experiences of their trained personnel. *Chapter 5: Sample Policies* contains a lengthy discussion of policy while this section looks at the topics discussed in Chapter 5 through the lens of training.

Training by Call Type

Suicide prevention hotlines receive multiple types of calls beyond the classically defined suicide crisis call; therefore training must include skills to handle not just suicide prevention calls but also other types of calls. The chart below illustrates the percentage of calls by types as indicated in the survey of hotline directors . Clearly, operators will be expected to field a number of different problems, with mental health concerns being the most common (38%). Combined, suicide crisis calls and referrals regarding suicide crisis form the greatest percent of calls, approximately 43%. But a crucial aspect of training by call type is related to the underlying links between suicide and other issues like substance abuse or mental health, as reflected in Figure 21.

Figure 21: Types of Calls by Mean Percent



Call Backs and Follow-up Calls

When an operator asks a person to call back to let the hotline know how they are doing it is known as a call back. In this instance, operators need to learn how to ask the caller in a way that helps the caller make that return call. Additionally, operator training should help operators understand that they may not be personally involved in taking the call back they requested, and that a caller may not choose to call back at all. Some centers use follow-up calls to check on a person who had demonstrated high-risk behavior. Call-back and follow-up calls should be clearly defined before training begins and operators should be trained to the organization's policy. They need to be given the opportunity to decide for themselves if they agree with the organizational policy—a decision that is possible only if the trainee clearly understands the policy.

High-risk calls are low in occurrence but high in impact

High Risk Calls

High-risk calls are low in occurrence but high in impact. As noted in the table above, only about 20% of calls are suicide related. Nonetheless, high-risk calls are very difficult for the caller and for the operator. Operators should have sufficient training to feel that they are ready to handle the high-risk calls.

Other Difficult Calls

Beyond the high-risk calls that involve life-threat, there are other difficult kinds of calls. Operators should be trained to handle calls such as frequent callers and silent callers. Another difficult type of call to manage is one in which the caller is calling out of concern for another person and then asks the operator to contact that person. Some calls may involve sexual violence and other types of violence. Callers may call to report or discuss a sexual assault that they or someone close to them have experienced. Other calls may involve negative sexual content. Any of these calls can be personally upsetting for some operators. Training needs to anticipate this so that operators are prepared to handle any eventuality, understand the organization's protocols, and are able to feel confident in how to manage the call. Alerting operators to the potential of receiving this type of call allows the operator time to adjust to the variety of calls—or, in some instances decide to withdraw from training. Clear, policy-based training also can reduce the potential negative effects on the operator

Other Hotline Policies

Other policy considerations may be incorporated into the training curricula based on an organization's unique protocol. The key is that policy be determined in advance of a problem arising and that the policy be mind-

ful of the positive and negative outcomes of a decision. In addition, policy must take into account the outcome on the operators. Care of volunteers and staff are important to the long-term viability of the organization.

Caller Acceptance and Confidentiality

The core of training is grounded in helping operators understand that the calls they take are to be accepted unconditionally. This is very different from accepting the behavior or even the conversation of the caller. A second fundamental part of training is about confidentiality. Operators must be trained in the details of confidentiality as the organization specifies. One of the thorny issues here is how to deal with a situation that the operator believes to be immediately dangerous. How an operator addresses this is dependent on the policy of the particular hotline; he or she may be trained to contact 911 or in another instance, to learn to tolerate the dangerous-feeling call and manage it the best way possible without breaking confidentiality. Organizations should be very clear in training operators how to handle difficult, potentially life-threatening situations. Trainees should have the opportunity to ask questions. They should be encouraged to decide for themselves if the organization's confidentiality policy is one they can accept.

Structure and Methodology to Be Followed for Hotline Calls

Stemming from the values of acceptance and confidentiality are the methods and procedures for conducting a call. Organizations typically provide a specified structure for operators to follow. The training should make the structure clear and ensure that trainees are given the opportunity to practice enough to feel confident with the structure. Far too often trainees are given only a lecture version of the call protocol and then asked to role-play the structure. This is insufficient for most trainees. In addition, while role-play is an important part of learning the structure, it should be monitored closely by instructors so that trainees do not "learn the wrong way" to do something.

Trainees should understand policies on legal, medical or religious advice

Providing Legal, Medical, Religious Advice

Most hotlines are established to provide emergency and referral information. Trainees should understand the organization's policy on providing legal, medical or religious advice. Training simulations and role-plays are an effective way for trainees to learn how to manage this kind of topic within the scope of the organization's services.

Caring for the Operators and Supervisors

Working at a hotline can be emotionally and physically stressful. Employee and volunteer retention and their quality of work can be maintained when centers recognize and then address the fact that operators and supervisors

may experience burnout or even trauma as a result of their work. On the other hand, enormous personal satisfaction can also be an outcome for operators and supervisors working with callers. To minimize the negative aspects of work at hotlines while enhancing the positive outcomes, hotlines can prepare supportive policies before problems arise. Policies should take into consideration how to build their workers' resilience and how to prevent and respond to the negative aspects of providing care to callers. Several well-known protocols and trainings are instructive for this, these include Risking Connection (www.riskingconnection.com), training courses from the Figley Institute (www.figleyinstitute.com), and the Professional Quality of Life (ProQol) information (www.proqol.org).

Good data collection is needed for continued funding

Record Keeping

Operators must be trained in proper recordkeeping so that the organization maintains appropriate documentation. Not only is it necessary to maintain accurate records for legal and financial accountability, but also good data is necessary for continued funding in terms of providing a record of transparency and responsibility. Finally, thorough recordkeeping helps interested parties outside of the organization understand the workings of, and importance of, the hotline.

An Idaho-Specific Training Program

The training curricula that we found should work very well for Idahoans training to work as hotline operators. Portions of QPR and ASIST provide excellent training protocols. Building on one of these programs, a hotline can add regional and organizational specific content. For example, each hotline has specific ways to keep records, methods of operator scheduling, protocols on locations from which to take calls, and supervisor methods. Most training programs are composed of various parts that were collected from other centers.

Scripted Role Plays: An Addition for Idaho Hotline Training

As mentioned earlier, the second stage of training is usually grounded in mock calls and mock calls form one common area for self-designed training. As important as this training stage is, mock calls can allow new trainees to move into scenarios that are too complex for their level of skill. In this instance, participants may model a scenario that has errors in it. It is possible to actually learn to handle a call incorrectly or in a way that has a negative impact to the caller. While most trainers are quite skilled at redirecting trainees, this can be difficult when there are a number of role-plays going on at the same time.

The transition from lecture to role-play may be too drastic and difficult for the trainees and trainer to manage. In Idaho, where we have rural and urban centers distributed across the state, training consistency can be chal-

lenging. Trainers are skilled at keeping trainees focused on learning skills but offering classes in locations across the state, sometimes with different trainers, can lead to divergence in training methodologies. One way to mitigate this could be using distance delivery. However, this comes with its own unique problems; namely, following the activities of groups at different sites is all but impossible in a situation where the trainer is in one location teaching to trainees at other locations.

Keeping these potential pitfalls in mind, an intermediate step was developed during the course of this report between basic skills training and free role-play mock calls. The step uses what is called scripted role-plays. Scripted role-play is directed by the trainer. Beyond training consistency, the advantages are two-fold. First, the scripted call gives the trainees a chance to practice a call. Second, it is an annotated script. Thus, trainees can focus on the content of the step and have a scripted response to link the call activity to what they say.

To test the concept of scripted role-plays, two rounds of training simulations utilizing a scripted roll play were conducted. Eight people volunteered to participate in the scripts, which contributed to quality improvement for future Idaho training. The first four participants were all given the same script. Following the first round of training simulations, improvements were made to the scripts based on the participants' feedback. Using the revised script, four more training simulations were conducted. Overall, the participants liked the scripted role-play idea very much. They thought it would be helpful to trainees because it provides them a "safe" way to practice. More information about these simulations is available in Chapter 3.

Scripted role plays can help trainees feel more confident

Scripted Role Plays

Scripted role-plays can be very complex, and in and of themselves, may not be particularly good training exercises. A fully developed, branching script conveys very well the incredible complexity that a call may have.

Branching

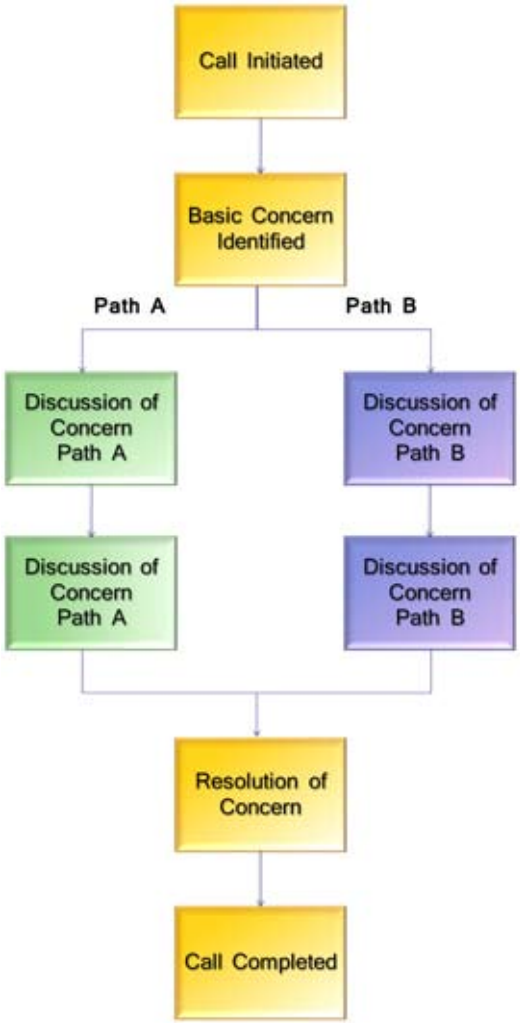
Operator trainees must learn that a call may not follow a standard, step-by-step pattern. Depending on the responses the caller or the operator make, a call can take very different paths. However, after branching, it is typical for a call to begin and end on the same basic path. Using a model with more than one path allows learners to understand that the start and the finish are the same but that the conversation may be different. Knowing this can help operators in training feel more confident and learn to be flexible with the many ways a call can unfold.

A fully branched model is important for advanced training but can be overwhelming to basic training. In the basic scripts, only two branches are provided. In the advanced scripts, as many branches as possible are given.

Figure 22 below illustrates the general idea of branching.

Following are groups of scripted role-plays. Each group contains the same scenarios. The first scenario is a third-party referral call made from a mother in regard to her daughter. The second scenario is from a person who is at risk for suicide.

Figure 22: Diagram of Scripted Role Play Branching



Text of the Basic Scripted Role Play

Figure 23: Basic Scripted Role Play

Basic Scripted Role Play

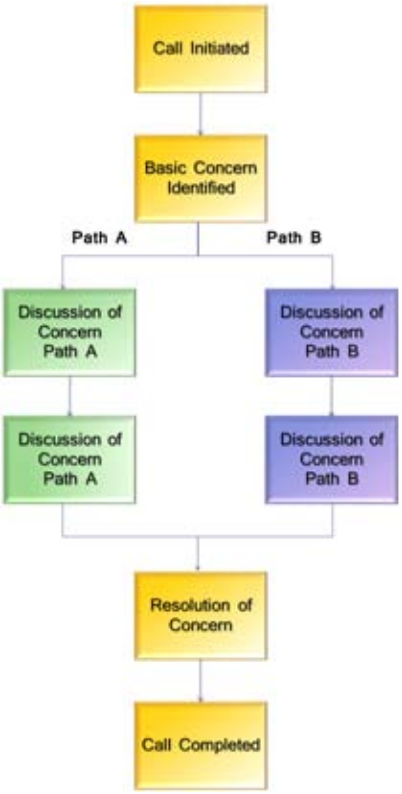
The goal of this scripted role-play is to help you learn what sort of things might happen in a call. The dialog is provided for you so you can concentrate on learning the process.

There are two things to focus on. First, at each step you will notice a brief explanation of what the step does. The second thing to focus on is the concept of branching. In this scenario you will see that the script starts with a set caller-operator dialog and then breaks into two paths the call could take. You will notice at the end, the two paths merge. This demonstrates that the start and the finish of a call may be the same but the middle sections are not.

The operator is the person who selects the path, based in large part on how the caller responds to the set questions. In the first script, you are the caller and I am the operator. Thus, I will pick the path. In the second scenario, you are the operator and you will pick the path.

If you pick path A, you will follow through with A until the script merges at the end. If you are on the path B, follow the B column.

Here is a diagram that looks like the path.



When the script starts branching, you pick A or B and then follow that path.

For this section of the training, we want the trainees to follow the script. Later in your training you will complete mock calls where there is no script.

Figure 23: Basic Scripted Role Play, cont.

SCENARIO #1: THIRD PARTY CALL

SCENARIO

A woman has called concerned about her daughter. Her daughter's behavior has changed drastically in the past couple of weeks. She used to be a very good student, but has started skipping school and talking back to her teachers. She has isolated herself from her friends and will not discuss the issue with her mother. The caller has called the hotline requesting help because she is concerned about her daughter's safety and is unsure what to do in this situation.

In this case, the daughter's grandfather died. None of the family has realized the connection between the youth's behavior and the loss of her grandfather. In this scenario we will work together to identify the presence of the loss and make a referral to something that will help the youth with her grief.

The recommendations can be informal such as suggesting that the mother talk with her daughter directly about the loss, letting her daughter know that grief is hard and that the family will be with her to talk about it. Other recommendations could direct the family to a grief self-help group or to a faith-based leader. A school counselor or teacher could help. A recommendation to talk with the family health professional is appropriate also.

CALL SCRIPT

Operator	Hello, how may I help you?
Caller	My daughter has suddenly started skipping school and talking back to her teachers. She was always a good student. She won't talk to me or her friends. I don't know what to do.
Operator	Have you tried to talk to your daughter?
Caller	I tried, but she won't talk to me.
Operator	**A** *Solicit Information about caller's guess as to what might have happened.* Is there anything you know of that may have caused her to react like this? **OR** **B** *Solicit information about other people daughter might talk with.* Ok. Is there anyone else in your family that she may be more open with?
Caller	**A** *Provides information about what might be happening. For example,* No, everything has been fine recently. **OR** **B** *Provides information about who the daughter might talk with. For example,* She is normally close to her grandparents.
Operator	**A** *Solicit Information about caller's guess as to what happened.* When did she starting acting like this? **OR** **B** *Solicit information about other people daughter might talk with.* Is she still close with them?

Figure 23: Basic Scripted Role Play, cont.

Caller	**A** *Provide information about caller's guess as to what might have happened.* It has been a couple of months. It started right after her grandfather died. **OR** **B** *Provide information about other people daughter might talk with.* She used to talk to her grandfather but he died a few months ago and she doesn't talk with anyone that I know of.
Operator	*Talk with mother about how grief can affect different people differently.* *Provide a few referrals and suggestions* 1. A youth grief self-help group that is run through the local hospice. 2. Faith-based grief group 3. School counselor 4. Always suggest that the family check with their health professional.
Caller	Thank you for your help.
Operator	I'm glad that you called. I hope your daughter will be better soon.

SCENARIO #2: SUICIDE RISK CALL

SCENARIO

A male calls and is showing the warning signs of suicide. He talks about being hopeless, alone, and having trouble sleeping. He finds himself drinking a lot, and putting himself in danger. He has not said directly that he wants to attempt suicide but has said he does not want to be alive anymore.

CALL SCRIPT

Operator	Hello, how may I help you?
Caller	I just called because I'm hopeless and alone. The only thing that helps is drinking. I just don't want to be alive anymore.
Operator	*Opening statement requires use of suicide risk assessment* *A risk assessment checks for (1) hopelessness, (2) thoughts of wishing being dead, (3) thoughts of suicide, (4) suicide plan, and (5) history of previous attempts.* *Questions 1 and 2 were addressed in the callers opening statement. Proceed to Questions 3-5.* *Question 3*. Have you thought about taking your life?
Caller	I've thought about it but I wouldn't do it. Somehow, today, it does seem more like a good idea.
Operator	*Question 4*. So today is different. Are you seriously considering taking your own life? Have you made a plan?
Caller	Well, I have been sitting here thinking about it. I thought about my guns but I don't think I would use one. Still.
Operator	*Question 5*: Have you felt this way before? Have you ever tried to take your life?
Caller	No, I haven't tried to kill myself. It seems too hard. I feel alone.
Operator	So, you feel alone but you don't think you're going to try to kill yourself.
Caller	I guess so.

Figure 23: Basic Scripted Role Play, cont.

Operator	**A** *Solicit Information about people or animals who are connected to the caller.* Do you have any family or pets? **OR** **B** *Solicit information about people that the caller may be able to talk to*. Do you have any friends you spend time with?
Caller	**A** *Provide information about family connections. For example*, I have a dog. **OR** **B** *Provide information about social activities or friendships. For example,* A couple of my friends go camping together.
Operator	**A** *Solicit Information about the caller's family connections*. Do you spend time with your dog? **OR** **B** *Solicit information about the caller's plans with friends*. Do you have any plans to go with them?
Caller	**A** *Provide information about caller's relationships with family.* Well my sister helps me look after him. **OR** **B** *Provide information about caller's plans with friends.* They were talking about going camping in a couple weeks.
Operator	**A** *Solicit Information about caller's connection to his sister.* Could you talk to your sister about what you're feeling? **OR** **B** *Solicit information about the caller's concrete plans with his friends.* Why don't you make plans to go camping with them next time?
Caller	**A** *Provide information about connection to sister.* For example, I guess I could talk to her. **OR** **B** *Provide information about social activities or friendships*. For example, I guess I could do that.
Operator	*Check suicide risk assessment again.* So how are you feeling now? Do you still feel like you want to be dead?
Caller	I guess not.
Operator	I'm glad to hear that you're not feeling like taking your life now. PAUSE, allow caller time to respond or not as they wish. If you are not convinced that the caller is ok, return to the assessment and probe more. I want you to promise to call back if you start feeling like taking your life. Will you do that?
Caller	OK. But I think I am going to be ok. I guess I should not drink so much alone.
Operator	*Provide a few referrals and suggestions* 1. Making plans with friends and family members 2. Becoming more involved in social groups that he is already a part of, like faith-based or school groups 3. Suggest talking with his health professional 4. Provide the hotline's information and hours in case the caller wants to call back
Caller	Thank you for your help.
Operator	I'm glad that you called. Please call again if you need to.

