



SUICIDE PREVENTION UPDATE - 2013

Allison Blake, Ph.D., L.S.W. - Commissioner



Report to Governor and Legislature on Implementation of Public Law 2011, Chapter 166

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Introduction

Pursuant to Public Law (P.L.) 2011, Chapter 166 (N.J. Stat. § 30:9A-29 et seq.), within 18 months of the effective date of its passage, the Commissioner of the Department of Children and Families (DCF) is required to report to the Governor and the Legislature on the implementation of the three provisions required by the act. Those provisions are as follows:

1. Develop and adopt a Statewide Youth Suicide Prevention Plan.
2. Prepare a report reviewing the effectiveness and sufficiency of services provided by the New Jersey-based suicide prevention hotlines.
3. Review of grant application procedures; applications.

DCF is pleased to report that all three of the statute's provisions have been successfully implemented.

The Statewide Youth Suicide Prevention Plan

In 2011, prior to the passage of P.L.2011, c.166, DCF issued the *New Jersey Youth Suicide Prevention State Plan 2011-2014* (The State Plan). The State Plan was the result of many months of hard work, and incorporated input from many dedicated individuals and advocates both within DCF and outside the department.

Because the State Plan was published less than a year prior to the enactment of P.L.2011, c.166, and its implementation was already well underway upon the statute's enactment, DCF determined that readopting the existing State Plan was appropriate. However, in order to comply with the statute's requirements, prior to the plan's July 5, 2012 re-adoption, DCF consulted with both the Department of Human Services (DHS) and the New Jersey Youth Suicide Prevention Advisory Council. Both entities were asked to provide their input, but no changes were proposed and both entities approved the existing Plan.

New Jersey has a comprehensive youth suicide prevention program in place Statewide. Further, DCF will continue to build upon the current infrastructure to improve and enhance its suicide prevention efforts. Preventing youth suicide is a collaborative effort, and DCF looks forward to working in partnership with its communities to move the plan forward.

A copy of the State Plan is attached as Appendix I. The State Plan may also be accessed online at the following link:

<http://www.nj.gov/dcf/families/csc/prevention/documents/preventionplan.pdf>.

Report on New Jersey-based suicide prevention hotlines

As required by N.J.S.A. 30:9A-30, in November 2012, the Commissioners of Human Services and Children and Families, in consultation with the Commissioner of Health, submitted a report entitled, "The Effectiveness and Sufficiency of Services Provided by the New Jersey-Based Suicide Prevention Hotlines" to Governor Christie and the New Jersey State Legislature.

The report's findings and recommendations were based primarily on data elicited from an eight page survey, jointly prepared by DCF and DHS, which was sent to New Jersey operators of suicide hotlines, designated screening centers, and similar services. DCF and DHS staff also held conference calls with providers to clarify and augment survey data. Analysis of this data allowed DCF and DHS to make findings regarding how effective the existing hotlines and similar services were in meeting the needs of New Jersey residents and identifying where gaps in service might exist.

Based in large part on data gathered for the report, in December 2012, the DHS-Division of Mental Health and Addiction Services (DMHAS) issued a Request for Proposals (RFP) for a New Jersey-based, Statewide suicide hotline. According to data provided by the *National Suicide Prevention Lifeline Network (Lifeline)* for the year 2011, over 60% of the calls made to *Lifeline* from New Jersey numbers were diverted to out-of-state *Lifeline* centers. This was due to a lack of capacity at the five New Jersey-based *Lifeline* centers. The goal of the RFP was to ensure that *all* calls to *Lifeline* from New Jersey numbers were answered in New Jersey. Staff from DHS and DCF collaborated in the RFP review process. The University of Medicine and Dentistry of New Jersey (UMDNJ) was awarded the contract and launched the NJ Hopeline in Piscataway on May 1, 2013. In its first week, the NJ Hopeline, which is staffed around-the-clock by trained volunteer and professional counselors, received approximately 300 calls. The NJ Hopeline will continue to serve as a critical backup function for the five New Jersey-based *Lifeline* centers when call volume is high as well as after their operating hours.

A copy of the hotline report is attached as Appendix II. The hotline report may also be accessed online at the following link:

<http://www.state.nj.us/humanservices/news/reports/NJ%20HOTLINE%20SURVEY%20REPORT%2011%2028%2012.pdf>

Review of grant application procedures

DCF recognizes the critical role grants play in supplementing State resources. Therefore, the responsibility for the coordination of grant searches and grant applications was assigned to the DCF Grants Management, Auditing and Records Unit (Grants Management). Grants Management regularly researches grant opportunities and communicates those of interest to appropriate members of DCF executive staff for further action. As mandated by the statute, DCF will continue to give thorough consideration to and, where appropriate, apply for any grants that may be used to assist in the State's suicide prevention efforts.

It is worth noting that in July 2012, the U.S. Department of Health and Human Services' Substance Abuse Mental Health Services Administration awarded a \$1.4 million Garrett Lee Smith (GLS) youth suicide prevention grant to the Traumatic Loss Coalition (TLC), a unit of UMDNJ's University Behavioral HealthCare (UBHC). The TLC serves as DCF's lead agency for youth suicide prevention and as a result was selected by DCF to apply for this funding on behalf of the State of New Jersey.

Because of the grant, new suicide prevention programming geared toward youth and young adults ages 10 to 24 is being made available in the State. Entitled "The New Jersey Youth Suicide Prevention Project," (the Project) the programming targets six pilot

counties (Bergen, Camden, Hudson, Middlesex, Monmouth, and Passaic) over a three-year period.

The grant allows UBHC to focus on best practices and evidence-based suicide prevention and intervention training programs for gatekeepers (non-mental health staff working with youth and young adults in schools and community programs), mental health clinicians, primary care physicians, other health care professionals, and youth peer leaders. The Project also includes a mental health and suicide screening component as well as an innovative social media project that will employ various social media properties to engage youth and young adults in suicide prevention activities, while connecting them with prevention resources across the State.

Progress on the State Plan

In addition to reporting on the implementation of the three provisions of the act, DCF committed to reporting on the progress of the implementation of the State Plan. The New Jersey Youth Suicide Prevention Advisory Council identified the following ten goals:

1. Improve and expand surveillance systems.
2. Promote awareness that suicide is a preventable public health problem.
3. Develop broad-based support for youth suicide prevention.
4. Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse, and suicide prevention services.
5. Strengthen and expand community-based suicide prevention and postvention programs.
6. Implement professional training programs for those who are in regular contact with youth at risk for self-injury or suicide.
7. Develop and promote effective clinical practices to reduce suicide attempts and completions.
8. Promote access to mental health and substance abuse services.
9. Improve reporting and the depiction of suicide, mental illness, and substance use in the electronic and print media.
10. Promote and support research on youth suicide and suicide prevention and its dissemination and incorporation into clinical practice and public health efforts.

