Implementation and Early Utilization of a Suicide Hotline for Veterans

| Kerry L. Knox, MS, PhD, Janet Kemp, RN, PhD, Richard McKeon, PhD, and Ira R. Katz, MD, PhD

Suicide crisis lines have a respected history as a strategy for reducing deaths from suicide and suicidal behaviors. Until recently, however, evidence of the effectiveness of these crisis lines has been sparse. Studies published during the past decade suggest that crisis lines offer an alternative to populations who may not be willing to engage in treatment through traditional mental health settings. Given this promising evidence, in 2007, the Department of Veterans Affairs in collaboration with the Department of Health and Human Services' Substance Abuse and Mental Health Administration implemented a National Suicide Hotline that is staffed 24 hours a day, 7 days a week, by Veterans Affairs clinical staff. We report here on the implementation of this suicide hotline and our early observations of its utilization in a largely male population. (*Am J Public Health.* 2012;102:S29–S32. doi:10.2105/AJPH.2011.300301)

KEY FINDINGS

- Reducing deaths from suicide is an important priority for the VA. Beginning in 2006, the VA implemented several broadly sweeping initiatives to address the public health problem of veteran suicide.
- Successful engagement of veterans, especially men, through use of a suicide hotline, was determined by VA leadership to have the potential to inform system-level changes to facilitate help-seeking behaviors in veterans who are suicidal or in distress.
- We report on descriptive information available from 3 years of operation of the VA's hotline and discuss implications for future research.

Suicide has been the focus of national attention for more than a decade.[1–4] During this period, a heightened awareness of suicide in the military and in veterans has developed, largely in response to the wars in Afghanistan and Iraq. A Department of Defense task force has underscored the urgent need to address this public health problem in military and veteran populations[5]; the recently established National Action Alliance for Suicide Prevention[6] has incorporated a work group focused on veterans as a target population for prevention.

The Department of Veterans Affairs (VA) has been on the forefront of this groundswell and has implemented a comprehensive suicide prevention strategy. This strategy includes widescale enhancements for delivery of mental health care, the VA's National Suicide Hotline, a national network of VA suicide prevention teams, and targeted programs such as safety planning and follow-up for veterans identified as at risk for suicide through both inpatient and outpatient venues.

Historically, efforts have been expended to encourage suicidal individuals to call suicide crisis line telephone centers, without evidence that this approach decreases events of suicide.[7,8] Joiner et al.[9] noted that because crisis lines offer accessibility during multiple points along the path to suicidal behavior, they are uniquely poised to intervene in this pathway, including when individuals are in immediate danger of taking their own life. In a practical manner, these telephone services offer the opportunity to intervene during a suicidal crisis when no other help may be acceptable or available. Essentially, crisis lines have served as anonymous venues of contact with little or no longer-term follow-up, systematic referrals for case management, or treatment.

Recent evidence has emerged regarding the potential usefulness and effectiveness of suicide crisis lines. King et al.[10] demonstrated that in a small sample of adolescents, suicidality decreased after a call to a suicide

FIGURE 1—Poster displayed in public transportation to promote the Department of Veterans Affairs Suicide Hotline.

crisis line. In studies funded by the Department of Health and Human Services' Substance Abuse and Mental Health Service Administration (SAMHSA), Kalafat et al.[11] and Gould et al.[12] provided data on the reduction in distress of callers to community suicide crisis lines at the end of a call and emphasized the need to conduct more rigorous suicide assessments. Mishara et al.[13,14] provided evidence that responder intervention styles play an important role in the outcome of the call. Despite these encouraging results, studies have reported that callers to suicide crisis lines are predominantly female and that positive effects during the course of the call are more likely to be detected in younger females.[10,12] In summary, suicide crisis lines in the general population thus far have been shown to be most effective for reaching a select population that is younger, female, and at a lower risk for self-harm.

The VA's population is largely male (representing predominantly Vietnam or returning veterans). Although evidence of the usefulness of suicide crisis lines existed at the time of implementation of VA's suicide hotline, whether a primarily male veteran population would call a hotline was unknown. The VA's suicide hotline is both similar to community suicide crisis lines and different in important ways. It is similar in that the hotline responds immediately to veterans in distress; it differs in that all hotline responders are trained clinicians who can access a veteran caller's electronic medical record regardless of the veteran's location, and records of the call can be immediately incorporated into the electronic medical record. Most importantly, a consenting veteran can be provided with an appropriate referral within the VA mental health care system.