Text of the Advanced Scripted Role-Play

This script may be used as role-play or as a classroom discussion tool. The complexity of the script is enormous and it will resonate with advanced trainees. They will have the experience to know that each call is unique although it begins and ends in the same place. The script provides an excellent way to help structure their experience into knowledge.

Figure 24: Advanced Scripted Role Play

Advanced Scripted Role Play

You will be given a scenario that a hotline operator might come across while answering calls. In the beginning you will be provided with information that you can use throughout the scenario. An initial starting scenario will be provided, and then you and the administrator will go through the rest of the dialogue for the mock hotline call. Sample questions are available at each stage of the call for you to use.

SCENARIO #1: THIRD-PARTY CALL

SCENARIO

A woman has called concerned about her daughter. Her behavior has changed drastically in the past couple weeks. She used to be a very good student, but has started skipping school and talking back to her teachers. She has isolated herself from her friends and will not discuss the issue with her mother. She has called the hotline requesting help because she is concerned with her daughter's safety and is unsure about what to do in this situation. In this scenario we will work together to identify the cause of the youth's change in behavior and make a referral to something that will help the youth.

The recommendations can be informal such as talking with her daughter directly. Other recommendations could direct the family to a self-help group or to a faith-based leader. A school counselor or teacher could help. A recommendation to talk with the family health professional is appropriate also.

CALL SCRIPT

Operator	Hello, how may I help you?
Caller	My daughter has suddenly started skipping school and talking back to her teachers. She was always a good student. She won't talk to me or her friends. I don't know what to do.

Proceed to Option tables.

Figure 24: Advanced Scripted Role Play, cont.

SCENARIO 1, DIALOG OPTION #1

1	**Operator:**	Have you tried to have a discussion with your daughter?		
	Caller:	Of course I have, but she won't discuss anything with me.		
2	**Operator:**	Is there anything you know of that may have caused her to react like this?		Ok. Is there anyone else in your family that she may be more open with?
	Caller:	No everything has been fine recently.		She's normally very close with her grandparents.
3	**Operator:**	When did she start acting like this?	Do you know anyone that she may be confiding in?	⇨*Jump to Option #3, Operator Line 3, right side, select either path.*
	Caller:	It's been getting worse over the past couple of months.	She's normally very close with her grandparents.	
4	**Operator:**	⇨*Jump to Option #2, Operator Line 2, select either path.*	⇨*Jump to Option #3, Operator Line 3, right side, select either path.*	

SCENARIO 1, DIALOG OPTION #2

1	**Operator:**	When did this start?			
	Caller:	It's been getting worse over the past couple months.			
2	**Operator:**	Is there anything that happened around the time she first started acting like this?		Did she show any signs in the beginning that could indicate what may be wrong?	
	Caller:	I think this may have started about 5 months ago.		No it started so slowly that I'm not sure.	
3	**Operator:**	What happened around that time?	Did she tell you about anything happening around that time?	Is there anyone in the family that she confides in?	Do you remember when this first started happening?.
	Caller:	Her grandfather had died the month before.	No she didn't tell me anything. But her grandfather did die the month before.	She's normally very close with her grandparents.	I think this may have started about 5 months ago.
4	**Operator:**	⇨*Jump to Option #3, Operator Line 4, far left path.*		⇨*Jump to Option #3, Operator Line 3, right side, select either path.*	⇨*Jump back to Operator Line 3, select other path.*

Figure 24: Advanced Scripted Role Play, cont.

SCENARIO 1, DIALOG OPTION #3

1	**Operator:**	Is there anything that has happened in your daughter's life that may have caused this change?			
	Caller:	Not that I know of recently, but then she won't talk to me.			
2	**Operator:**	When did she start acting like this?		Do you know anyone she may be confiding in?	
	Caller:	It's been getting worse over the past couple months.		She's normally very close with her grandparents.	
3	**Operator:**	⇨ *Jump to Option #2, Operator Line 2, select either path.*		Is she still close with them?	Have you tried talking to them?
	Caller:	She hasn't talked to them much since her grandfather's passing.		Yes. They haven't heard much from her recently.	
4	**Operator:**	I'm sorry. Could that be related to her change in behavior?	I'm sorry. Have you talked to them?	Did they notice when her behavior started changing? They may remember what was happening at the time.	Do they have some idea about what may have caused her change in behavior?
	Caller:	Maybe, but she seemed fine at the time.	Yes. They haven't heard much from her recently.	They started hearing less from her about 6 months ago. That was when her grandfather died.	They think it may have started about 5 months ago.
5	**Operator:**	Many people react differently to death. Have you talked to her about grief?	There are many stages of grief. Has she talked to anyone about his death?	⇨ *Jump back to Operator Line 4, select other path.*	⇨ *Jump to Operator Line 4, far left path.*	Can you remember what may have happened around that time?	Do they have an idea of what might have caused the change in her behavior?
	Caller:	No, she has experienced a death in the family before. I guess I should try.	No, is it possible to get a referral to a counselor.			Her grandfather died the month before.	They noticed that it happened after her grandfather died.
						⇨ *Jump to Operator Line 4, far left path.*	
6	**Operator:**	That may be a good solution. You can also have another family member talk to her as well.	Certainly. (Provide Referral)	It may be best if you or a family member talks to her first and if she feels the need to speak to a counselor we can provide you with a referral.			
	Caller:	Thank you for all your help.					
7	**Operator:**	Thank you for calling. Please call again if you need more assistance.					

Figure 24: Advanced Scripted Role Play, cont.

SCENARIO #2: SUICIDAL CALL

INFORMATION ON RISK AND PROTECTIVE FACTORS

Everyone has risk factors and protective factors that play a role in their commitment to attempting suicide. Risk factors are those factors which can increase someone's potential to attempt suicide. Examples of risk factors include feelings of hopelessness, history of suicide attempts, history of mental health concerns, and easy access to lethal methods. Protective factors are those factors that lessen a person's potential to attempt suicide. Examples include family and community support, religious beliefs or values that discourage suicide, and involvement in group activities. Throughout a hotline call it is important to note what risk and protective factors may be present.

The goal of a hotline call is to assist the caller in making the decision not to attempt suicide. This can be done in many ways. It is also necessary sometimes to provide the caller with additional support, whether this is through a referral to mental health professional or through the creation of a plan. Plans can include things like creating plans with friends or family members, making the decision to talk to someone, or getting involved in more group activities.

SCENARIO

A male calls and is showing the warning signs of suicide. He talks about being hopeless, alone, and having trouble sleeping. He finds himself drinking a lot, and putting himself in danger. He has said that he wants to attempt suicide.

CALL SCRIPT

Operator	Hello, how may I help you?
Caller	I just called because I'm hopeless and alone. The only thing that helps is drinking. I just don't want to be alive anymore.
Operator	*Opening statement requires use of suicide risk assessment* *A risk assessment checks for (1) hopelessness, (2) thoughts of wishing being dead, (3) thoughts of suicide, (4) suicide plan, and (5) history of previous attempts.* *Questions 1 and 2 were addressed in the callers opening statement. Proceed to Questions 3-5.* *Question 3*. Have you thought about taking your life?
Caller	I've thought about it but I wouldn't do it. Somehow, today, it does seem more like a good idea.
Operator	*Question 4*. So today is different. Are you seriously considering taking your own life? Have you made a plan?
Caller	Well, I have been sitting here thinking about it. I thought about my guns but I don't think I would use one. Still.
Operator	*Question 5*: Have you felt this way before? Have you ever tried to take your life?
Caller	No, I haven't tried to kill myself. It seems too hard. I feel alone.
Operator	So, you feel alone but you don't think you're going to try to kill yourself.
Caller	I guess so.

Proceed to Option tables.

Figure 24: Advanced Scripted Role Play, cont.

SCENARIO 2, DIALOG OPTION #1

1	**Operator:**	What's happening today that caused you to think about suicide?					
	Caller:	I was all alone.					
2	**Operator:**	Do you have any children or pets?				Are you involved in any social groups that would care about you?	
	Caller:	I have a dog.				A couple of my friends go camping together.	
3	**Operator:**	What would happen to him if you died?		What would he feel if he knew you were thinking about killing yourself?		⇨*Jump to Option #3, Operator Line 3, left side, select either path.*	
	Caller:	Well my sister might take him in.				Well I guess he wouldn't like it but I could always take him with me.	
4	**Operator:**	Could you talk to your sister about what you'refeeling?		Wouldn't he miss you though?		Are there others who you think would be unable to go on without you?	Do you have any hope that things might get better?
	Caller:	I guess I could talk to her.		Well I guess he wouldn't like it but I could always take him with me		Well I have my sister, but she would be fine without me.	No. I think I just need to go away.
5	**Operator:**	Why don't you give her a call and make plans to talk with her this week?	Would you like me to call her right now?	⇨*Jump to Operator Line 4, far right path.*		Could you talk to your sister about what you're feeling?	What would she say if she knew you were thinking about suicide?	Other than any plans you've made to end your life, have you planned to do anything else tomorrow or later this week?	Does anyone else know that you're having these feelings?
	Caller:	Yea. I guess that sounds like a good idea. Thank you.	No. I think I will call her myself.			I guess I could talk to her.	I guess she might be upset.	I'm supposed to have lunch with a friend, but I'll probably cancel.	No.
6	**Operator:**					⇨*Jump to Operator Line 5, left side, either path.*		⇨*Jump to Option #2, Operator Line 2, right side.*	⇨*Jump to Option #2 OperatorLine 4, far left path.*
7	**Operator:**	Wonderful. I will let you go do that, and can I call you back to see how you're doing?		Wonderful. I will let you go do that and you can call us back if you need to talk some more.		Could you talk to your sister about what you're feeling?		Would you want to make your sister upset?	

continue to next page

Figure 24: Advanced Scripted Role Play, cont.

SCENARIO 2, DIALOG OPTION #1, cont.

continued from previous page

	Caller:	Yes you can call me back. Here's my number, but don't leave a message. Thank you.	Thank you.	I guess I could talk to her.	Well, no.
8	**Operator:**	You're welcome.	You're welcome.	⇨*Jump to Operator Line 5, left side, select either path.*	
9	**Operator:**	Could you talk to your sister about what you're feeling?		Why don't you give her a call and make plans to talk with her this week?	
	Caller:	I guess I could talk to her.		Yea. I guess that sounds like a good idea. Thank you.	
10	**Operator:**	⇨*Jump to Operator Line 5, left side, select either path.*		⇨*Jump to Operator Line 7, left side, select either path.*	

Figure 24: Advanced Scripted Role Play, cont.

SCENARIO 2, DIALOG OPTION #2

1	**Operator:**	How do you see things turning out?					
	Caller:	I'll die.					
2	**Operator:**	How much do you want to end your life?			Other than any plans you've made to end your life, have you planned to do anything else tomorrow or later this week?		
	Caller:	I want to die.			I'm supposed to have lunch with a friend, but I'll probably cancel.		
3	**Operator:**	Does anyone else know that you're having these feelings?		Tell me how you feel about dying?	Why do you want to cancel?		Would you like to have lunch with him?
	Caller:	No.		I want to kill myself.	Cause I don't want to make him have lunch with me.		Yes.
4	**Operator:**	Is there someone you would be willing to talk to?	Who is the closest person to you in your life?	⇨*Jump to Operator Line 4, left side, select either path.*	Why don't you call and see if he still wants to have lunch?	Do you see yourself as a burden to others?	Could you talk to him about what you're feeling?	⇨*Jump to Fourth Operator line, middle right side, select either path.*
	Caller:	I guess I could talk to my sister.	My dog.		I guess I could do that.	No one cares about me so why would that matter.	I don't really know him that well.	
5	**Operator:**	⇨*Jump to Option #1, Operator Line 5, left side, select either path.*	⇨*Jump to Option #1, Operator Line 3, left side, select either path.*			⇨*Jump to Option #3, Operator Line 2, right side.*	⇨*Jump to Option #3, Operator Line 5, far right side.*	
6	**Operator:**	That's great. Why don't you give him some options for restaurants at the same time? That way you'll know where you're going.			That's great. You could also talk to him about how you're feeling.			
	Caller:	Yea. I really like Mexican so I could do that.			I don't really know him that well.			
7	**Operator:**	Wonderful. I will let you go do that, and can I call you back to see how you're doing?		Wonderful. I will let you go do that and you can call us back if you need to talk some more.	⇨*Jump to Option #3, Operator Line 5, far right side.*			
	Caller:	Yes you can call me back. Here's my number, but don't leave a message. Thank you.		Thank you.				
8	**Operator:**	You're welcome.		You're welcome.				

Figure 24: Advanced Scripted Role Play, cont.

SCENARIO 2, DIALOG OPTION #3

1	**Operator:**	How would others feel if you killed yourself?					
	Caller:	No one would care.					
2	**Operator:**	Are you involved in any social groups that would care about you?				Do you perceive yourself as a burden to others?	
	Caller:	A couple of my friends go camping together.				No one cares about me so why would that matter?	
3	**Operator:**	Have you ever gone with them?		Do you have any plans to go with them?		Who is the closest person to you in your life?	Are you involved in any social groups that would care about you?
	Caller:	A couple of times.		They were talking about going in a couple weeks.		My dog.	A couple of my friends go camping together.
4	**Operator:**	Why don't you make plans to go with them next time?	Can you call one of them and make plans?	Would they be willing to support you right now?	⇨ *Jump to Operator Line 4, far left side.*	⇨ *Jump to Option #1, Operator Line 3, left side, select either path.*	⇨ *Jump to Operator Line 3, left side, select either path.*
	Caller:	I guess I could do that.		I don't think they would want to spend time with me.		They don't really know me very well.	
5	**Operator:**	Why don't you try giving them a call and see what they say.	That's great. You could also talk to one of them about how you're feeling.	⇨ *Jump to Operator Line 5, far left side.*	Do you perceive yourself as a burden to others?	Is there someone you would be willing to talk to?	Who is the closest person to you in your life?
	Caller:	Yea. I guess that sounds like a good idea. Thank you.	They don't really know me very well.		No one cares about me so why would that matter?	I guess I could talk to my sister.	My dog.
6	**Operator:**		⇨ *Jump to Operator Line 5, right side, select either path.*		⇨ *Jump to Operator Line 3, middle right side.*	⇨ *Jump to Option #1, Operator Line 5, left side, select either path.*	⇨ *Jump to Option #1, Operator Line 3, left side, select either path.*
7	**Operator:**	Wonderful. I will let you go do that, and can I call you back to see how you're doing?		Wonderful. I'll let you go do that and you can call us back if you need to talk some more.			
	Caller:	Yes, you can call me back. Here's my number, but don't leave a message. Thank you.		Thank you.			
8	**Operator:**	You're welcome.		You're welcome.			

CHAPTER 7
CALL VOLUME & COST ESTIMATES

Estimating Call Volumes

Hotlines are housed in multiple types of settings. In the Director Study (see Chapter 3), the most commonly reported setting is a free-standing, nonprofit organization. Some hotlines are part of a 2-1-1 system; others are linked to a "for profit" or nonprofit health care organization such as a hospital or community mental health center. Hotlines may be housed at a university. Another system configuration is for hotlines to be part of a state-funded program. A hotline's configuration dictates specific policies and budget practices.

Caveats, Limitations, and Assumptions

In this chapter, we provide comparative information about various hotline configurations and costs. It should be said, and emphasized, that the information in this chapter is based on multiple assumptions. In most cases available data was either limited or nonexistent, so the configuration's conclusions in this chapter are theoretical. How an Idaho hotline would be managed and operated depends on implementation decisions and the arrangement of institutional support. The level of organizational commitment to a hotline and the external support that can be garnered will drive capacity and budget.

Implementation and institutional decisions will dictate management and operation

The information in this chapter, at best, provides a place to start. In the production of *Hotline Options*, a great deal of research was conducted to identify as many potential costs as possible (See Chapter 3 for more information). Even with all of our research, it was difficult to formulate a budget plan for an Idaho hotline. Across each line item we applied the same cost estimates to ensure that the budget's items were comparable. This does not mean that the selected budget items are necessary, complete, or even appropriate estimated costs. For example, the assumptions made about staffing needs for a hotline configured at a hospital may over- or underestimate

the actual personnel needed to staff a hotline in that setting. At minimum, the configuration information in this chapter can be used to identify potential line items and at best provide a realistic picture of configuration comparisons.

We do believe that the information presented here is unique to the hotline field, based on the best possible information, and specifically designed for Idaho.

Estimating the Call Volume for a Statewide Hotline

Limited historical data exists to ascertain suicide prevention hotline calls for the state of Idaho. Calls in 2006, when Idaho's hotline closed, do not take into account any additional calls handled through the Lifeline operators. Thus, it is difficult to piece together an accurate picture. Although other small hotlines do and have existed in Idaho, none of these serve the entire state. This lack of data is not unique to Idaho, but plagues the whole country.