Below is a sampling of the activities DCF has undertaken toward achieving these goals. It should be noted that many of the activities relate to several goals. As the lead youth suicide prevention program for DCF, much of the work is being undertaken by the TLC.

1. Improve and expand surveillance systems.

DCF publishes the annual Adolescent Suicide Report that integrates data from multiple State data management systems. Communication between DCF and the Department of Health (DOH) is critical to DCF's ability to draft the report. In order to fully achieve this goal, DCF will continue to explore ways to work with DOH and other stakeholders to improve coordination of data collection and to establish surveillance mechanisms that ensure more accurate reporting of suicide attempts.

2. Promote awareness that suicide is a preventable public health problem.

The TLC has developed and implemented a multifaceted public information campaign that includes a quarterly newsletter that is electronically disseminated to

over 2,000 recipients Statewide. In addition, the TLC regularly provides mental health, substance abuse, and suicide prevention, intervention and postvention information to school administrators, college staff, and other stakeholders. The TLC also maintains a robust website (<http://ubhc.umdnj.edu/brti/TLC/>) that provides an array of suicide prevention resources. The TLC also maintains pages on Facebook and YouTube, as well as Twitter and Tumblr blogs.

As previously noted, the TLC is using the GLS youth suicide prevention grant to fund the Project, which provides comprehensive suicide prevention programming focusing on best practice and evidence-based suicide prevention and intervention training for schools, mental health clinicians, primary care physicians, other health care professionals, and youth peer leaders. Among other trainings, the TLC will continue to provide Connect Gatekeeper Prevention/Intervention/Postvention¹; the Chronological Assessment of Suicide Events (CASE) approach²; the Columbia Suicide Severity Ratings Scale (C-SSRS)³; Sources of Strength Peer Leader Training⁴ for schools and community programs; and continue to reach youth through its social media project.

The Project's social media campaign is designed to reach youth and young adults in ways that are relevant, meaningful, and impactful to them. A major piece of the social media campaign was the launch of Jersey Voice (www.jerseyvoice.net), an interactive, peer to peer website that gives teens and young adults a forum to express themselves and to access suicide-prevention resources. The GLS grant will continue to enhance TLC's ability to promote awareness and achieve other goals in the State Plan.

In addition, the TLC Coordinators within each of the State's 21 counties hold coalition meetings approximately six times a year, which bring together a range of community stakeholders to discuss suicide prevention and trauma response. The TLC also holds an annual conference focusing on suicide prevention and related topics.

DCF has also added a webpage (<http://www.state.nj.us/dcf/families/csc/prevention/>) to its website that is dedicated to suicide prevention and related resources.

3. Develop broad-based support for youth suicide prevention.

The TLC, which includes central office personnel as well as county-based coordinators, provides a mechanism for fostering collaboration between youth-

¹ Connect training teaches gatekeepers including school personnel (primary, secondary, and college), social service personnel, faith leaders, and primary care providers, how to identify suicide warning signs and how to intervene with persons at risk. The program also fosters relationship building and exchange of resources among participants.

² The Chronological Assessment of Suicide Events (CASE) Approach provides front-line counselors and clinicians in high schools, colleges, and community-based programs with an overview of the most up-to-date strategies and techniques available to assess high school students for suicidal ideation, planning, and intent.

³ The Columbia Suicide Severity Ratings Scale (C-SSRS) is a tool used to identify youth and young adults who are at greater risk of attempting suicide.

⁴ Sources of Strength Peer Leader training is a comprehensive, evidence-based wellness program designed to impact suicide prevention by developing peer to peer and caring adult relationships in order to improve social norms, and enhance coping and social support with the goal of reducing conditions that can lead to suicide.

serving individuals, agencies, and organizations at the State, county, and local levels. This collaboration promotes mental health and suicide awareness, prevention, intervention and postvention strategies, and programming. The coalition meetings are important forums for helping to build support for suicide prevention.

In addition, as previously discussed, the TLC will continue to provide Connect and other training to primary, secondary, and college staff, social service personnel, faith leaders, and primary care providers.

The TLC will also continue to provide pamphlets, videos, and other materials to schools and other stakeholders on an ongoing basis to help develop broad-based support for youth suicide prevention. The TLC newsletter, TLC and Jersey Voice websites, the TLC's social media campaign, and its annual conference are also critical in achieving this and other goals.

4. *Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse, and suicide prevention services.*

Toward achieving this goal, the TLC has increased public knowledge that mental illness and substance abuse respond to specific treatments by developing training programs with national experts. Within the last several years, the TLC has trained thousands of teachers and other school personnel, as well as other stakeholders, on a variety of topics related to mental health and suicide prevention.

In addition, through the Sources of Strength Peer Leader Training, the TLC has worked to develop peer and caring adult relationships to improve social norms, enhance coping mechanisms, and increase social support in order to reduce conditions that can lead to suicide. This highly acclaimed program has also been shown to impact problems relating to substance abuse, violence, and bullying.

5. *Strengthen and expand community-based suicide prevention and postvention programs.*

As previously noted, the GLS grant will enable the TLC to expand trainings in Connect Gatekeeper Prevention/Intervention/Postvention, Sources of Strength Peer Leader Training, and other community-based suicide prevention and postvention programs. These trainings continue to increase the knowledge of community organizations and schools regarding best practices for suicide prevention, intervention, and postvention.

The TLC has also been actively involved in responding to the needs of children, families, and schools impacted by Superstorm Sandy. The TLC was invited by the Disaster and Terrorism Branch (DTB) of the New Jersey Department of Human Services – Division of Mental Health Services to assist with working with children in shelters in the immediate aftermath of the storm. From November 2012 through April 2013, the TLC provided training in Post Traumatic Stress Management, including advance training in Suicide Prevention Protocols, Classroom Based Intervention, and Skills for Psychological Recovery. The TLC continues to collaborate with the DTB. This collaboration has helped children better process the stress brought about by the storm.

6. *Implement professional training programs for those who are in regular contact with youth at risk for self-injury or suicide.*

The TLC has trained thousands of teachers and other gatekeepers in regular contact with youth at risk for self-injury or suicide. As indicated, the TLC continues to expand key gatekeeper prevention training including Connect and Sources of Strength for school personnel, parents, faith leaders, and other youth-serving individuals.

7. *Develop and promote effective clinical practices to reduce suicide attempts and completions.*

The TLC has provided training to mental health clinicians on evidence-based interventions and best practices in diagnosing and treating suicide and self-injury. The TLC will continue to provide training for clinicians and counselors across disciplines Statewide in the Chronological Assessment of Suicide Events Approach and the Columbia Suicide Severity Ratings Scale (C-SSRS). The TLC will also continue to bring in nationally recognized experts to conduct trainings on effective clinical practices to reduce suicide attempts and completions. A recent TLC sponsored webinar by Dr. Kelly Posner, Columbia University's principal investigator at its Center for Suicide Risk Assessment, and a key member of the team that developed the C-SSRS, netted over 500 registrants.