IMPLEMENTATION OF THE DEPARTMENT OF VETERANS AFFAIRS SUICIDE HOTLINE

In July 2007, the VA partnered with the SAMHSA to become part of SAMHSA's National Suicide Prevention Lifeline Network (Lifeline; Box 1). The SAMSHA-funded network consists of more than 145 crisis centers nationwide.[15] The partnership between the VA and SAMHSA allows the VA to directly provide services to veterans anywhere in the country with the advantage of training and technological support from Lifeline, including backup services in times of high volume or line outage when calls can be taken by any 1 of Lifeline's 5 backup centers to the VA's suicide hotline. The program also adopted the National Suicide Prevention Lifeline Suicide Risk Assessment Standards described in detail by Joiner et al.[16] The VA's hotline has now been widely promoted through public awareness campaigns, for example, posters displayed on public transportation that convey the message that getting help is a sign of strength (Figure 1).

FINDINGS

Since the inception of the VA's suicide hotline, the percentage of veterans self-identifying as veterans has increased from 30% to just over 60% as of September 30, 2010; the volume of calls as of this time was 171 000. Seventy percent of callers were male veterans, and those who disclosed their age were between 40 and 69 years old. Approximately 4000 referrals were made to the VA's suicide prevention coordinators as of 2008; there were 16 000 referrals at the end of September 2010. In addition to these referrals, simultaneous referrals were made to diverse programs in the VA, including programs for returning veterans from the wars in Afghanistan and Iraq, programs for women, programs for homeless veterans, and substance abuse services. Community referrals were made for veterans not eligible for care within the VA.

CONCLUSIONS

These are the first data to demonstrate that a population consisting primarily of men is willing to call a suicide hotline and accept follow-up referrals; this finding is unprecedented in the history of suicide hotlines. It also demonstrates that men, especially men in the middle years of life who are at high risk for suicide,[17] can be engaged in an intervention that may result in longer-term treatment owing to intensive follow-up. Moreover, the VA's hotline consists of trained clinicians, whereas most community hotline responders have little if any training in crisis intervention.[18] Key to evaluating whether the VA's suicide crisis hotline is an effective component of the VA's overall comprehensive suicide prevention plan is to (1) describe whether calling the hotline diminishes distress, (2) determine the longer-term clinical outcomes of callers to the hotline, and (3) describe responder intervention behaviors and determine whether intervention styles impact changes in distress during the call and willingness to accept a referral to a VA suicide prevention coordinator. Although it will never be possible for us to know about veterans who do not call the hotline, the VA's electronic medical record allows tracking of longer-term clinical outcomes of callers to the hotline in a manner not possible in community suicide crisis lines. Therefore, future longitudinal analyses of the hotline data will permit us to identify the relation between risk and precipitating factors for subpopulations of veterans, their degree of suicidal ideation or intent, and their previous or current use of mental health services in the VA. Future analysis will also provide critical information regarding outcomes in highly suicidal veterans or veterans suffering from mental distress resulting from, for example, depression, posttraumatic stress disorder, relationship problems, and substance use disorders. ■

About the Authors

Kerry L. Knox and Janet Kemp are with the Department of Veterans Affairs and the Center of Excellence for Suicide Prevention, Canandaigua VA Medical Center, Canandaigua, NY. Richard McKeon is with the Center for Mental Health Services, Substance Abuse and Mental Health Service Administration, Rockville, MD. Ira R. Katz is with the Department of Veterans Affairs, Washington, DC.

Correspondence should be sent to Kerry L. Knox, Center of Excellence for Suicide Prevention, Canandaigua VA Medical Center, 400 Fort Hill Avenue, Canandaigua, NY 14424 (e-mail: Kerry.Knox@va.gov). *Reprints can be ordered at http://www.ajph.org by clicking the "Reprints/Eprints" link.*

This article was accepted May 18, 2011.

Contributors

K.L. Knox originated the study and wrote the article. J. Kemp was the lead person for implementation of the hotline and provided the hotline data. R. McKeon and I.R. Katz provided background regarding the use of crisis lines. All authors reviewed drafts of the article.

Human Participant Protection

Institutional review board approval was not needed because no research was conducted.

References

1. *The Surgeon General's Call to Action to Prevent Suicide.* Washington, DC: US Department of Health and Human Services, Public Health Service; 1999.

2. *National Strategy for Suicide Prevention. Goals and Objectives for Action.* Rockville, MD: US Department of Health and Human Services, Public Health Service; 2001.

3. Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide, Board on Neuroscience and Behavioral Health, Institute of Medicine. *Reducing Suicide. A National Imperative.* Washington, DC: National Academy Press; 2002.

4. Knox KL, Conwell Y, Caine ED. If suicide is a public health problem, what are we doing to prevent it? *Am J Public Health.* 2004;94(1):37–45.

DEPARTMENT OF VETERANS AFFAIRS (VA) SUICIDE HOTLINE DELIVERY OF CARE

Callers to the National Suicide Prevention Lifeline receive the message that if they are a US veteran or are concerned about a US veteran, they should press "1," which then routes that caller to the VA's suicide hotline located at the Canandaigua VA Medical Center in Canandaigua, New York. Utilization of the existing 1-800-273-TALK number and the combined promotional efforts of the VA and the Substance Abuse and Mental Health Service Administration (SAMHSA) maximizes the likelihood that veterans at risk, or their friends and families, will hear about the veterans' suicide hotline.

An exclusive feature of the VA's suicide hotline is that concomitantly with the implementation of the hotline, the VA leadership mandated a Suicide Prevention Coordinators Program, which requires that every VA medical facility have a minimum of 1 full-time suicide prevention coordinator. Larger facilities now have teams comprising suicide prevention coordinators, suicide case managers, and administrative support. The VA's hotline responders provide referrals to these teams for follow-up of all veterans who call the suicide hotline and consent to be contacted. Thus, the hotline does not require veterans to initiate the process of accessing care through the usual means of entry to care, primarily through the VA's mental health system.

5. Department of Defense Task Force on Suicide Prevention. *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives.* Available at: http://www.health.mil/dhb/downloads/Suicide%20Prevention%20Task%20Force%20final%20report%208-23-10.pdf. Accessed September 16, 2011.

6. National Alliance for Suicide Prevention. Available at: http://actionallianceforsuicideprevention.org. Accessed September 16, 2011.

7. Leenaars AA, Lester D. The impact of suicide prevention centers on the suicide rate in the Canadian provinces. *Crisis.* 2004;25(2):65–68.

8. Mishara BL, Daigle M. Helplines and crisis intervention services: challenges for the future. In: Lester D, ed. *Suicide Prevention: Resources for the Miliennium.* Philadelphia, PA: Brunner-Routledge; 2000:153–171. DA99B-7369CB34B3D3651DFA357

9. Joiner TE, Walker RL, Rudd MD, Jobes DA. Scientizing and routinizing the assessment of suicidality in outpatient practice. *Prof Psychol Res Pr.* 1999;30(5):447–453.

10. King R, Nurcombe B, Beckman L, Hides L, Reid W. Telephone counseling for adolescent suicide prevention: changes in suicidality and mental state from beginning to end of a counseling session. *Suicide Life Threat Behav.* 2003;33(4):400–411.

11. Kalafat J, Gould MS, Munfakh JLH, Leinman M. An evaluation of crisis hotline outcomes. Part I: Non-suicidal crisis callers. *Suicide Life Threat Behav.* 2007;37(3):322–337.

12. Gould MS, Kalafat J, Munfakh JLH, Kleinman M. An evaluation of crisis hotline outcomes. Part II: Suicidal callers. *Suicide Life Threat Behav.* 2007;37(3):338–352.

13. Mishara BL, Chagnon F, Daigle M, et al. Which helper behaviors and intervention styles are related to better short-term outcomes in telephone crisis intervention? Results from a silent monitoring study of calls to the US 1-800 SUICIDE network. *Suicide Life Threat Behav.* 2007;37(3):308–321.

14. Mishara BL, Chagnon F, Daigle M, et al. Comparing models of helper behavior to actual practice in telephone crisis intervention: A silent monitoring study of calls to the US. 1-1800-SUICIDE network. *Suicide Life Threat Behav.* 2007;37(3):291–307.

15. National Suicide Prevention Lifeline. Available at: http://www.suicidepreventionlifeline.org. Accessed September 16, 2011.

16. Joiner T, Kalafat J, Draper J, et al. Established standards for the assessment of suicide risk among callers to the National Suicide Prevention Lifeline. *Suicide Life Threat Behav.* 2007;37(3):353–365.

17. Knox KL, Caine ED. Establishing Priorities for Reducing Suicide and Its Antecedents in the United States. *Am J Public Health.* 2005;95(11):1898–1903.

18. Daigle MS, Mishara BL. Intervention styles with suicidal callers at two suicide prevention centres. *Suicide Life Threat Behav.* 1995;25(2):261–275.