A shortage of data on call volumes exists nationally

To estimate the potential number of calls that an Idaho hotline could receive in a year, three methods were used, none wholly satisfying. The models are based on the limited available data. The existing data were gathered from our various research products presented in Chapter 3. Statistical methods were used to create the missing data. In order to use the statistical methods, multiple assumptions were necessary and the methods and assumptions for each model are noted below. For clarity, the actual data are presented in regular type and the statistically estimated data are shown in bold.

Although it was impossible to say specifically how many calls might come to a hotline, it was encouraging that the three models showed a consistent pattern of growth. They also fall in a range of calls that could be managed by the personnel presented in the configurations. The high and the low estimates should require the same amount of personnel to manage them. Most other costs are also stable. For example, with the same number of personnel, the floor space, the utilities, electronic equipment, and such remain the same. The costs for phone use and translations would increase or decrease.

Methods of Estimating the Number of Calls Possible for an Idaho Hotline

Three methods to create models are listed and explained below.

1. Logic Model. The logic model is based on experiential information from other hotlines.
2. Lifeline. A model based on calls made from Idaho to the National Suicide Prevention Lifeline (Lifeline) Hotline.

3. Boise Police Department. A model based on the Boise Police Department data of "suicide related" calls.

Available Data and Assumptions

Real data were available for 2007, 2008 and 2009 for Lifeline calls and the Boise Police Department suicide-related calls. As it was the most recent full year, 2009 was set as the baseline year. Some data was available from 2006 so the comparisons start at 2006 and continue through 2011. The interpolations were based on the official populations and the growth rate of the state as reported by the US Census Bureau (2008, 2009). While there are multiple ways to estimate missing values, a simple method was chosen due to the large number of missing data. In general the number was set for the baseline year (2009), decreased for prior years, and increased for future years based on the rate of growth of the Idaho population. This model assumes that the ratio of calls to population remains consistent. The growth rate for projected years (2010, 2011) was based on the average of the previous years. For example, Idaho's estimated growth rate for 2010 was the average growth rate for 2006, 2007, 2008, and 2009.

Logic Model

The logic model was set for 2009 based on three calls per shift, three shifts per day across 365 days per year. In 2009 this yielded 3,285 calls. All data for this model were statistically estimated based on the 3,285 number. Only the Idaho population and growth rate are real data.

Table 15: Calculation Table for Logic Model

Year	Idaho Population	% State Growth Rate	Calls
2006	1,464,413		**3,108**
2007	1,499,245	2.4%	**3,184**
2008	1,527,506	1.9%	**3,246**
2009 Baseline	1,545,801	1.2%	**3,285**
2010	**1,607,633**	**1.8%**	**3,345**
2011	**1,671,938**	**1.8%**	**3,407**

Formula used: base rate year +/- (1*growth rate). Statistically estimated numbers appear in bold

The Lifeline Call Model

This model is based on the actual Idaho call volume from Idahoans to Lifeline. Data were available for 2007, 2008, and 2009. The numbers for years 2006, 2010 and 2011 are statistically estimated based on the growth rate of the state as reported by the U.S. Census Bureau.

Table 16: Calculation table for Life Line Call Model			
Year	**Idaho Population**	**% State Growth Rate**	**Calls**
2006	1,464,413		**1473**
2007	1,499,245	2.4%	1534
2008	1,527,506	1.9%	2256
2009 Baseline	1,545,801	1.2%	3633
2010	**1,607,633**	**1.8%**	**3700**
2011	**1,671,938**	**1.8%**	**3767**

Formula used: base rate year +/- (1*growth rate). Statistically estimated numbers appear in bold

The Boise Police Department Model

On March 25, 2010, the Boise Police Department released the "Boise Police Department Mental Health Hold/Suicide Calls" data. For the purposes of this model, calls classified by the police department as "suicidal subject" were used. These data were then statistically estimated across the state based on actual U.S. Census population estimates for Boise City and for Idaho as a whole. Estimates were calculated based on the percentage of Boise City population to the State population.

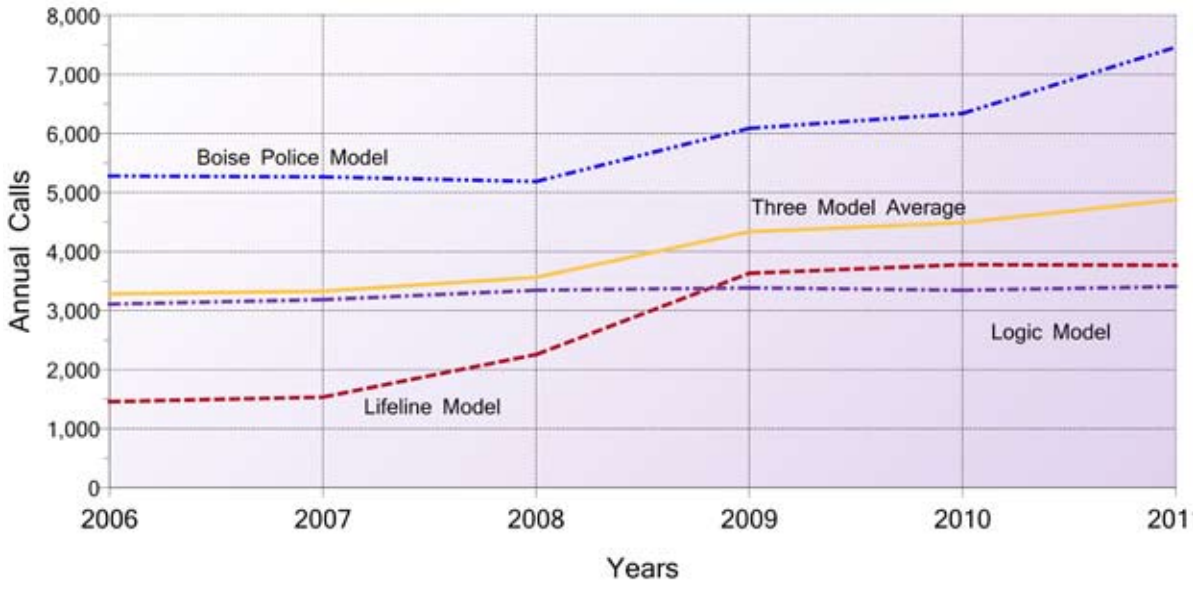
Table 17: Calculation table for the Boise (City) Police Department Model						
Year	**Boise City Population**	**Idaho Population**	**State Growth Rate**	**Number of suicide related calls**	**Boise City Percent of State**	**Estimate for State**
2006	199,986	1,464,413		721	14%	**5,280**
2007	202,736	1,499,245	2.4%	712	14%	**5,265**
2008	205,314	1,527,506	1.9%	697	13%	**5,186**
2009 Baseline	207,000	1,545,801	1.2%	815	13%	**6,086**
2010	**210,795**	**1,607,633**	**1.8%**	**849**	13%	**6,475**
2011	**214,660**	**1,671,938**	**1.8%**	**883**	13%	**6,877**

Formula used: Boise City Population/State Population. The growth rate was not estimated years 2006 to 2009 due to the availability of data from the Census Bureau. Growth for 2010 and 2011 was based on Population Base rate + (1*growth rate). The 2010 estimation was provided by the Boise Police Department. Statistically estimated numbers appear in bold.

Comparative Results of the Three Models

Below is a graphic showing the models projected from 2006-2011. Following the graph is specific information about the extrapolation of the models. The results of each method are shown independently and the average of the three methods is shown by the lavender line.

Figure 25: Graph Showing Call Volume Estimation Across Three Models



Model Averaging for Configurations Calculations

Because of the lack of strength of any one model, all three models were averaged to establish the number of calls used for the configuration calculations.

Table 18: Calculation table for the Three Models Used to Estimate Calls to an Idaho Hotline

	2006	2007	2008	2009	2010	2011
Logic Model	3,108	3,184	3,246	3,285	3,345	3,407
Lifeline Call Model	1,457	1,534	2,256	3,633	3,778	3,767
Boise Police Department Model	5,280	5,265	5,186	6,086	6,340	7,462
Three method average; number used for configurations	3,281	3,328	3,562	4,335	4,488	4,879
SD	1,917	1,870	1,490	1,527	1,619	2,244
Standard Error of the Estimate[1]	1102	1079	861	881	935	1296

[1]The Standard Error of the Estimate (SEM) is the standard deviation of the means which is associated with the potential inaccuracy of the models across any one year. Smaller numbers represent better estimates. This is one method to estimate the level of accuracy of the estimates for calls in any one year. Note that the SEM is smaller in years where more real data are available. The conclusion that can be drawn from this is that years with more real data provide better estimates than years where it was necessary to make more estimates.

Funding Sources and Ongoing Funding

This chapter does not address the sources of funding for various configurations. Establishing ongoing funding is probably the most difficult part of supporting a hotline. The configuration, in many ways, determines funding. For example, it may be necessary and even desirable, in any configuration to use volunteers and to raise funds to support the hotline. Data from the national Directors Study and the 2-1-1 Study, discussed earlier in Chapter 3, showed that about half of hotlines we surveyed had dedicated state and/or local government funding—typically 80% to 100% of their annual budget. Other organizations were housed within a government agency and thus were incorporated into a departmental budget. Hotlines that were housed within a hospital, community mental health center, or similar organization were also part of a larger departmental budget. Many hotlines rely on fundraising, grants and the United Way for portions of their budgets. Regardless of the source of income, accreditation requires that it be ongoing.

Freestanding hotlines funded with donations and grants often do not qualify for accreditation

Freestanding hotlines that are dependent largely or in whole on donations and grants (soft money) often do not qualify for accreditation because of the uncertain nature of this kind of funding. This has the secondary effect of greatly reducing the probability a hotline could join the national Lifeline. Since Lifeline offers its members the ability for calls to roll over into the national network if they are not picked up in Idaho, costs to operate a non-certified hotline would be expected to increase with retention of additional operators to ensure all calls are answered independent of Lifeline. In addition, with the ability to network with Lifeline's hotlines nationwide, an Idaho hotline would have access to translation resources to 150 languages. Providing this service for Idaho's hotline alone can be a significant budget item. In fact, this service could cost more than an Idaho hotline's rent. In these ways, it would actually be less expensive for a hotline to have dedicated ongoing funding rather than exclusively soft money. Finally, hotlines operating on soft money can be unstable and may have spotty coverage as volunteers may or may not be able to work phone lines. Funding sources are discussed in greater detail in *Chapter 8: Sustainability*.

Categorization of Operating Hours for Budget Sample Costs

This section explains the variety of information included within each possible configuration. Included here is an explanation of terms and why certain details were chosen to be included in the configuration.

Two types of operating hour models were used. The model termed "24/7" means an organization functions 24 hours a day, 7 days a week, 365 days a year. The second model was termed "business hours." This model was based on a minimum of a 40-hour week but could reflect longer hours such

as being open some nights and/or weekends. The division between the two models was based on whether an organization would be perceived as open all the time vs. having set open hours.

A second level of the decision regarding opening hours is based on whether the configuration would need additional operators to be fully staffed 24/7. Some organizations have 24/7 coverage using the Internet, a back-up service, or even a roll-over to an emergency services phone.

Here are three examples. A classic example of a 24/7 operation is 9-1-1. A community health center open from 8 to 5 would be a normal business hour organization. This would be further verified by the message a person calling off hours would hear. Most business hour organizations include information about leaving a message or what to do in case of an emergency, "hang up and call 9-1-1 or go to your nearest emergency room." It should be noted that use of answering machines is not permitted by accrediting agencies. Other organizations have a 24/7 presence but are not fully staffed for round the clock coverage.

Development of Sample Budgets

Budget Sample Format

The budget samples are presented in a generalized federal grant category format since it is a standardized format that allows for explicit information about budget items. The samples are organized into five categories. The categories are:

1. Personnel which includes salaries and fringe
2. Travel
3. Materials and Supplies
4. Contractual
5. Other

Determining the Costs for Various Configurations

In many cases, the line items that are included in the sample budget may not be specific to a particular organization that has been classified in that group. There are two key reasons for this.

1. The staffing needed to incorporate a hotline into an existing organization likely will be identified as part of that organization's planning and cannot be specifically known until a review of existing staffing and job assignments is completed. It should be noted that accreditation requires specific workers be assigned exclusively to take hotline calls.

2. Salaries and fringe benefits can vary greatly across organizations, even across similar organizations. Changes due to national healthcare reform may increase or decrease an organization's fringe benefit costs.

Similarly, non-personnel costs can be unknowable based on the organization's structure. For example, businesses or faith-based organizations may provide space to a nonprofit such as for Alcoholics Anonymous meetings. Trinity Episcopal Church in Pocatello houses two community programs operated out of the building but separate from the church organization. Our Gathering Place is an after school program for teens which has an average afternoon attendance 50 youth. Our Brother's Table is a weekend soup kitchen run out of the church facilities but staffed entirely by community volunteers who are coordinated by a community nonprofit. In situations such as this, an organization does not pay rent or utilities.

State salary rates were used for standardization

Establishing Cost Bases

As much as possible, actual costs were used to estimate expenses. Personnel and travel costs were based on State of Idaho regulations. For other cost estimates, prices were obtained from companies operating in the State of Idaho. In situations where there was product variation either an average or a reliable bid was used. When regional variations existed, such as rent and utilities, costs were checked in multiple places. The three locations from which local costs were taken include the Boise area, Idaho Falls and Pocatello. Clearly these three communities do not represent the whole state. Costs for hotlines housed in northern Idaho could be quite different. For example, costs in rural communities or resort communities probably reflect their varying demographics.

Estimating Personnel Types and Costs

For the ease of standardization, state job descriptions and the entry state pay rate were used to estimate personnel. Sample positions were selected based on discussions with the State of Idaho Division of Human Resources. These actual positions and the salary rates may or may not be useful by any specific organization. Organizations may pay more or less. They may arrange work differently. These state rates were utilized so that budget examples are comparable across the different configurations.

The following positions were used for the budget samples

1. *Community Resources Coordinator (Executive Director):* Class number, 07944, purpose: to plan and coordinate statewide information and referral and/or health promotion programs; develop and coordinate community resources; prepare and disseminate

health promotion materials or coordinate development of health services data; train community representatives and/or staff; perform related work.

2. *Volunteer Services Coordinator:* Class number. 07940, purpose: To plan, organize, and coordinate a program for recruitment and utilization of volunteer workers; perform related work.
3. *Development Associate:* Class number 05352, purpose: To implement [public television] fund-raising activities and special projects; perform related work. This position was designed for Idaho Public Television and was recommended by the State of Idaho Division of Human Resources as a rough equivalent to the needs of a hotline.
4. *Operator-Receptionist:* Class number 01125, Class purpose: To provide front-line customer service in person and/or by telephone to refer customers to appropriate office or staff; perform related work.

Estimating Fringe Benefit Rates

As with salaries, fringe benefit rates are specific to an organization and can vary depending on the type of position, the percent of full time and other factors. Some fringe is required under federal law; these include workers compensation and Social Security. Some organizations provide health insurance, retirement, sick and annual leave, and other benefits. Most state and federal organizations pay these fringe benefits. For budget purposes, it is common to use a 25% to 30% fringe rate. For the purposes of this report, a fringe rate of 25% was applied. Be aware that some organizations hire individuals as independent contractors, in which case fringe is the responsibility of the contractor.

Staffing Assumptions

1. *New 24/7 Staffing.* This scenario provides for a full time Community Resources Coordinator, a quarter-time Volunteer Services Coordinator, and a half time grants/contracts specialist whose job is to secure funding to keep the hotline open. If there is dedicated funding the Development Associate position is not included. Operators are calculated on three, 8-hour shifts each day, 365 days a year. This allows for an operator on duty at all times. The total number of hours annually to be covered by a 24/7 configuration is 8,760 hours. The number of hours in a typical full time position for a year is 2080 (40 hrs. over 52 weeks). Twenty-four/seven coverage requires 4.2 employees. The remaining .8 employee accommodates for annual and sick leave absences. Assuming 2 weeks annual leave, 2 weeks sick leave, and 10 holidays for each

employee, the actual in-office hours for five employees is 9,200. This is 88 hours over and above the total possible hours to cover a 24/7 hotline with one operator at any given time for a year.

2. *Existing 24/7 Staffing.* In this scenario an organization has the personnel resources to manage incoming suicide prevention calls. The personnel need additional training specifically for suicide prevention operators. The Community Resources Coordinator position may form a portion of an existing position. A Volunteer Services Coordinator and/or a Development Associate may be incorporated part-time or not included depending on the assumptions regarding the organization. Using the Community Resources Coordinator and Volunteer Services Coordinator to supplement answering calls is not uncommon in other states.
3. A*dditional Staffing to Expand to 24/7.* Some additional personnel would be needed to expand from business hours to a 24/7 operation. New and existing personnel need additional training specifically for suicide prevention operators. The Community Resources Coordinator position is included at some FTE (full-time effort) level. A Volunteer Services Coordinator and/or a Development Associate may be incorporated part-time or not included depending on the assumptions regarding the organization.

Business Hours

The business hour models are identical to the 24/7 with the difference being in the number of operators. The business hour models have two operators scheduled in order to have at least one operator on duty at all times during the organization's business hours (e.g., not nights and weekends). Two operators are necessary due to annual leave, sick leave, and holiday coverage. This also accommodates normal business hours that may extend past an 8-hour shift, for example, an 8 am to 6 pm Monday through Friday schedule

Initial, One Time Cost, Setup Costs

The initial costs associated with a hotline depend on the configuration. Most organizations would need to add more computers and more phones. A typical workstation includes a desk, chair, filing cabinet, desk accessories, computer, and phone. This is estimated at ~$2000 per workstation. Additional costs for new organizations include a printer/copier/fax (~$500) and general furniture and furnishings (~$5000). Thus, onetime costs can range from a low of no additional costs to a moderate addition of workstations at ~$2,000 each to ~$15,000 for the setup of an entirely new office. In addition, some organizations will need legal assistance estimated to cost

approximately ~$800. This assistance could include a 501 (c) 3 application, review of policies, review of the establishment of a board of directors, and other similar activities. In some cases an organization already has this infrastructure and thus would not need counsel or may have in-house counsel to accomplish the tasks.