8. *Promote access to mental health and substance abuse services.*

Beginning in the summer of 2012, services for youth with developmental disabilities and substance abuse challenges began to transition to the DCF Children's System of Care (CSOC). The coordination of all mental health, developmental disability, and substance abuse services for children and youth up to age 21 under CSOC will provide a single point of entry for all families into the public mental health, developmental disability, and substance abuse systems. DCF and CSOC have been meeting with stakeholders, including families and advocacy groups, to share information about how services can and will be accessed in the future. Having a single access point through PerformCare, CSOC's Contracted Systems Administrator, will make it easier for families to access mental health and substance abuse services.

CSOC has also expanded capacity in its Mobile Response Stabilization Services to continue to meet the demand for this key service. Mobile Response provides rapid access to mental health and other services and helps to prevent mental health and other issues from escalating.

Many of the activities of the TLC, including its extensive training programs, coalition building, promotion of DCF's 2NDFLOOR Youth Helpline, publication of a quarterly newsletter, website, and social media campaign, among other activities, promote access to mental health and substance abuse services.

As noted, the DMHAS recently launched the NJ Hopeline, a New Jersey-based, Statewide suicide hotline operated by UMDNJ. The NJ Hopeline is staffed around-the-clock by trained volunteer and professional counselors and serves as a backup for the five New Jersey-based *Lifeline* members. The NJ Hopeline will ensure that all *Lifeline* calls from New Jersey numbers are answered in New Jersey, and not out of State.

9. *Improve reporting and the depiction of suicide, mental illness, and substance use in the electronic and print media.*

Toward achieving this goal, the TLC has disseminated information on nationally recognized guidelines for reporting about suicide to stakeholder agencies. The TLC has also held webinar training sessions for news media professionals on guidelines for reporting on suicide. In addition, the TLC works with the American Foundation for Suicide Prevention, a leading not-for-profit organization exclusively dedicated to preventing suicide, as well as UMDNJ to address how suicide is reported in the media. Best practices regarding responding to media inquiries is also a component of the suicide prevention training the TLC provides to schools.

The DCF Office of Communications and Public Affairs also shares information about reporting guidelines with news organizations when it receives suicide-related inquiries.

10. *Promote and support research on youth suicide and suicide prevention and its dissemination and incorporation into clinical practice and public health efforts.*

As noted, the TLC has continued to promote ongoing dissemination of evidence-based suicide prevention models and the use of research-based strategies for suicide prevention. This is accomplished through ongoing dissemination of awareness, screening, and treatment programs via its quarterly newsletter, email blasts, informational tables at conferences, as well as its extensive trainings. The TLC also maintains a directory on its website of suicide prevention programs demonstrated to be effective and that employ best practice.

Conclusion

As enumerated in this report, all three of the provisions of P.L. 2011, c.166 have been successfully implemented. Moreover, DCF believes that the State Plan and other endeavors, such as “the New Jersey Youth Suicide Prevention Project,” are clear evidence of DCF’s continued commitment to youth suicide prevention.

Appendices

Appendix I – Readopted New Jersey Youth Suicide Prevention State Plan 2011-2014



New Jersey Youth Suicide Prevention Plan 2011 – 2014

**New Jersey
Department of Children and Families
Allison Blake, Ph.D., L.S.W
Commissioner**

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Introduction

In 2008, sixty-eight individuals aged 24 years and younger completed suicide (New Jersey Office of the State Medical Examiner). This number places youth suicide as the fourth leading cause of death for New Jersey's youth (National Center for Injury Control and Prevention, Centers for Disease Control).

The New Jersey Department of Health and Senior Services, reports:

- Every month seventy New Jersey youth make a suicide attempt serious enough for hospitalization.
- Over forty percent of the suicide attempts by minors are subsequent to previous suicidal behaviors.
- Suicide attempts result in significant medical and non-medical costs and include physical, emotional, and psychological damage to the victims as well as to their families and friends.
- Clusters of suicide attempts and deaths of youth have been reported in New Jersey.

NJ Suicide Statistics Relative to Other States

Relative to other states, New Jersey has low suicide rates at all ages. New Jersey has ranked as one of the four lowest states for suicide rates in the country (Thomson Healthcare). The reasons for New Jersey's relatively good standing can be attributed in part to the implementation of state regulations, policies, guidance, and resources identified in the professional literature to successfully prevent youth suicide (Cecil G. Sheps Center).

NJ's Suicide Prevention Activities

There are many factors and actions that have aided the suicide prevention efforts in New Jersey. New Jersey has had strict laws restricting minor's access to guns. The State has mandated staff training in schools for suicide prevention and the detection of warning signs. New Jersey has mandated the establishment of psychiatric screening centers in every county that include crisis hotlines staffed 24 hours a day, seven days a week. In addition, beginning in 2001, New Jersey has developed a state-wide Mobile Response and Stabilization System (MRSS) for youth available in every county in the State. This program provides 24/7 in community crisis intervention in situations where there may not yet be suicidal gestures, but there are often significant risk factors. The MRSS program is also able to provide up to eight weeks of immediate in-home/in-community therapeutic interventions.

These efforts regarding New Jersey's suicide prevention activities were noted as a "promising practice" in a 2004 report by the Cecil G. Sheps Center at the University of North Carolina at Chapel Hill. The report also indicated that New Jersey has a high degree of collaboration among state and local organizations as exemplified by the makeup of the New Jersey Youth Suicide Prevention Council (NJYSPAC) which includes representatives from the New Jersey Department of Health and Senior Services, the Department of Children & Families, the

Department of Education, the Department of Human Services, the Division of Mental Health Services, and the Juvenile Justice Commission.

New Jersey's lead State agency for youth suicide prevention is the Department of Children and Families (DCF). As of the writing of this plan, DCF's lead youth suicide prevention program is the Traumatic Loss Coalition for Youth at the University of Medicine and Dentistry – University Behavioral Health Care. This program is funded by the Department of Children and Families – Division of Child Behavioral Health Services.

The Traumatic Loss Coalition (TLC) has operated as a county-based collaborative since the year 2000. Each county employs a Coordinator who conducts meetings throughout the year bringing together school personnel, mental health clinicians, juvenile justice personnel, law enforcement officials, social service agencies, child welfare workers and many others who work closely with youth. The meetings are effective forums for reviewing traumatic loss events, identifying service needs, and providing professional development through the inclusion of an educational component. Speakers for the educational component are experts in topics related to the needs of youth. The Coordinators often collaborate with other agencies in their respective counties to co-sponsor workshops and conferences focused on issues pertinent to the mental health of the youth.