Non-English Speaking Callers and People with Disabilities

Costs for taking calls coming from people who do not speak English and for those with disabilities such as hearing impairment are estimated in the budgets. These costs are included under two situations. First, costs are included where certification is not possible. An example of this would be an organization that does not have stable, dedicated funding and therefore does not meet the criteria for accreditation. In this instance, the organization will need to absorb these costs as the hotline must be able to take these types of calls. Costs were not included in budgets where a hotline could be accredited and, thus, participate in Lifeline which provides its members access to Spanish speaking operators, tele-inerpreters in 150 languages, and TTY capacity.

Costs were not included for configurations where it is reasonable to expect that the existing organization would already have this capacity. An example of an organization where the capacity was assumed to exist is 9-1-1.

Five types of configurations found nationally were used

Configuration Comparisons

What follows is a brief discussion of each potential configuration; including a definition of the type of organizational structure, expected changes for existing organizations should they add a hotline, and the advantages and disadvantages of each configuration. Sample budgets are provided for a business-hour model and for a 24/7 model. Each configuration includes the following:

- A definition of configuration
- Expected changes for existing organizations
- Advantages and disadvantages
- Sample budget
- Business hours
- 24/7

Five types of configurations were considered. These five were selected based on (a) the types of configurations of hotlines across the United States, (b) the potential for use in Idaho, and (c) discussions with Idaho decision makers. Within-state key informant discussions were conducted with a person within each of the types of organizations represented. For more information on the national and in-state studies, see Chapter 3.

1. *Freestanding.* These hotlines are separate entities. They operate as a hotline business specifically. Typically they are nonprofit organizations.
2. *Hospital and Health or Mental Healthcare Organizations.* These have infrastructure to provide services and supports. These could include mental health centers, federally funded health clinics, private clinics, schools, or other similar organizations. These configurations may or may not be nonprofit.
3. *University Setting.* This configuration is based on a hotline being incorporated in some way as a part of a university or college.
4. *2-1-1 CareLine.* This configuration is based a single number community information and referral service. 2-1-1 lines may be part of a governmental organization or they may be freestanding and nonprofit.
5. *Emergency Number 9-1-1.* This configuration is based on having a centralized emergency phone dispatch system that people can call for police, fire, or ambulance emergency services. The 9-1-1 system is typically funded based on state laws that impose monthly fees on local and wireless telephone customers.

Freestanding Nonprofit Suicide Prevention Hotline

Slightly over one third (35%) of the hotlines that responded to the Director Study were freestanding hotline organizations. This means that the hotline organization stands alone and is not affiliated with any other organization. Most are 501 (c) 3 nonprofit entities and thus are required by state and federal statute to have a specific type of business structure that includes a board of directors, usually a charter, and nonprofit tax status. An Idaho example of this would be Hailey Crisis Hotline in Wood River Valley, Idaho. The Hailey Crisis Hotline serves a broader constituency than only suicide prevention calls. It fields information and referral, crisis, suicide crisis, domestic violence, mental health and substance abuse calls for Blaine County and most of Southern Idaho.

Expected Actions or Changes

To begin a new freestanding hotline would engender start-up costs of approximately $15,000 to $20,000. It would also be necessary to procure a physical location as well as recruiting and training staff and volunteers. Additionally, the new hotline would have to make decisions on policies and training before beginning training and then before to answer hotline calls. If the hotline were to decide to acquire nonprofit 501(c) 3 tax status, papers may need to be filed.

If a suicide prevention hotline were to integrate into a current freestanding hotline, additional space, supplies, and volunteers might be needed if there was sufficient increase in call volume. Unless the current operators had been trained in suicide prevention procedures, additional training would be needed. Organizational culture issues might also need to be addressed. For example, some hotlines/help lines (who are not suicide prevention hotlines) focus on call volume as an indicator or measure of success. More, and shorter, calls are considered better from a customer service perspective. For callers seeking information, the sooner they receive the correct information, the sooner their needs are met. Thus, authoritative and speedy service is a goal. While these characteristics may serve the suicide prevention hotline callers who are seeking referral information, neither of these are appropriate for a high-risk suicide call.

Advantages and Disadvantages

A main advantage of a freestanding hotline is the ability to work in the best interest of hotline callers and operators without having to adapt to current views and policies of a parent organization. This would mean decisions on policies, accreditation, training, and funding would be solely the responsibility of the hotline leadership and not the leadership of an overarching organization.

A freestanding hotline however may struggle with acquiring a dedicated ongoing funding source as it would not have a parent organizations budget on which to rely. It likely would become necessary to dedicate and in some situations even divert staff time to finding funding sources. Additionally, if a hotline were created independently from any other current Idaho organization there would be significant time lag between the decision to start a hotline and when it became functional during which decisions on hotline policy, accreditation, training, and funding were being made.

Budget Samples

Below are four sample budgets for freestanding hotlines. There are two budget samples based on 24/7 operation and two on a business hour operation. The samples are different based on either having ongoing dedicated funding or having to rely entirely on grants and donations.

As previously noted, any sample budgets are not specific to an organization. A detailed explanation of the sample budget line items is provided in the Sample Budget section.

Table 19: Freestanding Nonprofit Suicide Prevention Hotline, Budget Sample 24/7			
Personnel			
Source of Personnel	**Annual Salary**	**% assignment**	**Salary**
Community Resources Coordinator/Director	$34,507	100%	34,507
Volunteer Services Coordinator	$34,507	25%	8,627
(PTV) Development Associate	$30,805	50%	15,403
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Fringe			30,629
		Subtotals Personnel	**$199,249**
Travel			
Travel to Conference			1,689
		Subtotals Travel	**$1,689**
Supplies			
General Office Supplies			2,400
Telecommunications			7,389
Outreach materials (pocket cards, etc)			5,000
		Subtotals Supplies	**$14,789**
Contractual			
QPR Training (8 people)			280
Trainer			2,000
Translations (9.3% other than english at home)			23,849
		Subtotals Contractual	**$26,129**
Other			
Rent			6,000
Power			2,100
Water			300
Sanitation			1,800
Liability Insurance			500
Accreditation fee			2,000
		Subtotal Other	**$12,700**
		Estimated Total Direct Costs	**$254,557**

This configuration includes five full-time operators. There is also a full-time Community Resources Coordinator along with personnel to manage volunteer and funding procurement. The positions are not combined as each has a different focus, pace and hours worked.

Table 20: Freestanding Nonprofit Suicide Prevention Hotline Budget Sample, Business Hour			
Personnel			
Source of Personnel	**Annual Salary**	**% assignment**	**Salary**
Community Resources Coordinator/Director	$34,507	100%	34,507
(PTV) Development Associate	$30,805	50%	15,403
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Fringe			17,788
		Subtotals Personnel	**$97,743**
Travel			
Travel to Conference			1,689
		Subtotals Travel	**$1,689**
Supplies			
General Office Supplies			2,400
Telecommunications			7,389
		Subtotals Supplies	**$9,789**
Contractual			
QPR Training (8 people)			280
Trainer			2,000
Translations (9.3% other than english at home)			0
		Subtotals Contractual	**$2,280**
Other			
Rent			6,000
Power			2,100
Water			300
Sanitation			1,800
Liability Insurance			500
Accreditation fee			2,000
		Subtotal Other	**$12,700**
		Estimated Total Direct Costs	**$254,201**

This configuration includes two full-time operators. There is also a full-time Community Resources Coordinator along with personnel to manage volunteer and funding procurement. The positions are not combined as each has a different focus, pace and hours worked.

Table 21: Dedicated Funds for Freestanding Nonprofit Suicide Prevention Hotline, Budget Estimate 24/7			
Personnel			
Source of Personnel	**Annual Salary**	**% assignment**	**Salary**
Community Resources Coordinator/Director	$34,507	100%	34,507
Volunteer Services Coordinator	$34,507	25%	8,627
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Fringe			29,258
		Subtotals Personnel	**$151,847**
Travel			
Travel to Conference			1,689
		Subtotals Travel	**$1,689**
Supplies			
General Office Supplies			2,400
Telecommunications			7,389
Outreach materials (pocket cards, etc)			5,000
		Subtotals Supplies	**$14,789**
Contractual			
QPR Training (8 people)			280
Trainer			2,000
		Subtotals Contractual	**$2,280**
Other			
Rent			6,000
Power			2,100
Water			300
Sanitation			1,800
Liability Insurance			500
Accreditation fee			2,000
		Subtotal Other	**$12,700**
		Estimated Total Direct Costs	**$183,305**

This configuration includes five full-time operators, a full-time Community Resources Coordinator and a Volunteer Services Coordinator. No Development Associate is included because the hotline has dedicated funding. Additional fundraising could be done by the Community Resources Coordinator with the assistance of volunteers.

Table 22: Dedicated Funds for Freestanding Nonprofit Suicide Prevention Hotline, Budget Estimate Business Hour			
Personnel			
Source of Personnel	**Annual Salary**	**% assignment**	**Salary**
Community Resources Coordinator/Director	$34,507	100%	34,507
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Fringe			29,258
		Subtotals Personnel	**$82.861**
Travel			
Travel to Conference			1,689
		Subtotals Travel	**$1,689**
Supplies			
General Office Supplies			2,400
Telecommunications			2,217
Outreach materials (pocket cards, etc)			5,000
		Subtotals Supplies	**$9,617**
Contractual			
QPR Training (8 people)			1,500
Trainer			2,000
		Subtotals Contractual	**$3,500**
Other			
Rent			6,000
Power			2,100
Water			300
Sanitation			1,800
Liability Insurance			500
Accreditation fee			2,000
		Subtotal Other	**$12,700**
		Estimated Total Direct Costs	**$110,368**

This configuration includes two full-time operators and a full-time Community Resources Coordinator. No Development Associate is included because the hotline has dedicated funding. No Volunteer Services Coordinator is included for the same reason. The Community Resources Coordinator and volunteers recruited specifically for their fundraising skills could share the responsibility of volunteer coordination and additional fundraising.

A Hospital, Healthcare, or Mental Health Care Organization

About one third (35%) of the organizations that answered the Director Study survey were part of a hospital or another healthcare organization . Eastern Idaho Behavioral Health Center currently houses a phone line that receives calls regarding information and referral, crisis, suicide crisis, mental health, substance abuse, hospital admissions, and outpatient scheduling calls from Idaho Health and Welfares Region 6 and 7. Often, community mental health or social service organizations take on the role of hotline operators. Although hospitals, healthcare and mental health organizations are in many ways different, they are grouped together here based on an institutional structure that provides health care, social care, or other services.

Expected Actions or Changes

The integration of a hotline with a hospital or health care organization may require an increase in staffing and the purchase of necessary office supplies, including phones and computers. Current staff would need to be trained to assist callers through different operator methods besides mental health referrals, including options that involve creative problem solving and the creation of plans of action.

The changes that may come with integrating a hotline into a community mental health or social service organization parallel the expected changes noted for hospital or health care organizations . The addition of a hotline may create more budgetary items for the organization, including an increase in staffing and a need for additional office items like phones and computers. Further, the staff will need to be aware of alternatives to mental health referrals, including helping the caller make a plan of action. Accreditation requires dedicated staff/volunteers specifically to answer hotline calls.

Advantages and Disadvantages

A distinct advantage of having a hotline located within a hospital, healthcare, or mental health care organization is the easy access to mental health professionals. The coordination between a hotline and hospital or health care organization also allows for further follow up with callers and additional support for current patients of the hospital or health care organization. Staff is already trained in dealing with crisis situations, so most of the training would need to focus on the difference between hotline crisis interaction and face-to-face crisis interaction. Additionally, most hospitals are already accredited so they could begin applying for Lifeline membership earlier than organizations that would still need to seek accreditation.

One more advantage of combining a social service organization with a hotline is its ready access to already compiled referral information. Professional staff would be available to answer hotline calls, allowing the organization to concentrate on improving service delivery to current patients and hotline callers.

A disadvantage for the hospital or health care organization setting includes the potential of having to divert staff from direct patient care to assisting hotline callers when there is a major influx of calls. Also, the hotline would be dependent upon the organization's operating budget and may have problems if budgets need to be cut due to the economy. The organization also needs to be conscious of distributing referrals to all community resources, and not to show preference toward referrals within its own organization.

Problematic for combining a hotline with a community mental health or social service organization is that a reliance on current professional staff may mean the hotline receives inconsistent support when staff are involved with current patients. Adding a hotline to the organization's responsibilities may cause budget constraints depending upon the organization's funding source, and the availability of funds.

Table 23: Sample Hospital, Healthcare, or Mental Healthcare Organization, 24/7			
Personnel			
Source of Personnel	Annual Salary	% assignment	Salary
Community Resources Coordinator/Director	$34,507	50%	17,254
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Fringe			12,259
		Subtotals Personnel	**$61,294**
Travel			
Travel to Conference			1,689
		Subtotals Travel	**$1,689**
Supplies			
General Office Supplies			2,400
Telecommunications			7,389
Outreach materials (pocket cards, etc)			5,000
		Subtotals Supplies	**$14,789**
Contractual			
QPR Training			105
Trainer			2,000
Translations (9.3% other than english at home)			0
		Subtotals Contractual	**$2,105**
Other			
Accreditation fee			2,000
		Subtotal Other	**$2,000**
		Estimated Total Direct Costs	**$81,877**

This configuration includes two full-time operators, and a half-time Community Resources Coordinator. In this budget, the half-time Community Resources Coordinator was assumed to come from a portion of an existing employee who was reassigned to oversee a hotline.

Table 24: Sample Hospital, Healthcare, or Mental Healthcare Organization, Business Hours			
Personnel			
Source of Personnel	Annual Salary	% assignment	Salary
Community Resources Coordinator/Director	$34,507	50%	17,254
Operator	$15,891	100%	15,891
Fringe			12,259
		Subtotals Personnel	**$41,431**
Travel			
Travel to Conference			1,689
		Subtotals Travel	**$1,689**
Supplies			
General Office Supplies			2,400
Telecommunications			2,217
Outreach materials (pocket cards, etc)			5,000
		Subtotals Supplies	**$9,617**
Contractual			
QPR Training			105
Trainer			2,000
Translations (9.3% other than english at home)			0
		Subtotals Contractual	**$2,105**
Other			
Accreditation fee			2,000
		Subtotal Other	**$2,000**
		Estimated Total Direct Costs	**$56,842**

This configuration includes one full-time operator, and a half-time Community Resources Coordinator. In this budget, the half-time Community Resources Coordinator was assumed to come from a portion of an existing employee who was reassigned to oversee a hotline.

University

Idaho's previous suicide prevention hotline was housed at Boise State University. Because of this, Boise State could provide ready assistance with housing the hotline, and access to a supply of potential operators already trained to work in this venue.

Expected Actions or Changes

The university would need to determine which department the hotline would be best suited to work within. This may mean a reorganization of resources within the department to ensure there is adequate support of the hotline while covering current responsibilities. The university would also need to establish a separate phone line and physical location for a hotline operation.

Advantages and Disadvantages

The model previously used when Idaho's hotline was housed at Boise State University can be adapted to fit a new setting. By being located on a university campus the hotline would have access to a large population of students who may be willing to volunteer at the hotline. This would limit the amount of employees needed to staff the hotline, and the influx of volunteers may provide coverage for 24/7 service.

The previous hotline had to shut down due to lack of funding. It would be necessary to ensure the necessary long-term funds to avoid later financial difficulties. This may be difficult due to the current state of the economy and the issues that the economy has caused for Idaho universities. Because the hotline would most likely rely on student volunteers there may be a high rate of turnover involved, leading to more time and resources spent on recruiting and training new volunteers. Also, given that students form a transient population—leaving for breaks and summer—it might be difficult to maintain adequate operators during times of known increases in suicide attempts such as school holidays.

Table 25: Sample Budget University, 24/7

Personnel			
Source of Personnel	Annual Salary	% assignment	Salary
Community Resources Coordinator/Director	$34,507	25%	8,627
Volunteer Services Coordinator	$34,507	25%	8,627
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Fringe			11,020
		Subtotals Personnel	**$60,055**
Travel			
Travel to Conference			1,689
		Subtotals Travel	**$1,689**
Supplies			
General Office Supplies			2,400
Telecommunications			7,389
Outreach materials (pocket cards, etc)			5,000
		Subtotals Supplies	**$14,789**
Contractual			
QPR Training			140
Trainer			2,000
Translations (9.3% other than english at home)			0
		Subtotals Contractual	**$2,140**
Other			
Accreditation fee			2,000
		Subtotal Other	**$2,000**
		Estimated Total Direct Costs	**$80,673**

This configuration includes two full-time operators, a quarter-time Community Resources Coordinator, and a quarter-time Volunteer Services Coordinator. The half-time Community Resources Coordinator was assumed to be a portion of an existing employee, reassigned to oversee a hotline. The operators are presumed to cover the evening and night hours not covered by a university clinic to form a base to build on with volunteers.