The Coordinators also work within their counties to direct a Lead Response Team (LRT) to assist schools when needed following a traumatic loss event, or as in the case of several counties, support the director of an existing team. Post Traumatic Stress Management (PTSM) training is provided for members of these teams.

The State report completed by TLC in 2010 indicated that in the 18 month period ending March, 2010:

- **3,991** individuals received on-site trauma response assistance to schools and communities including postvention after a death by suicide, homicide, accident or illness, and other critical incidents;
- **9,740** individuals attended training programs on mental health disorders and suicide prevention for youth-serving individuals and groups; and
- **2,448** individuals attended training programs for school and community personnel who must respond to the needs of youth in the aftermath of suicide, homicide, accidental death, and other critical incidents such as a natural disaster or terrorist strike (postvention).

The Traumatic Loss Coalitions for Youth Program has created an expanding statewide network that effectively works to prevent suicide and promote healing and resiliency in the aftermath of traumatic loss (UBHC, UMDNJ, Traumatic Loss Coalitions for Youth, 2010).

NJ Youth Suicide Prevention Advisory Council

In January of 2004 due to an overwhelming concern about youth suicide, The State of New Jersey created through legislation (N.J.S.A. 30:9A-22 et seq.) the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC). This purpose of the NJYSPAC is to examine existing needs and services and make recommendations to the Department of Children and Families for youth suicide reporting, prevention, and intervention; advise the Department of Children and Families on the content of informational materials to be offered to persons who are required to report attempted or completed suicides; and to advise the Department of Children and Families on the development of regulations pursuant to the act which created the NJYSPAC.

Everyone is affected by suicide. Council members are dedicated to youth suicide prevention and give freely of their time and commitment to developing strategies for suicide prevention and intervention.

***This plan is dedicated to the youth and families
whose life has been touched by suicide.***

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*Organizational affiliations are those at the time of the individual's involvement.

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New Jersey’s Youth Suicide Prevention Plan

In 2001, the U.S. Department of Health and Human Services released a report entitled, “National Strategy for Suicide Prevention: Goals and Objectives for Action.” This report described suicide as a serious public health problem throughout the United States, and introduced a blueprint for addressing suicide prevention. The Surgeon General also recommended that each state adopt a youth suicide prevention plan that would incorporate the national recommendations.

This New Jersey Youth Suicide Prevention Plan seeks to build on the existing efforts in New Jersey by remaining focused on the risk and protective factors associated with the prevention of suicide in children, youth, and young adults. The plan outlines goals, rationale, and objectives for increasing the prevention effort throughout the state. Achieving these goals will require the continued partnership and collaboration among all stakeholders. Accountability for the goals will necessitate that all stakeholders work in concert with each other focused upon the needs of our children, youth, young adults, their families, and support networks.

The plan presents the overall goals for the prevention of suicide and is broken down into ten sections. Found within each section are specific objectives. The sections and format of the plan were not arbitrary. Rather the plan was modeled in content and in form after the 2001 National Strategy for Suicide Prevention and the joint Suicide Prevention Resource Center and SPAN USA 2010 Progress Review of the National Strategy.

New Jersey’s Youth Suicide Prevention Plan Goals

	Goals
1	Improve and expand surveillance systems;
2	Promote awareness that suicide is a preventable public health problem;
3	Develop broad-based support for youth suicide prevention;
4	Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse, and suicide prevention services;
5	Strengthen and expand community-based suicide prevention and postvention ¹ programs;
6	Implement professional training programs for those who are in regular contact with youth at-risk for self-injury or suicide;
7	Develop and promote effective clinical practices to reduce suicide attempts and completions;
8	Promote access to mental health and substance abuse services;
9	Improve reporting and portrayals of suicide, mental illness, and substance use in the electronic and print media; and
10	Promote and support research on youth suicide and suicide prevention, its dissemination and incorporation into clinical practice and public health efforts.

¹ A strategy or approach that is implemented after a crisis or traumatic event has occurred

Goal # 1: Improve and expand surveillance systems.

Rationale

The quality of surveillance data on completed suicides is relatively high in New Jersey due to our state's participation in the CDC-funded National Violent Death Reporting System. The New Jersey Violent Death Reporting System (NJVDRS) is a detailed surveillance system of all violent fatalities, which integrates medical examiner, death certificate, and law enforcement data to provide accurate and timely data on all suicides. Additionally, the NJVDRS provides detailed information about suicide circumstances, and how they differ for adolescents as compared with those in other age groups. Despite this, death certificates sometimes fail to correctly identify suicides as the cause of the death. Information on completed suicides is obtained from the New Jersey Department of Health and Senior Services, Vital Records, as coded by medical examiners on death certificates. A problem arises in those ambiguous youth deaths where suicide is suspected, but no clear evidence is available to make a definitive statement of this specific cause. In those cases, the medical examiners will enter another code based on secondary circumstances surrounding the death (e.g., substance abuse, motor vehicle accident, undetermined, unintentional). This problem leads to potential under-reporting of youth suicide.

Data on suicide attempts or ideation are lacking and are similarly affected by some of the same surveillance challenges noted above. These data are expected to be collected by mental health providers, screening centers, and emergency room personnel. But there are gaps in how these data are collected and made available for further review by prevention initiatives.

A related issue is the extent to which information on youth suicide from schools is utilized regarding broad-based prevention efforts. The New Jersey Board of Education requires public middle and high school students to complete the New Jersey Student Health Survey, which is administered periodically to middle and high school students in the state. This survey asks about depression, suicide plans, ideation, and attempts. However there is an enormous discrepancy between the prevalence of self-reported attempts and the prevalence as captured by hospital discharge data, suggesting that the majority of these self-reported attempts are relatively low in terms of lethality. As adolescents age, their rate of reporting suicidal plans and attempts declines, while the rate of actual attempts increases. This is a serious problem as a 2009 nationwide survey of youth in grades 9-12 in public and private schools in the United States (U.S.) found that 13.8 % of students reported seriously considering suicide, 10.9 % reported creating a plan, and 6.3 % reported trying to take their own life in the 12 months preceding the survey (CDC Youth Risk Behavior Surveillance).

Objectives:

- 1.1 The Department of Children and Families will publish an annual report on suicide in New Jersey that integrates data from multiple state data management systems.
- 1.2 Improve coordination of data collection regarding suicide investigations with state, local agencies, and their partners.

1.3 Establish surveillance mechanisms across entities that track the use of mental health services as well as suicide attempts.

1.4 Establish a mechanism for systematic collection and analysis of suicide attempt data.

Goal # 2: Promote awareness that suicide is a preventable public health problem.

Rationale

Many individuals are not aware that suicide is the fourth leading cause of youth death in New Jersey. Therefore, enhanced awareness that suicide is a serious public health issue is expected to influence people to be more vigilant about identifying the risk of suicide in themselves, peers, and others.