Table 26: Sample Budget University, Business Hours			
Personnel			
Source of Personnel	Annual Salary	% assignment	Salary
Community Resources Coordinator/Director	$34,507	25%	8,627
Volunteer Services Coordinator	$34,507	25%	8,627
Operator	$15,891	100%	15,891
Fringe			6,897
		Subtotals Personnel	**$40,042**
Travel			
Travel to Conference			1,689
		Subtotals Travel	**$1,689**
Supplies			
General Office Supplies			2,400
Telecommunications			2,217
Outreach materials (pocket cards, etc)			5,000
		Subtotals Supplies	**$9,617**
Contractual			
QPR Training			105
Trainer			2,000
Translations (9.3% other than english at home)			0
		Subtotals Contractual	**$2,105**
Other			
Accreditation fee			2,000
		Subtotal Other	**$2,000**
		Estimated Total Direct Costs	**$55,452**

This configuration includes one full-time operator, and a quarter-time Community Resources Coordinator and a quarter-time Volunteer Services Coordinator. The quarter-time Community Resources Coordinator was assumed to be a portion of an existing employee, reassigned to oversee a hotline. The operators are presumed to cover evening and night hours not covered by a university clinic to form a base to build on with volunteers.

2-1-1 CareLine

CareLines are set up to accept information and referral calls that are on a range of topics. They collect community referral information that they then can provide to their callers. Idaho's 2-1-1 CareLine already accepts information and referral, crisis, suicide crisis, domestic violence, mental health, substance abuse, fraud, child care, and child abuse or neglect calls.

Expected Actions or Changes

Idaho's 2-1-1 CareLine would receive an increase in calls if a hotline were added to its responsibilities. This increase would necessitate additional staffing requirements. The greater costs potentially could come from increased staffing and an increase of toll-free calls, or the establishment of a dedicated line for the hotline (required for accreditation). In addition, extra time would be needed to meet the training requirements for accreditation.

Advantages and Disadvantages

Advantages to integrating a hotline with Idaho's 2-1-1 CareLine include access to trained professional staff, established practices, and departmental affiliation. Additionally, it is easier to market the new hotline as there is one number that provides access to both information and referral and suicide crisis. Operators' skills would be strengthened since they would have to be trained in both areas.

The increased training time and staff requirements can be a disadvantage. The demands of information and referral are different from suicide crisis which may lead to a conflict. Increased calls could lead to a need to prioritize calls when call volume is high and staff are unable to cover all the calls, leading to some dropped calls. It also may be hard for Idaho's population to associate 2-1-1 CareLine with a suicide prevention hotline as it is normally marketed as an information and referral line.

Table 27: Sample Budget 2-1-1 CareLine, 24/7			
Personnel			
Source of Personnel	**Annual Salary**	**% assignment**	**Salary**
Community Resources Coordinator/Director	$34,507	25%	8,627
Volunteer Services Coordinator	$34,507	25%	8,627
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Fringe			14,843
		Subtotals Personnel	**$79,769**
Travel			
Travel to Conference			1,689
		Subtotals Travel	**$1,689**
Supplies			
General Office Supplies			2,400
Outreach materials (pocket cards, etc)			5,000
		Subtotals Supplies	**$9,617**
Contractual			
QPR Training			490
Trainer			2,000
Translations (9.3% other than english at home)			0
		Subtotals Contractual	**$2,490**
Other			
Accreditation fee			2,000
		Subtotal Other	**$2,000**
		Estimated Total Direct Costs	**$93,348**

This configuration includes three full-time operators, a quarter-time Community Resources Coordinator and a quarter-time Volunteer Services Coordinator. The quarter-time Community Resources Coordinator was assumed to be a portion of an existing employee who was reassigned to oversee a hotline. The operators are presumed to cover evening and night hours currently covered and to form a base from which to build volunteers.

Table 28: Sample Budget 2-1-1 CareLine, Business Hours			
Personnel			
Source of Personnel	**Annual Salary**	**% assignment**	**Salary**
Community Resources Coordinator/Director	$34,507	25%	8,627
Operator	$15,891	100%	15,891
Fringe			6,130
		Subtotals Personnel	**$30,648**
Travel			
Travel to Conference			1,689
		Subtotals Travel	**$1,689**
Supplies			
General Office Supplies			2,400
Telecommunications			2,217
Outreach materials (pocket cards, etc)			5,000
		Subtotals Supplies	**$9,617**
Contractual			
QPR Training			490
Trainer			2,000
Translations (9.3% other than english at home)			0
		Subtotals Contractual	**$2,490**
Other			
Accreditation fee			2,000
		Subtotal Other	**$2,000**
		Estimated Total Direct Costs	**$46,444**

This configuration includes on one fulltime operator, a quarter-time Community Resources Coordinator and a quarter-time Volunteer Services Coordinator. The quarter-time Community Resources Coordinator was assumed to be a portion of an existing employee who was reassigned to oversee a hotline. The operators are presumed address the additional call volume over the current operation.

Emergency Number 9-1-1

The 9-1-1 emergency number is widely known and understood as a number to call for help. Placing a hotline within a 9-1-1 system would further connect the hotline to emergency services. 9-1-1 systems are already set up to assist those individuals that attempting suicide.

Expected Actions or Changes

The addition of a hotline to 9-1-1 systems responsibilities would require the purchase of an additional phone number to reassure callers that they were not calling for emergency services. There would also be an increased amount of calls routed through 9-1-1 centers, which would most likely require additional staffing. Employees and volunteers would also have to be trained on how to handle hotline crisis calls versus 9-1-1 calls. In the case of 9-1-1 calls, an immediate referral to the appropriate agency is conducted and the staffer stays on the phone till personnel arrive. This differs greatly from a hotline crisis call where the call is spent discussing the situation with the caller before providing support through a referral or the creation of an action plan. Finally, emergency personnel are only called upon to act in cases where the caller is in imminent risk; that is generally not the case with hotline calls which can be lengthy.

Advantages and Disadvantages

Connecting a hotline to an already established 9-1-1 system would provide easy access to many of the required supplies and trained personnel. It would also help encourage a relationship between a focus on suicide prevention via a hotline and emergency services. This could make the transition between a hotline call to a rescue call smoother, and provide the hotline with more information to assist in following up with callers.

Integrations of the two systems can pose disadvantages. The structure of the types of calls and the missions of the organizations are not consistent with one another, which may cause problems. Additionally, there is an increased cost involved because of the need to hire more personnel and to train both new personnel and retrain current personnel on how to respond to hotline calls in ways far different from traditional 9-1-1 calls. Representatives of the Idaho 9-1-1 system felt the marriage of 9-1-1 and a hotline would be detrimental.

Table 29: Sample Budget 9-1-1

Personnel			
Source of Personnel	Annual Salary	% assignment	Salary
Community Resources Coordinator/Director	$34,507	100%	34,507
Volunteer Services Coordinator	$34,507	25%	8,627
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Operator	$15,891	100%	15,891
Fringe			21,313
		Subtotals Personnel	**$112,120**
Travel			
Travel to Conference			1,689
		Subtotals Travel	**$1,689**
Supplies			
General Office Supplies			2,400
Telecommunications			739
Outreach materials (pocket cards, etc)			5,000
		Subtotals Supplies	**$8,139**
Contractual			
QPR Training			210
Trainer			2,000
Translations (9.3% other than english at home)			0
		Subtotals Contractual	**$2,210**
Other			
Accreditation fee			2,000
		Subtotal Other	**$2,000**
		Estimated Total Direct Costs	**$126,158**

This configuration includes three full-time operators, and a full-time Community Resources Coordinator with a one-quarter time Volunteer Services Coordinator. The personnel are presumed to address the different types of calls and additional call volume over the current operation.

Other Considerations

Multi-Site Hotlines

Conceptually, a hotline made up of multiple networked organizations, such as medical and psychiatric hospitals, across the state could provide hotline services. Technology to route calls to the closest organization members could ensure callers receive someone in their own communities to provide crisis services. For example, Idaho's psychiatric hospitals have crisis-call capacity and utilize existing staff to handle calls. Existing organizations have phone lines, a physical plant, and other resources, such as office equipment and supplies. Utilization of hospital-based organizations brings with it existing accreditation that likely would be accepted to become a Lifeline member.

Expected changes

Personnel at multiple sites would need to be trained specifically on best practices for handling suicide crisis calls to ensure statewide consistency among the call centers. Documentation and supervision would occur at each site, creating the need for supervisors to adhere to uniform criteria.

Advantages and disadvantages

While a hospital-based, networked hotline brings with it members who are accredited, it is not known if the network itself carries that accreditation with it. In entering the accreditation process, we might find that the existing accreditation does not extend to the network and AAS or CUSA accreditation may not be likely. A crisis at the network organization could pull staff from hotline duty, leaving a gap in service. Uniform training, operator supervision, consistent policies and data collection and analysis are challenges. Allocation of funds, as available, would need to ensure each organization received an equitable share.

Communication Devices

Hotlines currently rely in large measure on the use of land-based telephones for incoming calls and the equipment at the hotline itself. New technology and a new generation of people using hotlines make a discussion of alternate technology necessary. Two high-risk populations, youth and older adults have different likings for, and access to, varying technology. At this point, the recommendation from the accreditation agencies is that land-based phone lines are still the best choice. One of the allures of new technology is that it can dramatically reduce phone costs. However, each alternative brings with it new challenges. At some level technology is limiting because it is not available or not a preferred method of communication.

Cell Phones

Using cell phones could reduce costs and increase the flexibility of staffing a hotline. Likely many calls are placed to hotlines using cell phones. However, using cell phone coverage for the actual hotline operation is strongly discouraged by the American Association of Suicidology (AAS) and Lifeline due to confidentiality concerns and the potential for terminated calls. It is impossible to ensure that an operator would take calls at a secure location. Cell reception in Idaho also can be spotty, potentially creating a problem if a caller were cut off.

Voice over Internet Protocol (VoIP)

VoIP technology uses the Internet for phone calls and the costs of VoIP are usually quite low. The drawbacks are primarily in the consistency of the service quality. While call quality can be quite good, the potential for developing quality problems still exists, seemingly at a greater rate than land-based lines. In addition, privacy issues can also be a problem as although most VoIP programs encrypt calls, some do not.

Email and Text Messages

The primary identified problem with email is the lack of immediate interaction that includes words and emotional information. Hotlines that are using this technology have to dedicate on operator per shift to cover a computer.

Technology could be used to manage hotline services

Web Interfaces

Web interfaces such as a comment box and social media dialogues are increasingly popular, in particular with youth who are a high-risk population. While there are problems similar to email and text messaging, including workload issues, one of the unanticipated problems is that people can find the site from anywhere in the world and may ask for help. Because it is easily accessible online, hotlines have found that they end up being contacted by "people they are not meant to serve," thus increasing a hotline's workload, need for additional operators, and need for more money. In centers currently handling internet "calls", an operator is assigned exclusively to online services. These centers report that it is impossible for one operator to take calls and handle internet services simultaneously.

Budget Sample Line Item Explanations

Personnel

For the purposes of the sample budgets, state job descriptions and the entry state pay rate was used. These actual positions and the salary rates may or may not be useful by any specific organization. Organizations may

pay more or less. They may arrange the work differently. These state rates were utilized so that budget examples are comparable across the different configurations.

1. *Community Resources Coordinator/Executive Director:* Class number, 07944, purpose: to plan and coordinate statewide information and referral and/or health promotion programs; develop and coordinate community resources; prepare and disseminate health promotion materials or coordinate development of health services data; train community representatives and/or staff; perform related work. State Pay Grade K: entry level $34,507. (This position would act as de facto director of the hotline, a position required for accreditation and certification.)
2. *Volunteer Services Coordinator*: Class number, 07940, purpose: To plan, organize, and coordinate a program for recruitment and utilization of volunteer workers; perform related work. State Pay Grade K: entry level $34,507
3. *Development Associate*: Class number, 05352, purpose: To implement funding activities and special programs, set review goals and budget analysis. Pay grade I: entry level $27,331.
4. *Operator-Receptionist*: Class number, 01125, Class purpose: To provide front-line customer service in person and/or by telephone to refer customers to appropriate office or staff; perform related work. State Pay Grade E: $15,891

Fringe Benefits

Fringe rates are specific to an organization and can vary depending on the type of position, the percent of full time, and other factors. Some fringe is required under federal law. These include worker's compensation and Social Security. Some organizations provide health insurance, retirement, sick and annual leave and other benefits. Most state and federal organizations pay these fringe benefits. It is common to use a 20% to 30% fringe rate.

For the purposes of this report we estimated in the mid range of customary practice at 25% of the salary. Positions that are less than 50% time are calculated at the federally required workers compensation rate of 8.9%.

Some organizations hire individuals as independent contractors and fringe is the responsibility of the contractor.

Travel

Table 30: Travel		
	Item	**Cost**
1.	Conference Travel	
2.	Conference fees	$600
3.	Transportation cost	$582
4.	Lodging	$150
5.	Per diem	$47
6.	Ground Transportation	$73

1. *Conference travel.* Funds will be needed to travel to professional conferences of AAS as is necessary for accreditation by that organization. Costs were established using the State of Idaho allowable travel expenses. (www.sco.idaho.gov/web/sbe/sbeweb.nsf/pages/trvlpolicy.htm)
2. *Conference fees.* Registration fees are required as admittance or attendance fees for official participation in conferences, conventions, or other meetings. Estimate is based on the 2010 AAS Annual Conference.
3. *Transportation cost.* Employees shall use the most practical mode of travel from the standpoint of time and expense. Estimates based on the U.S. Department of Transportation's Consumer Fare Report, Quarter 4, 2009. http://ostpxweb.dot.gov/aviation/x-50%20Role_files/consumerairfarereport.htm. Boise to Washington, DC, approximately 2049 miles each way with an average one-way fare: $291.
4. *Lodging.* The actual cost of lodging plus applicable tax will be reimbursed to the traveler. If the traveler is attending a conference and the conference hotel is more than the General Services Administration (GSA) lodging rate, the traveler will provide a justification.
5. *Per diem* is defined as the reimbursement for meals, meal gratuities, and fees and tips out of state rate set at federal rate or if there is no established federal rate at $45 per day.
6. *Ground Transportation.* Taxi or bus fares to and from depots, airports, and hotels, and other ground transportation costs necessary to conduct official state business while on authorized travel status. Travel to and from the airport $25 each way and 50 miles in a personal car at 45.5 cents per mile.

Supplies

Table 31: Supplies				
	Item	**Rate**	**Number**	**Cost**
1.	General office supplies	$200	12	$2,400
2.	Telecommunications	$561	12	$6,729
3.	Outreach materials			$5,000

1. *General office materials.* Office supplies, copies, and postage are needed for operator training and general project operation.
2. *Telecommunications.* The costs are for one business line @ $55 per month. The toll-free hotline number is based on $55 per month and toll-free minutes at $0.07 per minute for 4335 calls at an average of 20 minutes each. Estimates obtained from Qwest.
3. *Outreach Materials.* Include pocket cards, fliers, handouts, and promotional items.

Contractual

Table 32: Contractual		
	Item	**Cost**
1.	One operator training in QPR	$35
2.	Group trainer	$2000
3.	Translators	$23,849

1. *QPR Training.* Basic operator training cost in May 2010, $35 per person.
2. *Training.* This contract is for an instructor to provide training as is necessary for operators, such as ASIST (Applied Suicide Intervention Skills training), cultural sensitivity training, and disability training.
3. *Translators.* Cost of simultaneous translation. The estimate is based on the US Census Bureau's data that 9.3% of Idahoans speak a language other than English at home. The cost is based on 9.3% of 4335 calls (403) calls for 20 minutes @ $2.99 per minute. Estimates obtained from Interpreter.com.

Other

Table 33: Other

	Item	Cost
1.	Rent	$6,000
2.	Power	$2,100
3.	Water	$300
4.	Sanitation	$1,800
5.	Liability Insurance	$500
6.	Annual Accreditation Fee	$2,000

1. *Rent.* Based on $500 per month for 500sq ft based on three real estate estimates in Idaho Falls and one in Pocatello.
2. *Power.* $175 per month for 12 months based on Idaho Power Company's Boise monthly power charge.
3. *Water.* $25 per month for 12 months, based on estimates obtained for Idaho Falls at $21/month and Pocatello at $25/month
4. *Sanitation.* $150 per month for 12 months, based on Idaho Falls estimated at $155.20/month and Pocatello at $73.35/month.
5. *Liability Insurance.* Based on insurance quote from Rockport Insurance www.rockportinsurance.com/
6. *Accreditation fee.* Estimate of annual accreditation fees for national suicide prevention accreditation organization.

CHAPTER 8
SUSTAINABILITY

Sustaining a hotline is an important but challenging task. Regardless of the configuration, community members and stakeholders are at the very center of a hotline's success. The Idaho Suicide Prevention Hotline Advisory Partnership was involved in identifying and reviewing sustainability resources.

Finding Potential Funding Sources for Hotlines

Having ongoing, dedicated money is the best way to support the long-term success of a hotline. Dedicated, ongoing funding is often called hard money. Hospitals, counties/cities, or law enforcement may provide ongoing funding. In some cases this will be legislated funds or funds provided by a local/regional governmental agency. If a hotline is part of a parent organization such as a for-profit hospital, the hotline may be a budget item in the organization's expenses. On occasion, a hotline may be the beneficiary of a trust or permanent gift such as a bequest from an individual or family. Identifying dedicated, ongoing funds, whether governmental or gifts, requires a champion. A champion is committed to the hotline and has the ability to help encourage people to voluntarily change their attitudes or behaviors so that they help procure dedicated funds for the hotline.

Ongoing, dedicated funding is the best way to support a hotline

While hotlines supported by dedicated funding have the most operating stability, many hotlines use grants and small gifts. Grants and small gifts are often called soft money. Regardless of the funding source, long-term, sustainable financial support has to exist for a hotline to be accredited.

Finding Grant or Foundation Funding

The benefit of grants or other competitive funding is that they provide an infusion of funds. The bad part is that the funds are not ongoing and someone must be responsible for keeping the grant funds flowing. It is a sad reality of the grant process that even the best projects may not be funded.