Increased awareness should result in more caregivers of children, youth and young adults to seek assistance when there is a risk of suicide. Awareness among policy makers may result in efforts to modify policies and to allocate resources toward suicide prevention efforts.

Objectives

2.1 Develop and implement a public information campaign that explains that suicide in youth is preventable and is related to mental health, substance abuse and other at-risk behaviors.

2.2 Establish and enhance existing mechanisms and structures for suicide prevention designed to foster collaboration with stakeholders and the general public on prevention strategies across disciplines.

2.3 Increase the number and quality of both public and private institutions that are involved in collaborative and complementary dissemination of current suicide prevention information on the Internet.

2.4 Promote awareness of youth suicide as a public health issue in communities through community-based organizations.

2.5 Increase awareness of suicide risk and prevention strategies for all providers of DCF out-of-home services including resource homes, treatment homes, and various residential placements.

Goal # 3: Develop broad-based support for youth suicide prevention.

Rationale

Because youth suicide and attempts are the result of complex, multidimensional biological and psychosocial factors, the prevention of suicide requires an ecological, multidisciplinary approach. Similar collaborative efforts will be required at the state and local levels in New

Jersey. These collaborative efforts like NJYSPAC will need public and private partnerships at the local, state and national level to generate the greatest impact regarding suicide prevention.

The National Strategy for Suicide Prevention supports the development of collective leadership and of increasing the variety of groups working to prevent suicide. This effort applies to the state and local level. The development of broad-based support for suicide prevention will require ready access to information, research, literature resources, best practices, and program models. This effort will include the identification of multiple sites that can disseminate these resources.

Objective

3.1 Encourage agencies and organizations involved in suicide prevention to work within a collaborative framework at the state and local level.

3.2 Promote access to materials such as monographs, periodicals, videos, outreach posters, information pamphlets, electronic communication and related materials on suicide prevention in New Jersey.

3.3 Increase the number of state, local, professional, volunteer, and other groups that can integrate suicide prevention activities into their ongoing programs and activities.

3.4 Include suicide prevention information on the DCF website and encourage DCF contracted agencies to include suicide prevention information on their websites.

Goal # 4: Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse and suicide prevention services.

Rationale

Harris and Barraclough, 1997, found that sixty to ninety percent of all suicidal behaviors are associated with some form of mental illness and/or substance use disorder (National Strategy for Suicide Prevention). The negative stigma of mental illness and substance abuse prevents many children, youth and young adults from seeking assistance and has contributed to the silence and shame associated with mental health problems and suicide. Family members of those surviving a suicide attempt often hide the behavior from those that could help or provide support, believing that it reflects badly on their own relationship with the suicide attempter or that attempting suicide is shameful or sinful (National Strategy for Suicide Prevention).

Objective

4.1 Increase coordination among state agencies and entities such as the Governor's Anti-stigma Council and DCF to decrease stigma.

4.2 Increase public knowledge that mental health and physical health are intertwined components of overall health.

4.3 Increase public knowledge that mental illness and substance abuse, similar to physical illness, respond to specific treatments.

4.4 Increase public knowledge that consumers of mental health, substance abuse, and suicide prevention services are pursuing fundamental care and treatment for their overall health.

4.5 Encourage professional groups, associations, and individuals to address the issue of stigma associated with using mental health and substance abuse services.

Goal # 5: Strengthen and expand community-based suicide prevention and postvention programs.

Rationale

Effective suicide prevention requires a broad-based community commitment. Although there is not any one “suicide type,” there are youth who are at a higher risk based on particular risk factors. To help youth in need, community professionals and organizations must mobilize resources, identify risk and protective factors, and bring focused attention to the issue of suicide.

Successful suicide prevention, intervention and postvention strategies are based on the public health approach. Evidence-based methods are needed. Evaluations are also needed as programs are developed and implemented. The science of suicide prevention is still developing. Therefore, emerging strategies, promising practices, and other strategies with a foundation based in best practices may be used in addition to existing evidence-based strategies. These programs require an even more rigorous evaluation process to measure effectiveness.

Objectives

5.1 Expand and improve training efforts in suicide prevention to increase knowledge regarding best practices for suicide prevention, intervention and postvention for community-based organizations and schools.

5.2 Improve coordination with cultural and faith-based entities to share resources and information on issues of suicide.

5.3 Focus specific suicide prevention and postvention efforts towards higher risk populations such as adolescents, college students, gay/lesbian/bisexual/transgender youth, immigrants, non-English speaking youth, those addicted to and/or abusing substances, and youth in the correctional/juvenile justice system or other out-of-home settings.

Goal # 6: Implement professional training programs for those who are in regular contact with youth at-risk for self injury or suicide.

Rationale

There are many different settings where trained personnel can intervene with youth at-risk for self-injury or suicide. Pirkis & Burgess, 1998, found that approximately 45 percent of all individuals who die by suicide have had some contact with a mental health professional within the year of their death (National Strategy for Suicide Prevention). Trained personnel who come into contact with youth at risk for suicide are referred to as “key gatekeepers.” Key gatekeepers include, but are not limited to, teachers, clergy, police, resource parents, physicians, nurses, and therapists. Providing appropriate training for this broad array of key gatekeepers is an opportunity to enhance suicide prevention efforts.

Objectives

6.1 Maintain and expand key gatekeeper suicide prevention training programs in New Jersey to ensure adequate recognition and treatment of youth who are at-risk for suicide.

6.2 NJYSPAC will make concrete and specific recommendations to DCF about the adequacy of existing training for DCBHS and DMHS providers and about improvement, including specific curricula, which are preferable.

6.3 Maintain training programs in the recognition and treatment of risk factors associated with suicide across disciplines, including physical and mental health and substance abuse systems, legal systems, the education systems, and religious organizations. These trainings should include instruction on the identification of persons at risk, appropriate counseling, and referral to community-based services.

6.4 NJYSPAC will make specific recommendations to DCF:

6.4.1 That identifies who the “key gatekeepers” are; determine how they are organized across the state; recommend engagement strategies for each group; and suggests courses of action for engagement in youth suicide prevention efforts.

6.4.2 That identify preferred youth suicide prevention training strategies for key gatekeeper groups; training strategies will be cognizant of and sensitive to the particular mission, goals, needs, and organizational structures of each group.

Goal # 7: Develop and promote effective clinical practices to reduce suicide attempts and completions.

Rationale

For every youth who completes suicide there are many others who have made non-lethal attempts. Professionals in the health and mental health/substance abuse fields, clergy, education, and law enforcement are involved in the identification and referral of people at-risk for suicide. Service referrals should be made to programs evidencing high quality services, best practices and evidence based treatments when possible and appropriate. The quality of treatment for at-risk youth will be improved by the identification and implementation of these effective clinical practices. It is essential that all referral sources know how and where to locate providers whose practices are evidence based and reliant upon best practices. It is necessary that individuals at risk for suicide are engaged in prompt and effective treatment.