Many different kinds of soft money can be found. Parent organizations of hotlines may provide intermittent funds. Federal grants include those issued by the Department of Health and Human Services (DHHS), Centers for Disease Control and Prevention (CDC), and Substance Abuse and Mental Health Services Administration (SAMSHA). State resources include the Millennium Fund and legislative appropriation. Professional organizations or individual mental health providers can also provide funding when the hotline helps to support its members, for example practicing psychiatrists, psychologists, therapists, and counselors. Some funding may be in the form of "in-kind" resources in which cash is not provided but instead an alternative is offered other then legal tender, such as providing an operating location without charge.

Procuring Grant or Foundation Money

Finding Grant and Foundation Opportunities

Research means follow leads and keep asking questions

There are multiple ways to identify sources of grant funding. Public libraries typically have print or electronic databases. Online searches may also work. Talking with a town or county development office may be useful. Follow some leads and keep asking questions. Many times a granting office can make suggestions for other funding options.

Completing Applications

Persistence is important. More applications mean more opportunities for your applications to be considered. It is very important that you select your prospective grants carefully, that you complete the writing exactly to their criteria, and that your application is exactly the way they want to receive it. Generally, applications that are not correctly completed are removed from the competition before they are even considered.

Grant or foundation funding sources may provide details about their application package as part of the announcement. Others provide application package details once an application request is initiated. In nearly every case an organization must provide a tax identification number as part of the application, often at the beginning of the process. Funding opportunities target different types of organizations. Some funds are only available to governmental organizations. The definition of a governmental organization typically includes state, tribal, or federal governments. In some cases quasi-governmental organizations, such as an advisory council, may be included. Some are available to nonprofit organizations that typically include schools, universities, and 501 (c) 3s. Less common, but not unheard of, are grants that are also available to for-profit organizations.

Potential Grant and Foundation Funding Sources

In this chapter, we have provided a list of potential funding sources. Some are federal, others state and a few are local. Do not limit your search to this list. Some grants are a one-time competition and would not show up in the list. Diligence in searching is important. Equally important is the fit between your request and the values, goals, and objectives of the funding agency. A good fit improves your prospects of being given an award.

The list focuses on publicly available funding opportunities. They are sources of funding that have continuous grant competitions. It does not include internal grant funding opportunities. Internal grants are those that are competed across, but open only to, units within that organization. An example of internal support would be a grant opportunity made to a unit within a corporation that allowed those units to make proposals for internal funding of special projects.

Many grants or gifts require extensive applications and competition for the funds may be stiff. Other grant-funding organizations provide fewer funds, but they may be less difficult to obtain. Sometimes you will find grants that require annual applications with no assurance of ongoing funding.

Many grants require extensive applications and competition is stiff

The potential funding sources listed in this chapter are presented below, first by national opportunities, then by regional opportunities, followed by state, and then local opportunities. Each section begins with a brief narrative of the potential funding program. At the end of each section is a summary table that includes ratings of the grant opportunity.

The grants are rated based on a simple review of the difficulty of the application package. This ranking is very general but can serve as a rough guide as you review funding options. The rating is based upon a scale of 1 to 4, with 1 being a smaller application package and 4 being a very extensive application package. The rating is increased based upon the number of items or amount of information required for grant submission. Additionally, ratings increase based upon the complexity of each application requirement.

National

Bank of America Grant Programs

Bank of America offers a Local Grant Making Program that provides funding in accordance with its philanthropic mission of neighborhood excellence. They normally give to organizations that focus on community development or neighborhood preservation, education, health and human services, and arts and culture. Local grants are reviewed based upon the needs of the community. www.bankofamerica.com/foundation

Enterprise Holdings Foundation

The Enterprise Holdings Foundation's mission is to give back to communities where their customers and employees live and work. They will not fund operating or salary costs and do not support multi-year grants. Requests for grants can only come from employees and their spouses or established customers. Grant amounts vary based upon previous grants awarded to your organization. www.enterpriseholdings.com/sustainability/eh_foundation.html

Verizon Foundation

The Verizon foundation provides funding for organizations that work in the areas of education, literacy, domestic violence prevention, technology for health care, and health care accessibility. Their goal is to help people increase literacy and educational achievement, avoid domestic violence, and achieve and sustain their health and safety. Grants last for one year; however you can receive grants in three consecutive years, after which a one-year hiatus is imposed. http://foundation.verizon.com/grant

The Wachovia Wells Fargo Foundation

The Wachovia Wells Fargo Foundation's mission is to "build strong and vibrant communities, improve the quality of life, and make a positive difference." They do so by providing Community Needs Grants to organizations that focus on education, community development, health and human services, arts and culture, environment, or civic projects. The grants cannot be used for general operating expenses if the organization is already receiving significant support through the United Way. https://www.wachovia.com/wachoviafoundation

Wells Fargo Charitable Contributions

Wells Fargo supports organizations that are improving their communities through community development, education, health and human services, and arts and civic projects. If an agency has received funding for three consecutive years it may be requested that they take a one-year hiatus. Wells Fargo will not provide grants to agencies that receive more than 10% of their operating budget from the United Way. https://www.wellsfargo.com/about/charitable/id_guidelines

Substance Abuse & Mental Health Services Administration

SAMHSA is a federal program that works to "reduce the impact of substance abuse and mental illness on America's communities." As part of its work, SAMHSA provides ongoing opportunities for grant funding in the areas of mental health and substance abuse. Some grants may include funding opportunities for suicide prevention. The best way to find op-

Table 34: National Funding Sources[1]

Funding Source	Type of Funding	Length of Funding	Range of Funds	Application Due	Application Package Rating
Bank of America Grant Programs	Grant	One year	Number and size of awards not specified, state allocation for all grants of $750,000	Year Round	Varies: application details available when application is initiated
Enterprise Holdings Foundation	Grant	One year	Up to $1,500	April 1 and September 1	Varies: application details available when application is initiated
Verizon Foundation	Grant	One year	Average grant is $5,000 to $10,000	January 1 to October 31	4
Wachovia Wells Fargo Foundation	Grant	One year	$1,000 to $3,350,000 in 2008	Year Round	Varies: application details available when application is initiated
Wells Fargo Charitable Contributions	Grant	One year	$100 to $5,000	January 1 to October 1	2
SAMHSA	Grant	Up to 5 years	Varies	Contact Organization	4
CDC	Grant	Up to 5 years	Varies	Contact Organization	4

[1] All information should be verified with the funding organization before beginning the application process.

portunities that are a good match to your funding desires is to review the agency's website. The website typically lists open competitions and those that have closed recently. Reviewing the recently closed information can help provide information about funding opportunities that may reopen in future years. http://samhsa.gov/grants

Centers for Disease Control and Prevention

The federal program, the CDC, promotes health; works to prevent disease, injury, and disability; and prepares for new health threats. The CDC provides a wide range of health-related grants. Some grants support activities related to suicide, suicide prevention, and intentional injury. The agency's website provides information on open and recently closed funding opportunities. This provides an organization with information on currently available opportunities and on those that may reopen in future years. www.cdc.gov/od/pgo/funding/grants/grantmain.shtm

Regional

Albertsons Foundation

The Albertson's Foundation works to build stronger communities where Albertson stores are located. The foundation focuses on hunger relief, health, and nutrition. They will not provide funding to organi-

zations that receive more than 30% of their funding from the United Way. https://shop.albertsons.com/eCommerceWeb/CommunityAction.do?action=beginCommunity

Intermountain Healthcare Fund

"The mission of Intermountain Healthcare is excellence in the provision of healthcare services to communities in the Intermountain Region. The region that Intermountain serves is defined as the state of Utah and portions of southern Idaho." The Intermountain Healthcare Fund provides two potential opportunities for financial assistance in running a hotline. One is their Community Partner Fund and the other is the Intermountain Healthcare Foundation. http://intermountainhealthcare.org/communitysupport/community/givingprograms

- *Community Partner Fund* is for donations to nonprofit health-related organizations that carry a similar mission to Intermountain Healthcare and are within their service area. The donation is to be used for "community health improvement services, health education and conferences, activities that improve health, fundraising events for health-related groups and other similar programs and services."
- *Intermountain Healthcare Foundation* provides grants for primary healthcare activities, pregnant women and newborn children healthcare programs, children's healthcare programs, and other programs related to Intermountain Healthcare's mission. They will not fund organizations that receive more than 40% of their general operating budget from United Way. The funds cannot be used to build, remodel, or purchase property; in addition the funds cannot be used to purchase equipment. They do not support multi-year funding projects.

The Steele-Reese Foundation

Founded in 1955 by Eleanor Steele Reese, the Steele-Reese Foundation is a private foundation. The foundation provides funding to organizations in Idaho, Montana, and Kentucky that focus on rural education, welfare, conservation, health, and humanities. Funds can be used for operating expenses and for the purchase of new equipment. Additionally, grants can last from one to five years depending upon the project. www.steele-reese.org

Great Day Foundation

The Great Day Foundation provides funds to organizations focused on supporting children, education, and the medical community. It supports both new and continuing projects and will help fund equipment and building costs. www.greatdayfoundation.org

Table 35: Regional Funding Sources[1]

Funding Source	Type of Funding	Length of Funding	Range of Funds	Application Due	Application Package Rating
Albertsons Foundation	Grant	One year	Varies	Year Round	1
Community Partner Fund	Donation	Once per year	Up to $5,000	Year Round	1
Intermountain Healthcare Fund	Grant	One year	$5,000 to $50,000	March 1, and September 1	4
Steele-Reese Foundation	Grant	One to Five years	$5,000 to $150,000	March 1	2
Great Day Foundation	Grant	One year	$2,500 to $10,000	Year Round	3

[1] All information should be verified with the funding organization before beginning the application process.

State

First Federal Foundation, Inc.

The First Federal Foundation was established in 2003 by First Federal Bank. Its mission is "to serve the needs of its communities by actively seeking community development opportunities to support educational, civic, health, human services, social, and cultural organizations that address these objectives." The foundation provides grants that support capital projects, and not operating expenses. They do not accept applications for multi-year commitments. www.firstfd.com/2062/mirror/foundation.htm

Home Federal Foundation

Established in 2004, the Home Federal Foundation supports the needs of communities served by Home Federal Bank. Focus areas include health and human services, arts and culture, education, and community reinvestment-act qualified projects. www.myhomefed.com/about-us/home-federal-foundation.html

Wal-Mart State Giving Program

The Wal-Mart Foundation's mission is to "provide opportunities that improve the lives of individuals in our communities." With that goal in mind they provide grants that support organizations working in education, job skills training, environmental sustainability, and health. The State Giving Program will not fund capital improvements or general operating expenses. They will not assist with multi-year commitments; however you can reapply for the grant annually. http://walmartstores.com/CommunityGiving/8168.aspx

Idaho Power Employee Community Fund

The Idaho Power Employee Community fund was set up to support communities where Idaho Power's employees live and work. Funding goes to organizations that promote health services, human services, social welfare, drug use prevention, and hunger. Grant-seeking agencies may reapply for funding every two years. www.idahopower.com/NewsCommunity/Community/empCommServFund.cfm

Idaho State Legislature

Idaho's government has provided one-time, Community Collaboration Grants to provide services or facilities for people with mental illness within each region of the state. These grants are funded by legislative appropriation, and therefore awarded amounts and availability vary from year to year. Each region's application is submitted by the regional Mental Health Board and is reviewed by an interagency group that makes decisions on awards.

St. Luke's Health Foundation

St. Luke's mission is "to improve the health of people in our region." As part of this mission the foundation has a Community Health Improvement Fund that provides grants to local organizations. Funded organizations support the area served by St. Luke's Health System, and are focused on youth, family and women, health, wellness and fitness, immunizations, prevention of heart disease and cancer, and domestic violence and child advocacy. The foundation grant will fund construction costs. www.stlukesonline.org/giving

Blue Cross of Idaho Foundation for Health, Inc.

Blue Cross of Idaho Foundation for Health was established to support health improvement initiatives. They work to create partnerships with local organizations focusing on wellness and prevention through various means including prevention and educational programs. www.bcidahofoundation.org

Idaho Community Foundation

The Idaho Community Foundation's mission is "to enrich the quality of life throughout Idaho." In accordance with its mission, the foundation supplies grants to organizations focusing on arts and culture, conservation and environment, education, emergency services, health, libraries, public projects, recreation, and social services. Grants can fund already established projects or new projects that will meet a community need. Applications are based

Table 36: State Funding Sources [1]

Funding Source	Type of Funding	Length of Funding	Range of Funds	Application Due	Application Package Rating
First Federal Foundation, Inc.	Grant	One year	$1,000 to $10,000	June 16, and November 16	3
Home Federal Foundation	Grant	One year	Varies	February 26	4
Wal-Mart State Giving Program	Grant	One year	$25,000 or more	February 1 to August 20	Varies: application details available when application is initiated
Idaho Power Employee Community Fund	Grant	Two years	Varies	Contact organization	1
Idaho State Legislature	Grant	One year	$5,000 to $135,000	Contact organization	Varies
St. Luke's Health Foundation	Grant	One year	Varies	September 30, verify date	1
Blue Cross of Idaho Foundation for Health, Inc.	Partnership	Varies	Varies	Contact organization	Varies
Idaho Community Foundation	Grant	One year	Up to $5,000	North: November 1 to January 15, East: February 1 to April 1, Southwestern: May 1 to July 1	3
Laura Moore Cunningham Foundation	Grant	One year	Varies	May 15	3
J.A. and Kathryn Albertson Foundation	Grant	Contact organization	Minimum $25,000	Contact organization	Varies

[1] All information should be verified with the funding organization before beginning the application process.

upon region; however, organizations that cover the entire state can apply for a grant in each region as long as a county in that region is listed as the primary county on the grant application. www.idcomfdn.org

The Laura Moore Cunningham Foundation

Laura Moore Cunningham Foundation grants are awarded to organizations focusing on rural healthcare, educational programs for children, and programs for underserved communities and populations. They prefer not to provide funding for administrative costs. The foundation does not normally fund multi-year commitments, and smaller grant amounts have more probability of being funded. http://libraries.idaho.gov/files/LMCF%20APPLICATION%2009.pdf

J.A. and Kathryn Albertson Foundation

The J.A. and Kathryn Albertson Foundation works to improve education in Idaho. They support grants focused on education. They do not accept unsolicited grant proposals. www.jkaf.org/about/grantmaking

Local

Wal-Mart Store and Sam's Club Giving Program

Wal-Mart stores work to provide funding to organizations that are important to the community. Grants can focus on education, job skills training, environmental sustainability, and health. The grant amount is based upon the store at which the application is submitted and you can receive grants from multiple locations.
http://walmartstores.com/CommunityGiving/238.aspx

Bear Lake Valley Healthcare Foundation

The Bear Lake Valley Healthcare Foundation provides "Healthier Community" grant funds in an effort to promote a healthier community by improving the health of Bear Lake Valley residents. www.blmhospital.com/foundation.html

Portneuf Healthcare Foundation

The Portneuf Healthcare Foundation's mission is to "enhance the health of citizens throughout eastern Idaho by supporting quality medical services, and through the delivery of wellness and prevention programs." As part of this effort they provide grants to organizations that work towards improving the health of residents within their community. www.portfound.org/grants.html

St. Alphonsus Foundation

The St. Alphonsus Foundation's current projects include a healing garden, women's wellness van, and cancer patient assistance. The foundation also has an Endowment Grant program to invest in projects initiated by St. Alphonsus associates. Additionally, St. Alphonsus provides Community Contributions to local nonprofit organizations in the form of sponsorships or donations. www.saintalphonsus.org/Foundation.html www.saintalphonsus.org/AboutUs_commcontribution.html

United Way of Southeastern Idaho

United Way of southeastern Idaho provides grants to those organizations "who share a vision of prosperity for all of Southeastern Idaho." Organizations who have received grants include free clinics, food banks, crisis centers, and senior and youth programs. http://idaho.unitedway.org/partneragencies.htm

United Way of Treasure Valley

The United Way of Treasure Valley provides grants through its Community Fund. The goal is to assist low-income individuals and families by addressing their needs through various organizations. Grants are provided to organizations working in the areas of education, income, and health. Decisions about grants are made by community volunteers who ensure that the most critical needs of the community are met. www.unitedwaytv.org/default__2d.aspx

United Way of South Central Idaho

The United Way of South Central Idaho's mission is to "help increase the organized capacity of people to care for one another." In this spirit their Community Care Fund provides grant to organizations whose mission is to provide programs in the fields of health and human services that parallel the United Way's focus on health, education, and financial stability. www.unitedwayscid.org

CHC Foundation

The CHC Foundation provides grants to organizations that work within ten specific counties in Eastern Idaho: Bonneville, Bingham, Butte, Clark, Custer, Fremont, Jefferson, Madison, Lemhi, and Teton. Grants are provided to organizations that "enhance the social, cultural, and community service needs" of the areas where CHC Foundation works. The Foundation prefers to provide grants for one-time projects, however they may consider long-term projects if there are matching funds or funding independent of CHC Foundation funds. They will not provide grants for operating expenses, including but not limited to salaries, fees, rents, and honorariums. However they will provide grants for material assets, for example real estate, equipment, and machinery. www.chcfoundation.net

Idaho Women's Charitable Foundation

The Idaho Women's Charitable Foundation "inspires women to collaborate, pool their resources, and individually direct their giving to positively impact their community through educated philanthropy." Grants should be used to meet an immediate community need, support a start-up project, or address a time-worn problem in a new way. Focus areas include cultural

Table 37: Local Funding Sources[1]