Objectives

7.1 DCF will facilitate interdepartmental collaboration to develop and promote best practice on the recognition of the antecedents of suicidal behavior.

7.2 Identify, disseminate and train the various provider groups on evidence-based and best practice guidelines in the diagnosis and treatment of suicide and self-injury. The primary audiences for this effort may include emergency care providers, primary care providers, mental health care providers, substance abuse providers, juvenile corrections personnel, school personnel, clergy, and other professionals who work with youth at-risk for suicide. Training should support providers efforts to treat youth at high-risk for suicide, youth that attempt suicide, and families, friends and those likely to be affected by a suicide or suicide attempts.

7.3 Promote, and support evidence-based and best practice guidelines for prevention and treatment of suicide or self-injury.

7.4 Facilitate the training of providers who treat children, youth, and young adults who are suicidal in best practices and evidenced based treatments.

Goal # 8: Promote access to mental health and substance abuse services.

Rationale

Youth with untreated mental health and substance abuse problems are at high risk for suicide; therefore, access to high quality mental health and substance abuse services is critical. Barriers to access should be reduced and linkages among various community agencies, mental health, and substance abuse treatment programs need to be enhanced. Where possible, services should be integrated and coordinated to avoid conflicting policies from potential funding sources.

Objectives

- 8.1 Identify and address barriers to mental health and substance abuse services.
- 8.2 Increase community awareness of risk behavior and increase awareness of culturally competent and linguistically relevant services.
- 8.3 Work with all appropriate state departments to increase access to an integrated network of effective, efficient, culturally competent and linguistically accessible mental health and substance abuse services that include suicide prevention and counseling services.
- 8.4 Promote DCF's youth helpline, "2nd Floor." Continue to enhance this helpline's ability to respond to youth at risk and explore potential for this helpline serving as a National Suicide Prevention Lifeline networked hotline.
- 8.5 Increase the number of calls answered in New Jersey from New Jersey residents that call the National Suicide Prevention Lifeline. Identify, coordinate, and prepare New Jersey based hotlines to serve as a recipient of National Suicide Prevention Lifeline calls.
- 8.6 Encourage all DCF contracted agencies to promote NJ Mental Health Cares helpline as a resource for families seeking mental health services.

Goal # 9: Improve reporting and the depiction of suicide, mental illness, and substance use in the electronic and print media.

Rationale

Media representations of suicide can potentially influence the suicidal thoughts and actions of youth. The collaborative efforts of the American Foundation for Suicide Prevention, American Association of Suicidology, and Annenberg Public Policy Center with support from the Centers for Disease Control, National Institute of Mental Health, Office of the Surgeon General, and Substance Abuse and Mental Health Services Administration have issued guidelines for reporting on suicide.

Objectives

- 9.1 Disseminate information on nationally recognized guidelines for reporting about suicide with an effort to reduce the stigma and prevent future suicides.
- 9.2 Utilize the nationally recognized guidelines outlined in the Reporting on Suicide: Recommendations for the Media (Annenberg Public Policy Center 2001) for reporting on suicide and local experts on suicide and suicide prevention for consultation and training with the media and academic programs in journalism.
- 9.3 Work with New Jersey academic journalism programs to include guidance on the appropriate depiction and reporting of mental illness, suicide and self-injury in their curricula.

Goal # 10: Promote and support research on youth suicide and suicide prevention and its dissemination and incorporation into clinical practice and public health efforts.

Rationale

Suicide prevention is a growing field, with an expanding knowledge base. More youth suicide prevention programs have been evaluated and resources are available to help community-based programs evaluate their suicide prevention efforts. Additional research on suicide prevention efforts and information from an increased number of evidence-based practices needs further systematic replication and evaluation.

Suicide prevention efforts at the state and local program level can be strengthened by promoting research-based strategies, using research in program planning and development, collection of data on process and outcome and an evaluation component for each program. There is a need for more training in evaluating suicide prevention efforts.

Objectives

10.1 Promote ongoing dissemination of evidence-based suicide prevention models and use of research-based strategies for suicide prevention.

10.2 Encourage all New Jersey suicide prevention programs to review best-practice and evidence-based research and to include an evaluation component that demonstrates outcome effectiveness.

10.3 Increase the number of suicide prevention programs that conduct program-specific research or participate in research and evaluation efforts of others.

10.4 Establish and maintain a directory of suicide prevention programs with demonstrated effectiveness as recognized by best-practice.

Next Steps

This plan is a three (3) year plan; however it is designed to be a base for longer range planning as well. Not all of the objectives listed in this plan will be able to be met within three years and will carry over to future plans. It is the hope of DCF that the NJYSPAC will provide ongoing recommendations for suicide prevention and planning and this State plan may be amended as often as annually. At a minimum, the plan will be fully reviewed and updated every three (3) years.

DCF will continue to accept and review all advice and recommendations provided by the NJYSPAC. The NJYSPAC will meet on a regular schedule and DCF will provide a liaison to the NJYSPAC.

References:

1. American Foundation for Suicide Prevention. American Association of Suicidology. Annenberg Public Policy Center. (2001). Reporting on Suicide: Recommendations for the Media.
2. CDC. Web-based Injury Statistics Query and Reporting System (WISQARS™). U.S. Department of Health and Human Services, CDC, National Center for Injury Prevention and Control, 2007. Available at <http://www.cdc.gov/ncipc/wisqars/default.htm>.
3. Guild, P. A., Freeman, V. A., & Shanahan, E. (2004). Promising Practices to Prevent Adolescent Suicide: What we can Learn from New Jersey. University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research.
4. New Jersey Department of Health & Senior Services, Center for Health Statistics.
5. New Jersey Office of the State Medical Examiner. (2009). Final Report: Independent Assessment of New Jersey's Children's Behavioral Health Care System. Trenton, NJ: Author.
6. Suicide Prevention Resource Center and SPAN USA. David Litts, editor. Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead. (2010). Newton, MA: Education Development Center, Inc.
7. Thomson Healthcare. Mental Health America. (2007, December). Ranking America's Mental Health: An Analysis of Depression Across the States. Washington, DC: Author.
8. University Behavioral Healthcare, University of Medicine and Dentistry of New Jersey. (2010, March). Traumatic Loss Coalitions for Youth. Piscataway, NJ: Author.
9. U.S. Dept. of Health and Human Services, Public Health Service. (2001). National Strategy for Suicide Prevention: Goals and Objectives for Action. Rockville, MD: Author.
10. U.S. Dept. of Health and Human Services. Centers for Disease Control and Prevention. (2010, June). Youth Risk Behavior Surveillance-United States, 59 (SS-5).
11. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. (1994, April). Suicide Contagion and the Reporting of Suicide: Recommendations from a National Workshop, 4 (22).

***Appendix II – The Effectiveness and Sufficiency of Services
Provided by the New Jersey-Based Suicide Prevention Hotlines***

State of New Jersey



The Effectiveness and Sufficiency of Services Provided by the New Jersey-Based Suicide Prevention Hotlines

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Executive Summary

On January 5, 2012, the Governor Christie signed into law Public Law 2011, Chapter 166. Among the provisions of the law is a requirement that the Commissioners of Human Services and Children and Families, in consultation with the Commissioner of Health, prepare a report reviewing the effectiveness and sufficiency of services provided by the New Jersey-based suicide prevention hotlines.

In order to meet the law's requirement, an eight page survey was sent to seven New Jersey organizations that provide crisis call services. Staff followed up with survey respondents to review their responses, clarify data, and gather additional information. The survey revealed that data collection is not uniform among providers in terms of the data elements and process.

Existing New Jersey Crisis Hotline Services

The existing New Jersey-based crisis hotlines surveyed for this report can be divided into two categories; state-government supported and non-state government supported.

State Government supported crisis hotlines

- The *Mental Health Association in New Jersey* (MHANJ) operates *MentalHealthCares*, a statewide helpline and an internet portal. For the 12-month reporting period, *MHA-NJ* received 24,000 total calls, of which 1,200 (5%) were suicide related.
- *NJ 2-1-1 Addictions*, a unit of the *NJ 2-1-1 Partnership*¹, is available statewide, 24/7. For a recent 12-month period, *NJ 2-1-1 Addictions* reported that of the 13,000 total calls received, 100 (.8%) were at risk emergent/urgent.²
- The *University of Medicine and Dentistry of New Jersey (UMDNJ) - University Behavioral Health Care (UBHC)* operates several unique statewide, 24/7 hotlines targeted to distinct populations; *Cop2Cop*, *Vet2Vet*, and *Mom2Mom* (for mothers of children with special needs). For the 12-month period reported, *Cop2Cop* received 5,888 total calls, of which 318 (5.4%) were urgent/emergent; *Vet2Vet* received 3,441 calls (and internet chats), of which, 34 (1.0%) were urgent/emergent; and *Mom2Mom* received 8,163 total calls, 108 of which, (1.3%) were at risk emergent/urgent.
- *2NDFLOOR* youth helpline and its interactive website are geared to youth statewide, between the ages of 10-24. Services are available 24/7. For the 12-month period reported, the agency received 118,095 total calls, of which, 29 (.025%) were suicide related.
- *Designated Screening Centers* provide psychiatric crisis stabilization services, 24/7, to every geographic area of the State. In state fiscal year 2011, these agencies provided slightly over 88,000 episodes of emergency mental health care; 17,000 episodes of emergency mental health care involving children, aged 18 and younger; and 70,000 episodes of emergency mental health care to adults.

¹ *NJ 2-1-1 Partnership*, which is not funded by DCF or DHS, reported that of the 108,000 total calls, 100 (.1%) were at risk emergent/urgent.

² "At risk emergent/urgent" calls include suicide related and non-suicide related crisis calls, e.g. family violence, etc.

Non-State Government supported crisis hotlines³

- *CONTACT of Burlington County* serves residents of Burlington County, 24/7. For a recent 12-month period, the agency reported approximately 25,000 total calls, of which, 50 (.2%) were suicide related.
- *CONTACT of Mercer County* serves Mercer County and the 609 area code Monday-Sunday 7 a.m. to 11 p.m. For a recent 12-month period, the agency reported approximately 11,000 total calls, of which, 300 (2.7%) were suicide related.
- *CONTACT We Care* serves Essex, Middlesex, Morris, Somerset and Union counties Monday-Sunday 7 a.m. to 11 p.m. For a recent 12-month period, the agency reported approximately 11,224 total calls, of which 641 (5.71%) were suicide related (youth & adults). Of the suicide related calls, the agency reported approximately 628 (5.6%) were from adults (over 18) and 13 (.11%) were from youth.

Lifeline

The National Suicide Prevention Lifeline Network (Lifeline) is a nationwide network of crisis call centers. Currently five New Jersey based hotlines are *Lifeline* members. The two newest New Jersey *Lifeline* members began providing in-state backup coverage only during limited hours in September 2012.

The call data reported by *Lifeline* for New Jersey, contained in this report, is for the three crisis call centers that were, at the time of the survey, the only certified *Lifeline* members. The call data includes all calls (suicide and non-suicide related) and includes all age groups. For calendar year 2011 *Lifeline* reported of the New Jersey based certified *Lifeline* members there were a total of 19,310 calls, 17% were answered in-state, 60% were answered out-of-state, 3% were answered by the *Spanish Lifeline* and 19% were answered by the *Veterans Lifeline*. For January 1, 2012 through June 30, 2012 *Lifeline* reported a total of 11,354 calls, 17% of all calls were answered in-state, 68% of all calls were answered out-of-state, 2% were answered by the *Spanish Lifeline* and 13% were answered by the *Veterans Lifeline*.

Findings

The following are key findings drawn from a review of the survey data and follow up information provided by survey respondents, as well as national research specific to suicide prevention hotlines.

Call volume and coverage

- Most calls to New Jersey suicide/crisis hotlines are not from people at risk for suicide. Research demonstrates that this is the case nationally as well⁴.
- Data provided by survey-respondents, as well as *Lifeline*, indicates that crisis call volume is increasing each year.
- With the exception of Burlington County, there is no in-state *Lifeline* member providing primary or backup coverage Monday-Sunday between 11 p.m. and 7 a.m.
- *Lifeline* reports that the highest call volume to its network is between the hours of 8 p.m. and midnight.
- Over 60% of New Jersey *Lifeline* calls are answered out-of-state.

³ All the three New Jersey Contact programs surveyed are members of the *Lifeline* network.

⁴ A large number of calls relate to such things as domestic violence, general mental health information, and broader social service issues.

Funding

- New Jersey based organizations accredited by *CONTACT USA (CUSA)* are primarily funded by foundations and private sources, with little or no government funding.
- *American Association of Suicidology (AAS)* accredited organizations are primarily funded by government.
- A crisis call center's capacity, as it relates to hours of operation, staffing and training, cultural competence, and data collection, analysis, and reporting is limited by its funding.

Staffing and Training

- The number of full-time paid staff for New Jersey based crisis call centers varies significantly.
- The three *CONTACT* affiliated agencies maintain large volunteer staffs, ranging from approximately 80 to 150 people.
- Required training hours for new and existing employees of New Jersey based crisis call centers, varies significantly.
- All agencies surveyed provide training specific to cultural competence and all have at least some Spanish language ability. The ability to service people who speak other languages varies.
- Not all agencies have access to a TTY line for the deaf.