Funding Source	Type of Funding	Length of Funding	Range of Funds	Application Due	Application Package Rating
Wal-Mart Store and Sam's Club Giving Program	Grant	One year	Minimum $250 Maximum varies	February 1 to December 31	Varies: application details available when application is initiated
Bear Lake Valley Healthcare Foundation	Grant	One year	$200 to $2,500	March 1	Varies
Portneuf Healthcare Foundation	Grant	One year	Varies	March 15	1
St. Alphonsus Foundation	Grant	One year	Varies	Contact organization	Varies
United Way of Southeastern Idaho	Grant	One year	$250 - $40,000	January	Varies: application details available when application is initiated
United Way of Treasure Valley	Grant	One year	$5,000 to $129,438 in 2009	Letter of Intent typically in fall. Verify details	2
United Way of South Central Idaho	Grant	One year	Varies	January 21	4
CHC Foundation	Grant	One year	$10,000 to $125,000 in 2008	January 6 to February 26	3
Idaho Women's Charitable Foundation	Grant	One year	$5,000-$25,000	Letter of Inquiry typically in winter. Verify details	3
Latah County Community Foundation	Grant	One year	Up to $3,000	April 24, and October 15 Verify dates	3
John F. Nagel Foundation	Grant	One year	Avg. $20,000	October 31	1
Boise Legacy Constructors Foundation	Grant	Contact organization	Varies	Contact organization	Varies

[1] All information should be verified with the funding organization before beginning the application process.

arts, financial security, education, environment and health, and any other areas of interest to the members of the foundation. www.idahowomen-scharitablefoundation.org

Latah County Community Foundation

The Latah County Community Foundation's mission is to improve "the quality of life of the citizens of Latah County, through the accumulation, management, and disbursement of charitable donations of programs or projects associated with education, human services, environment, health youth services, civic improvement, the arts and various other charitable interests." They provide grants to established and new organizations that will fulfill an unmet need in the community. The three main types of funding are program support for new or existing programs, capacity-building

support, and operating support for start-up or existing programs. However, the Foundation is not an annual source of operating support as they only will fund organizations for a limited period. www.latahfoundation.org

John F. Nagel Foundation

The John F. Nagel Foundation focuses on charities in southwest Idaho in the areas of education, youth programs, and human concerns. "The foundation believes in the impact people can make to build a better community when given an opportunity to better themselves through education, health care and social welfare." Grant funds are intended to help disadvantaged individuals as directly as possible. The foundation will not fund capital projects or administration. www.nagelfoundation.com

Boise Legacy Constructors Foundation

The Boise Legacy Constructors Foundation provides one-time grants to organizations that work within the Boise/Treasure Valley area. Focus areas include health and human services, civic and community, education, and culture and arts. The foundation will not fund organizations located outside of Boise, Idaho. www.boiselegacyconstructorsfoundation.com

Sustainability is the greatest challenge to a successful hotline

Summary and Recommendations

Sustainability is perhaps the greatest challenge to the success of a hotline. Stable funding is necessary for accreditation. Grants and small gifts can enhance funding or may be used for one-time expenditures. In kind funding such as free operating space can also make a significant contribution to the sustainability of a hotline.

Establish a Dedicated, Ongoing Funding Source

Hotlines require dedicated ongoing funds to assure stability. They also must have an ongoing funding source to qualify for accreditation

Seek In Kind Opportunities

Many hotlines have donated operating space or phone charges. Finding an organization that has a stable physical space or other resources such as toll free telephone lines can greatly enhance an organization's "base" upon which to build.

Continue to Search for Additional Funding Options

While this chapter provides a list of potential funding opportunities for a hotline, the list does not include all sources of available funding. Additionally, funding opportunities are constantly changing and it is necessary to continue to research available opportunities to give the hotline the best opportunity for financial stability.

Identify Funds for Start-Up Expenses

Initial start-up for the hotline can be costly and add to its future general operating expenses. It is therefore necessary to look at organizations that may provide more assistance to cover this initial cost. In addition, it is necessary to review each funding organization's grant guidelines as some will not cover these costs. Good examples of organizations that will help to cover start-up costs include Wachovia Wells Fargo Foundation, CHC Foundation, and the Steele-Reese Foundation. The Steele-Reese Foundation may be especially beneficial if a multi-year grant was awarded as this can also help cover operating expenses and provide financial stability.

It is necessary to to maintain a diverse selection of funding sources

Identify Funds for Ongoing Operating Expenses

Some grant-funding organizations will not cover the cost of operating expenses. Therefore, it is necessary to search and apply for grants that designate that the funds can be used for operating expenses. Examples of organizations that provide grants for operating expenses include Intermountain Healthcare Foundation, Idaho Community Foundation, and Latah County Community Foundation.

Maintain a Variety of Funding Options

Many organizations have limits on the amount of times an agency can receive grants, so it is necessary to continue to maintain a diverse selection of funding sources. Organizations' funding is based upon a variety of factors including political, economic, and social. Each organization has different funding limits, the size or geographic focus of funders does not allow for assumptions regarding the dollar amount of the grant. In sum, it is important not to rely solely on one funding source. Prepare to apply to a variety of different organizations for funding, whether they are national, regional, state, or local.

Small Amounts Are Still Helpful

The needs of the hotline will vary from year to year for both operating expenses and equipment purchases. It is therefore necessary to pay attention to organizations that offer smaller amounts of funding as they may cover the supply purchases when a larger source of funding may not. Remember to look at the guidelines for funding sources in addition to the amounts.

CHAPTER 9
MARKETING PLAN

Introduction

This chapter explores methods for promoting and marketing a hotline in Idaho. Various target audiences are explored and methods to reach them are discussed. Teens, veterans, substance use and mental health consumers, domestic violence victims and the needs of elders are among the audiences identified along with how marketing efforts to encourage them to call a hotline can be undertaken. This portion of the report was prepared by the Advisory Partnership, with support from ISU-IRH.

Also included in this chapter is a camera-ready suicide hotline card that can be a part of a total package of marketing materials used. The card is an adaptation of the national Lifeline pocket card, which the Advisory Partnership reviewed. More than 100 hotline websites were explored to identify publicity materials. The Lifeline card was the most extensive, appropriate and evidence-based. It has been customized by providing Idaho information. An Idaho hotline number has been left blank. Once a hotline is created, the selected phone number and website address can be inserted.

More than 100 hotline websites were studied

Marketing Plan

The following table illustrates the marketing plan. It outlines not only target audiences and message themes, but also existing ways to communicate with them and new communication tools that could be needed. The Advisory Partnership felt small wallet cards or cards no larger than 3x8 inches were ideal because they are small and easy to distribute discreetly.

Table 38: Marketing Plan[1]

All communication materials will be tested with a target audience.

Key Themes: Confidential, 24/hour, Idaho/local, hope, practical help, talk to a real voice, talk to someone who really cares

Optional Concepts for Single Overriding Communications Objective (SOCO): *Expect to Be Helped. A Place to Call for Support. Call Now Before It's too Late. Make a Plan for Safety.*

Who are our audiences?	What do they need to know? (What is our message?)	What do we want them to do?
Teens	The hotline provides callers with a place to share problems anonymously. Warning signs.	Call the hotline if they are suicidal or if they have a friend who is.
Veterans	"Never Leave a Fallen Comrade: Buddies Can Prevent Suicide." U.S. Army language. Warning signs.	Call the hotline if they are suicidal or if they have a buddy who is
Substance Abuse. Consumers in and out of treatment	The hotline provides callers with a place to share problems anonymously. Warning signs.	Call the hotline if they are suicidal or if they have a friend or family member who is.
Mental Health Consumers	The hotline provides callers with a place to share problems anonymously. Warning signs.	Call the hotline if they are suicidal or if they have a friend or family member who is
Domestic Violence Victims at risk for suicide	The hotline provides at-risk callers with a place to share their problems about suicide anonymously. Warning signs.	Call the hotline if they are suicidal or if they have a friend or family member who is.
GLBT (gay, lesbian, bisexual, transgendered) populations	The hotline provides at-risk callers with a culturally appropriate place to share their problems about suicide anonymously. Warning signs.	Call the hotline if they are suicidal or if they have a friend or family member who is.
Elders	The hotline provides callers with a place where elders are understood, so they can share their problems about suicide anonymously. Warning signs.	Call the hotline if they are suicidal or if they have a friend or family member who is.
The Unemployed	The hotline provides callers with a place where you are understood so you can share your problems about suicide anonymously. Warning signs.	Call the hotline if they are suicidal or if they have a friend or family member who is.
Faith Communities	The hotline provides callers with a place where you are understood so you can share your problems about suicide anonymously. Warning signs.	Call the hotline if they are suicidal or if they have a friend or family member who is.
Concerned Families/ Friends	The hotline provides callers with a place where you are understood so you can share your problems about suicide anonymously. Warning signs.	Call the hotline if you have a friend or family member who is suicidal and we will help you through it.
Native Americans/ Alaska Natives	The hotline provides callers with a place where you are understood so you can share your problems about suicide anonymously. Warning signs.	Call the hotline if you have a friend or family member who is suicidal and we will help you through it.
Spanish-speakers/ Hispanics	Lifeline has access to Spanish-speaking operators. NOTE: If an Idaho hotline is a member of Lifeline, we can link to their system of operators who speak other languages. Warning signs.	Call the hotline if you have a friend or family member who is suicidal and we will help you through it.
Asian and Pacific Islanders	The hotline provides callers with a place where you are understood so you can share your problems about suicide anonymously. Warning signs.	Call the hotline if you have a friend or family member who is suicidal and we will help you through it.
Occupational Groups At Risk	The hotline provides callers with a place where you are understood so you can share your problems about suicide anonymously. Warning signs.	Call the hotline if you have a friend or family member who is suicidal and we will help you through it.

[1] © Ann Kirkwood 2002

What are the existing opportunities for communication?	What are the new tools that would help us communicate?
School bulletins. School morning announcements: Get Help. Get Hope. Manual	Posters, wallet cards, special programs with speakers.
Extensive Army materials for active duty, reserve, civilian, and family members available at http://usachppm.amedd.army.mil/HIOShoppingCart/	May need to revise existing materials for Idaho.
Providers' offices, places people gather such as bars, churches, recreation sites, primary care physicians, grocery stories, post offices, community bulletin boards, commercial establishments where customers wait for services (e.g., tire stores).	Posters, wallet cards, special programs for education about warning signs.
Mental health providers' offices, recreation facilities, churches, colleges, primary care physicians, grocery stores, post offices, community bulletin boards, commercial establishments where customers wait for services (e.g., tire stores).	Posters, wallet cards, special programs for education about warning signs.
Domestic violence shelters, primary care and pediatrician offices, dentists, children's education, and recreation facilities.	Posters, wallet cards, special programs for education about warning signs.
Trevor Project materials and 1-800 number for hotline specifically for this population.	Trevor Project materials
Distribute the National Strategy for Suicide Prevention Lifeline (Lifeline) information among the elderly, http://mentalhealth.samhsa.gov/suicideprevention/elderly.asp, Senior Centers, Meals on Wheels, primary care offices.	Posters, wallet cards, special programs for education about warning signs.
Unemployment offices, churches, recreation facilities, grocery stores	Posters, wallet cards, special programs for education about warning signs.
Church bulletins, sermons, health ministries	Posters, fact sheets, education classes.
Mental health providers' offices, recreation facilities, churches, colleges, primary care physicians, grocery stores, post offices, community bulletin boards, commercial establishments where customers wait for services (e.g., tire stores). NAMI Family to Family classes.	Posters, brochures, education classes.
Where people gather on Reservations. Need to collect Native American culturally appropriate materials. Check content with Idaho tribal members.	Culturally appropriate posters and pocket cards.
Hispanic groceries, worksites, cultural events	Posters, flyers and pocket cards (Available from Lifeline).
Churches, civic groups, colleges/universities	Posters, flyers and pocket cards in relevant languages spoken by various cultural groups (if not English).
Professional and trade groups, e.g., Farm Bureau, professional associations, etc. newsletters or emails. Banks. Presentations to civic organizations, such as the Elks Club or Rotary or via their newsletters.	Posters, flyers and pocket cards, educational activities.

Materials

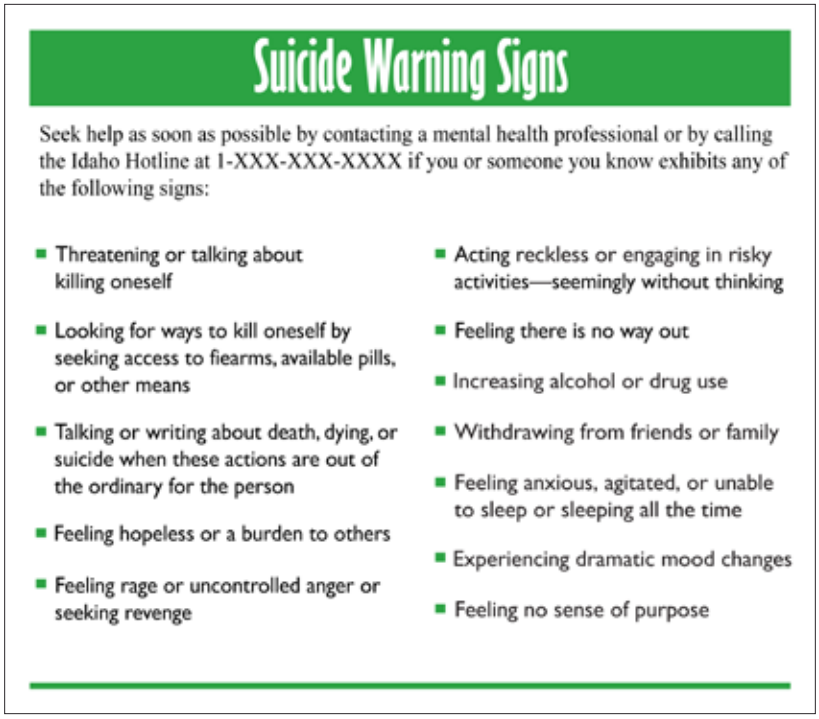
As noted in the previous chart, Partners on the project outlined marketing aspects for different target audiences. A re-occurring theme was the need to create a small, portable and eye-catching product for general audiences for the initial launch of a hotline. As the hotline would age and mature, additional materials would be created, especially focusing on the target audiences identified by the Partners as priority populations.

The following design was adapted from an existing Lifeline pocket card which ISU-IRH was given permission to customize for Idaho's purpose. Customized content and design were recommended by the Partners.

Figure 26: Pocket Card Example Front Face

Figure 27: Pocket Card Example Rear Face

Figure 28: Pocket Card Example Inside Content



Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the Idaho Hotline at 1-XXX-XXX-XXXX if you or someone you know exhibits any of the following signs:

- Threatening or talking about killing oneself
- Looking for ways to kill oneself by seeking access to fiearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless or a burden to others
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling there is no way out
- Increasing alcohol or drug use
- Withdrawing from friends or family
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Feeling no sense of purpose

CHAPTER 10
CONCLUSIONS & RECOMMENDATIONS

Introduction

This chapter summarizes the *Hotline Options* report's findings and offers considerations and recommendations for decisions about an Idaho hotline. *Hotline Options* analyzed types of potential hotlines and their costs as well as the role of accreditation. The efficacy of hotlines in addressing suicide crises also was explored. To complete the report, data were gathered on the public health concerns and economic costs of suicide in Idaho. In sum, the best available data were collected to guide our findings and recommendations. In some cases, data were not available either in Idaho or nationally, and we then conducted interviews with the state's stakeholders and hotline directors nationwide to gather needed information. Additionally—and due to a lack of available data—we developed theoretical models to explore various options for Idaho decision makers.

A hotline is an option for reducing Idaho's high suicide rate

A suicide prevention hotline represents one potential method for addressing the tragedy of suicide in Idaho. Idaho consistently ranks among states with the highest suicide rates. Across Idaho, rural areas have the highest rates of suicide, while urban areas have the largest number of suicide completions. Many of these parts of the state are federally designated health professional shortage areas (HPSA), which limits the ability for people at risk of suicide to obtain mental health or substance abuse treatment. A suicide prevention hotline would be available statewide, regardless of geographic or economic barriers and augment limited access to mental health services in rural Idaho (AAS, n.d. a; Rural Youth Suicide Prevention Work Group, 2008; SPRC, 2008c). National studies show that suicidal individuals will seek help by calling hotlines and that callers benefit from hotline services (Gould, et al., 2007; Kalafat, et al., 2007). This indicates that a hotline has the potential of addressing suicide as a public health concern in Idaho.

Currently, Idaho is the only state in the nation without its own nationally certified hotline. Idaho's previous hotline closed in early 2007. Since that time, the National Suicide Prevention Lifeline (Lifeline) has been accepting Idaho's calls, as a professional courtesy and at its own cost. During this period, there has been a marked increase in Idaho call volume. In 2009, Lifeline received 3,633 calls from Idaho residents, up from 2,256 in 2008 (Lifeline, 2010). Based on our analysis of existing data, and the link between unemployment and suicide (AAS, n.d. a; SPRC, 2008c), we can expect the number of calls to continue to climb. Lifeline has expressed the need for Idaho to form its own suicide prevention hotline, and become part of the Lifeline network. Once certified, an Idaho hotline could receive ongoing assistance from Lifeline, including backup for overflow calls, information on best practices and technology, risk assessment, interpretation services for non-English speakers and people with disabilities, data collection, and access to funding.

Suicide represents a significant public health concern for Idaho, and the establishment of a hotline would offer one solution to addressing this human tragedy. A hotline can provide an anonymous, confidential, and accessible resource for a suicidal individual to seek assistance. Suicidal individuals, especially those in rural areas, can avoid stigma and negative stereotypes by accessing care by telephone. Additionally, hotlines and the connection they provide to community resources, allow for a range of care and a variety of options to assist callers through referrals or the creation of self-care plans. A hotline also enhances the continuum of mental health and substance abuse services, filling in gaps as needed. A hotline would provide an economical way for Idaho to address the issue of suicide in the state while providing suicidal individuals with better access to the care they require.

A hotline enhances the continuum of mental health and substance abuse care

Findings

As this report was being created, data were collected from around 20 individual sources and various research projects were instigated to complete *Hotline Options*. Our research included conducting individual interviews with members of organizations that run help lines, hotlines, and emergency lines in Idaho. In addition, we interviewed directors of 2-1-1 centers around the U.S. and conducted a nationwide, online survey of executive directors of hotlines. We collected information on suicide rates and demographics from the states with the highest suicide rates as well as the call volume that Lifeline has received from Idaho in the past three years. We collected information on the cost of various items needed to establish a hotline. A training simulation was created and completed in an effort to provide more information on how Idaho could establish a unique and effective training program for operators. Additionally, an economic analysis of the cost of suicide in Idaho was completed.

The National Suicide Prevention Hotline Executive Director Survey , which we completed for this report, provided us with valuable information, including details on organizational structure, types of calls received, accreditation decisions, and funding sources. Of the 23 hotlines that responded to the survey, 78 percent were nonprofit organizations and 65 percent were either free standing or part of a hospital or other health care organization. Hotlines reported receiving a variety of call types, including suicide crisis, referral, substance abuse, domestic violence, mental health, and child welfare. The majority of calls were mental health related, followed by referral calls and suicide crisis calls. People with mental health concerns are at very high risk for suicide. Seventy-seven percent of the hotlines that responded were accredited. Funding sources for the organizations included grants from federal, state, county, or local sources; dedicated funds from federal, state, county, or local sources; and assistance from foundations, fundraising efforts, and the hotline organization itself. Half of the hotlines reported that government funding was their primary source of money; other funding sources that were mentioned frequently were state and local grants, along with fundraising efforts. All of the information provided by the hotline executive directors could be used to assist in the formation of a hotline, including decisions that need to be made regarding funding, configurations, accreditation, and certification.

Half of hotlines interviewed said government is their primary source of funds

Accreditation and Certification

Before being able to join the Lifeline network of national hotlines, an Idaho hotline needs to first be accredited by an accreditation organization. Examples include the American Association of Suicidology (AAS), Contact USA (CUSA), the Commission on Accreditation of Rehab Facilities (CARF), Alliance of Information Referral Systems (AIRS), the Joint Commission (JCAHO), and the Council on Accreditation (COA), all of which are discussed in *Chapter 4: Accreditation and Certification*. Accreditation confirms that a hotline is following nationally recognized standards while the accrediting organization offers the hotline a ready support network and access to additional resources. Once accredited, hotlines can apply for Lifeline membership. Benefits of Lifeline membership include backup for overflow calls; access to language services; real time caller ID, 9-1-1 locater; resources like ASIST (Applied Suicide Intervention Skills Training), webinars, information on best practices; and support from other Lifeline centers. In addition, Lifeline provides an annual stipend to its members, and Lifeline membership provides hotlines with access to significant SAMHSA grants.

The choice between the two hotline-specific accrediting agencies is up to the hotline once it is founded; one of the main distinctions between the two is that AAS requires that a hotline intervene when a caller's life is perceived to be in danger (rescue calls) while CUSA does not. Once the hotline determines the accrediting agency that best fits its organization,

Lifeline membership is the next step in helping to establish Idaho's hotline as a nationally recognized organization. Some accrediting bodies require hotline operation for a period of time before an application can be submitted. In this case, it may be possible to obtain provisional membership in Lifeline at the discretion of the certification network.

Recommendations

- AAS and CUSA accreditation are specific to the operation of hotlines and their requirements should be studied as an Idaho hotline is created. For example, if AAS or CUSA policy guidelines are followed at the outset, gaining accreditation will be easier in the long run.
- An Idaho hotline should seek certification from Lifeline because of the benefits that certification will provide for operation of the hotline.
- Lifeline certification requires accreditation; therefore an Idaho hotline should review accreditation options and apply for accreditation as soon as possible.
- Although certification requires prior accreditation, it may be possible to negotiate provisional network membership in Lifeline as long as an Idaho hotline demonstrates clear and progressive activities leading to accreditation over a specified length of time.

Policy manuals lessen liability issues

Sample Policies

One requirement for accreditation and Lifeline certification is the ability to demonstrate that the hotline has a policy manual. *Chapter 5: Sample Policies* discusses some of the policies that a hotline may need to create, including those covering issues involving hotline calls, confidentiality, and care of operators and supervisors after difficult or traumatic calls. Requirements for manuals are specified in AAS and CUSA materials. It is extremely important to have a policy manual that reflects the chosen accrediting organization's requirements, if accreditation is to be sought. A well-constructed policy manual provides support networks, guides staff and volunteers when in a difficult situation, and protects them if anything harmful were to happen. A specific issue to address in a hotline policy manual is that of confidentiality when faced with a situation where the caller is at risk (rescue calls). What form of policy a hotline establishes is important both for the operation of the hotline and possible accreditation. Policy manuals also address liability issues by providing clear standards that will be beneficial in seeking liability insurance. Once a policy manual is established, staff and volunteers should be trained on how these policies affect hotline procedures.

Recommendations

- One of the first steps an Idaho hotline should take is the creation of a policy manual, specifically looking at the issues involved in hotline calls, confidentiality, and care of operators and supervisors. Model policy manuals from other hotlines nationally are available upon request and concepts are offered here (Chapter 5) for reference.
- A review of accreditation requirements should be made before the creation of a policy manual in an effort to include policy issues deemed important by the accrediting organization. Even if decision makers decide not to seek accreditation, following AAS or CUSA policy guidelines can be used as best practices to guide development of Idaho's document.

Training

The creation of a training program is an important step in the formation and implementation of a hotline. *Chapter 6: Training* addresses many of the issues that a hotline should review before creating its training program. As training is being formulated, it is important to be aware of the training criteria necessary for accreditation. Even if decision makers choose not to seek accreditation, training standards of AAS and CUSA are widely accepted as best practices. Operators should be trained in the content knowledge involved in a hotline call. Some of those items include providing information on certain types of calls, on certain topics that can be covered in the calls, and on how the policies of the hotline translate into hotline call procedure. The needs of various types of callers also should be a training topic. Two national training programs, QPR and ASIST, are widely used as supplements to local training programs. We also designed a unique interim training step to guide real time interactions with callers.

The needs of various types of callers should be a training topic

Recommendations

- When creating a hotline training program, review the accreditation requirements so that the training criteria for accreditation have been addressed and/or best practices are followed.
- The training program should provide information on the types of calls and the material that may be covered in hotline calls, including issues like substance use and violence. Our unique training program should be studied when creating the overall approach to training.
- A review of the hotline's policies should be done in an effort to make sure that operators are trained on how these policies will affect hotline call procedures.

- Operators should be trained to deal with multiple cultures, such as American Indian, Alaska Native, Spanish-speakers, Asian and Pacific Islanders, and other populations. This also should include refugees and high-risk groups, such as previous attempters or GLBT (gay, lesbian, bisexual, or transgendered) individuals. If the hotline becomes Lifeline certified it will gain access to interpretation services for 150 languages, a significant cost reduction for Idaho, and a special phone line for U.S. Veterans.
- Operators should be trained to understand issues concerning people with disabilities and to offer appropriate accommodations and services.

Call Volume and Estimates

One of the largest issues to address before the creation of a hotline is where the organization could be housed. *Chapter 7: Call Volume and Cost Estimates* addresses the various possible configuration options, including combinations of a 2-1-1 information and referral system, 9-1-1 system, hospital or other health care organization, community/regional health or social service organization, university, and/or a freestanding nonprofit organization. The pros and cons of each configuration are explored. Additionally, each configuration affects the costs of a hotline, the accreditation options that may be best, and funding possibilities. An essential point to note is that the best configuration for Idaho will be based upon the organization's commitment to hotline services and the support it can garner for the formation and sustainable operation of the hotline.

Advantages and disadvantages for each configuration type should be studied

There are advantages and disadvantages to each configuration, which should be discussed thoroughly by decision makers before the creation of a hotline. As an example, some of the advantages of Idaho's existing 2-1-1 CareLine Information and Referral system include the fact that CareLine already has an established reputation, established hours of operation, a professional staff, and a funding base. However, 2-1-1 does not currently operate 24/7, which may need to change depending upon the requirements for a hotline and wishes of the decision makers. In addition, the existing staff would need to be trained on how to specifically handle crisis calls as the goals of an information/referral call versus a crisis call vary. The Idaho Department of Health and Welfare's (IDHW) 2-1-1 CareLine services might be enhanced if partnered with IDHW's statewide child and adult mental health services, including crisis response teams, if available. Substance abuse services also may be helpful for referrals.

Another configuration example is the potential use of housing a hotline with a 9-1-1 system, which is already functioning 24/7 and has immediate access to emergency personnel for rescue calls. The system however has a much different structure and mission than a hotline, and increased costs would be incurred through the training of current and new personnel. The

work of a 9-1-1 dispatcher and a suicide crisis operator are very different, time limits on calls vary, and matching the two might not be desirable to decision makers. A third possible option is housing a hotline at a hospital or health care organization, which already has access to trained mental health personnel, funding sources, and operates 24/7. However, there may be concerns with the allocation of staff if the hotline diverted staff from direct patient care.

Other configuration options include community mental health and social service organizations, universities, or a freestanding hotline. Multi-site hotlines also are possible, combining a network of organization types or among hospitals. Community mental health and social service organizations already have reputations for providing assistance to those that may call hotlines, and have easy access to trained mental health professionals. Reliance on current staff though may mean the hotline is not covered at all times if there is an influx of patients, and the hotline could be reliant on the organization's operating budget, which may cause budget constraints depending upon the availability of funds. A hotline based at a university would have easy access to volunteers to help run the hotline during business hours or 24/7. Student volunteers would need to be supplemented during breaks and school vacations. Funding may be an issue if the hotline is solely reliant on the university's budget. Idaho's previous hotline operated on the campus of Boise State University. One final configuration is a freestanding hotline. An advantage of this would be the hotline's ability to establish its own policies, procedures, image, and reputation. At the same time, funding may prove problematic as the organization would not have a base to build upon but would be starting from the beginning.

Dedicated staff are needed to answer calls

All of these configuration options represent opportunities for an Idaho hotline, and all the options should be reviewed before a configuration is selected.

Recommendations

- A review of the advantages and disadvantages of each configuration option, and the expectations for hotline operation, should be made before deciding on the best configuration for an Idaho hotline. Some criteria to consider by configuration option are included below.
- If decision makers want a hotline to operate 24 hours a day 7 days a week, the 9-1-1 system, a hospital or health care organization, or a freestanding hotline represent potential configurations. The existing 2-1-1 system, currently operating during regular business hours, would need to add hours to achieve 24/7 coverage.

- If a hotline is needed only during normal business hours then the current 2-1-1 CareLine system, community mental health or social service organization, and a university setting represent potential configurations. While not ideal, a hotline could be initiated with business-hour operations only and expanded to 24/7 over time. Accreditation and certification officials would need to be approached about such a plan.
- A university system or freestanding hotline would provide better access and marketability to obtain volunteers. Universities' access to students with an academic interest in the topic offer staffing and other resource advantages while freestanding hotlines generally attract committed volunteers from the general public. In either case, a staff person will be needed to recruit, train, and retain volunteers over time.
- If ready access to trained mental health personnel is an objective, a hospital or health care organization, a community mental health organization, or a social service organization would be potential configuration options. These organizations would need to demonstrate how certain staff are dedicated to answering hotline calls to ensure that clinical demands at the facility do not result in missed calls, which places callers at increased risk of suicide.
- The 2-1-1 CareLine system and hospitals already have access to a variety of funding sources that would assist a hotline in beginning and continuing operation.
- In terms of marketability, hospitals or health care organizations and community mental health or social service organizations represent configurations that already have well-recognized missions and reputations. Careful examination of each organization's mission and vision should be made to ensure it is in alignment with a hotline. A freestanding hotline could establish its own reputation and could be marketed specifically for its discreet mission of a suicide prevention hotline.

Hotlines need staff dedicated to fundraising

Sustainability

Finding funding for the hotline will be an important step in establishing its presence in Idaho. Without primary funding from a dedicated ongoing source, staff will need to be hired to conduct fundraising, which can involve significant time and energy. Fundraisers would need to pursue financial support, and not be used to answer hotline calls, thus increasing the overall costs of a hotline. A discussion of potential resources is in *Chapter 8: Sustainability* and was completed in cooperation with this project's Advisory Partners. The list of options for establishing the hotline's long-term sustainability, however, is not inclusive and some time should be spent looking at and for other potential funding sources. Because some grantors

will not provide funds for start-up costs or operating costs, it will be important to look specifically for these kinds of funding. Additionally, small amounts, of "in-kind" funding and a variety of funding support sources can still be useful. The National Suicide Prevention Hotline Executive Director Survey that we conducted showed that the most common source of funding was dedicated government funds. Over half the hotlines reported their primary source of funding being from the government, of which state funding was the most common. Additionally, the respondents receive more than 90 percent of their funding from a dedicated, ongoing source, which demonstrates the need for this to be a top priority when establishing a hotline in Idaho. A public-private operation also could be created.

Recommendations

- Establishing a dedicated, ongoing funding source should be a first step priority when forming a hotline in Idaho. If accreditation is desired, the accrediting agencies will require a hotline to show the commitment of a stable, long-term, sustainable funding source. Even if decision makers choose not to seek accreditation, a stable, funding source still will be needed for long-term sustainability. Starting a hotline with limited funds, then losing those funds and closing, means Idahoans could be placed at risk.
- When looking for funding sources it is also necessary to review the requirements for each funding option in an effort to ensure that funding for start-up and operating expenses or other administrative items are permissible.
- A variety of funding options should be reviewed. Some smaller smaller donations could be available for supplemental hotline services, such as education, marketing, and outreach. Some funders may be willing to make "in-kind" donations that could be helpful at start up.
- Dedicated staff will be needed, regardless of configuration, to seek and obtain funding for the hotline initially and in the long term. Grant writing can seem deceptively easy and in reality is far more complicated and time-consuming than one might think.

Establishing dedicated, ongoing funding is a first step

Marketing Plan

With the assistance of the Advisory Partners, we created a marketing plan to assist an Idaho hotline in reaching target populations. These populations include teens, veterans, elders, GLBT populations, Native Americans/Alaska Natives, Spanish speakers, and Asian and Pacific Islanders. Some of the marketing materials discussed for distribution by a hotline are posters, flyers, education programs, and wallet or pocket cards. A draft Idaho pocket card (see pages 174-175) was created and, with the addition

of Idaho's hotline number and Web site, it will be ready for printing. This is one of the first items we recommend distributing as part of an Idaho hotline, marketing plan. Additionally, materials are available for specific groups like veterans, Spanish speakers, and the GLBT community, which should be reviewed as part of a plan to market to these individuals. An important note to make on all marketing materials is that the hotline is a suicide prevention hotline, as without this distinction the hotline could attract significantly more non-suicide-related calls than is usual.

Recommendations

- One of the first items that should be distributed as part of the marketing plan for an Idaho hotline is the pocket card, which is included this report (see pages 174-175). Initial visibility for a hotline will be needed.
- Additionally, other items like posters, flyers, and brochures along with materials directed to specific audiences should be created and distributed following *Chapter 9: Marketing Plan*.
- Partners indicated that, on all materials, the distinction should be made that the hotline is a suicide prevention hotline to avoid confusion with other crisis services, such as domestic violence.

A hotline can reduce the human tragedy and economic cost of suicide

Costs of Suicide in Idaho

Economic analysis of suicide in Idaho by Idaho State University's Institute of Rural health (ISU-IRH), found that in 2008 the Idaho medical cost of suicide was approximately $861,000 with lost productivity costs totaling around $343.8 million (See Chapter 3, Study 11, Economics Study). These two figures lead to a total annual lifetime cost of around $344.5 million for completed suicides in Idaho in just 2008 (See Chapter 3, Study 11, Economics Study). The annual lifetime medical and productivity loss cost of one completed suicide is approximately $1.4 million (See Chapter 3, Study 11, Economics Study). Non-fatal suicide attempts cost Idaho roughly another $53 million in 2008 with administrative costs adding an estimated 10.3% more (See Chapter 3, Study 11, Economics Study). Idaho's current suicide figures demonstrate the major effect that this issue is having on Idaho.

Recommendations

- In addition to addressing the human tragedy of suicide, decision makers in Idaho can alleviate the cost of suicides to the state by creating an Idaho hotline. While we were unable to obtain data, it is highly likely that some hospitalizations and emergency room visits resulting from suicide attempts can leave medical providers with uncompensated care, thus increasing health care costs statewide.

- Ongoing data collection by a hotline will be needed to continue to track call volume and advise decision makers in the future. Suicide rates should be monitored.

Conclusion

Hotlines are uniquely suited to prevent individuals at the risk of suicide from attempting or completing a suicide. Studies have found that individuals in crisis or at risk for suicide, call hotlines and, by the end of the call and at follow up, have experienced reductions in emotional distress and suicidality (Gould et al., 2007; Kalafat et al., 2007). A national study found that around 12% of callers, when interviewed 1 to 52 days after their call, spontaneously reported that their call to a hotline saved their lives (Gould et al., 2007). The formation of a suicide prevention hotline in Idaho represents an opportunity to effectively address the issue of suicide attempts and completions in the state. By providing anonymous, confidential phone services accessible to anyone statewide, a hotline can become a valuable resource for the state. This *Hotline Options* report aids decision makers in the process of making informed choices regarding the formation of a hotline in Idaho. It provides an analysis of options, costs, configurations, and tools that can be used to help reduce Idaho's high suicide rate. Best available data were collected and, when not available, studies were performed to shed light on Idaho's suicide statistics and make recommendations for the future.

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