Accreditation

- There are two national accrediting bodies with a primary focus on suicide prevention hotlines, *CUSA* and the *AAS*.
- *CUSA* accreditation appears better suited to organizations that are largely staffed by volunteers. The three *CONTACT* affiliated agencies are *CUSA* accredited.
- *AAS* accreditation appears better suited to organizations that employ individuals with professional counseling training. *2NDFLOOR* is accredited by *AAS*. *MHANJ* is in the process of obtaining *AAS* accreditation.
- *UMDNJ* is both *AAS* and *Joint Commission on Accreditation of Healthcare Organizations (JCAHO)* accredited.
- *NJ211 Addictions* is Alliance of Information Referral Systems (*AIRS*) accredited.

Services

- New Jersey based crisis call centers provide an extensive array of other support services in addition to suicide prevention including:
 - Mental health information and referral
 - General crisis hotline
 - Outreach & education
 - Texting capability
 - Online chat capability
 - Suicide prevention training
 - 2-1-1 access
 - Rape crisis
 - Reassurance calls
- All of the New Jersey based suicide prevention hotlines surveyed have implemented recognized practices (e.g. policies for screening callers at imminent risk of suicide, routine follow up procedures for suicidal callers, etc.) that research shows have a positive impact on callers to crisis hotlines in terms of significant decreases in suicidality and significant improvements in the mental state of youth.

Ways to improve New Jersey Crisis Hotline Services

- Increase in-state, statewide primary and backup coverage Monday-Sunday between 11 p.m. – and 7 a.m.
- Enhance the use of technology, i.e. the internet, text messaging, online chat services, and/or social media.
- Strengthen the linkage between crisis hotlines and local community crisis intervention services.
- Standardize data collection to the extent possible, i.e. capture specific call types (suicide, financial crisis, housing crisis, bullying, etc.) as well as demographic data (age, gender, race, sexual orientation, language, etc.).
- Enhance cultural competence including available language services, services for the deaf, and sensitivity to people of varying sexual orientation.

Background on the Suicide Prevention Hotline Survey Report

On January 5, 2012, Governor Christie signed into law, Public Law 2011, Chapter 166. Among the provisions of the law is a requirement that the Commissioners of Human Services and Children and Families, in consultation with the Commissioner of Health, prepare a report reviewing the effectiveness and sufficiency of services provided by the New Jersey-based suicide prevention hotlines. The purpose of the legislation is to ensure that New Jersey has sufficient resources to address the needs of an extremely vulnerable population.

The law does not make reference to the broader network of social service hotlines that exist in New Jersey. Psychiatric crisis intervention hotlines, social service informational helplines, domestic violence hotlines, rape crisis services and numerous other crisis oriented service lines that may provide services to suicidal callers are outside the purview of the law's required analysis. Nevertheless, some analysis and discussion of these services will be helpful in fully assessing the sufficiency of New Jersey's suicide prevention hotline infrastructure.

The Suicide Prevention Hotline Survey Report is a preliminary step to understand the current capacity of suicide prevention hotlines in New Jersey. This report provides a brief explanation of the terms, definitions and acronyms; the accreditation process for a suicide prevention hotline and membership in the *National Suicide Prevention Lifeline Network*; and short summaries of the helplines/hotlines surveyed.

A national study indicates most hotline calls are not from people at risk for suicide but need informational/referral to service. Seven % are imminent suicide crises, and 17% are suicidal ideation.⁵ Another study found of nearly 350,000 crisis calls over a 5 year period and coded into one of 11 crisis call categories, including suicide, the top problem categories were Parent/Adult Issues, Youth Issues and Mental Health concerns.⁶ Further research of crisis hotlines indicates that suicide prevention accounts for 5-20 % of the calls.⁷ The data provided by the survey respondents for this report, supports these findings.

This report includes existing accredited suicide prevention hotlines in New Jersey, which received their accreditation from AAS or *CONTACT USA*; two statewide providers, which received accreditation in September 2012; and six Designated Screening Centers.

Methodology

An eight page survey (Appendix C) was sent to seven New Jersey organizations that provide ten crisis call services. Completed surveys were followed up by a meeting or phone call to review their responses, clarify information or to gather additional details. The helpline/hotlines included:

⁵ Kirkwood, A.D., Stamm, E.H., Hudnall, A.C., & Blampied, S.L. (2010) *Idaho Suicide Prevention Hotline: Analysis of Options for Decision Making*. Meridian, ID & Pocatello, ID: Idaho State University. Available at: www.isu.edu/irh/publications/Hotline_Report_2010_web_pwp.pdf

⁶ Ingram, S., Ringle, J.L., Hallstrom, K., Schill, D.E., Gohr, V.M., & Thompson, R.W. (2008) *Coping with Crisis Across the Lifespan: The Role of a Telephone Hotline*. Journal Child & Family Studies. Available at: <http://www.springerlink.com/content/0j218x533r78jk06/>

⁷ Millstein, D.L., (2009) *Predictors of Caller Feedback Evaluations Following Crisis and Suicide Hotline Calls*. A Dissertation submitted to the Faculty of The Graduate School of Applied and Professional Psychology of Rutgers The State University of New Jersey. Available at: <http://mss3.libraries.rutgers.edu/dlr/showfed.php?pid=rutgers-lib:26144>

- *2NDFLOOR Youth Helpline*
- *CONTACT of Burlington County*
- *CONTACT of Mercer County*
- *CONTACT We Care, Inc.*
- *Mental Health Association in New Jersey, Inc.(MHA-NJ)*
- *NJ 2-1-1 Partnership*
 - *NJ 2-1-1 Addictions*
- *UMDNJ-University Behavioral Healthcare (UBHC)*
 - *Cop2Cop*
 - *Mom2Mom*
 - *Vet2Vet*

MHA-NJ was included because it is responsible for coordinating the Disaster Response Crisis Counselor Certification (DRCC) and recertification process. The training offered by *MHA-NJ* focuses on trauma and crisis management to meet the state’s mental health needs following a disaster.

NJ 2-1-1 was included because it provides emergency preparedness, response and recovery services.

An abbreviated version of the above-referenced survey was also sent to six *Designated Screening Service Programs*. Services offered through these programs include crisis intervention, assessment and stabilization; mobile outreach; screening for hospitalization; and operation of a 24-hour hotline. Pursuant to regulation, all hotline calls to the State’s *Designated Screening Service Programs* are answered at all times directly by clinical personnel.

Background on Suicide and Suicide Prevention Hotlines

Suicide is a widely acknowledged public health problem. The most recent data available from the *Center for Disease Control (CDC)* indicates that suicide is the tenth leading cause of death in the United States.⁸ The CDC also reports that suicide is the second leading cause of death among 25-34 year olds and the third leading cause of death among 15- to 24-year olds. Suicide is believed to be a complex behavior with ambivalence about living a common emotional characteristic.⁹

Suicide prevention initiatives date back about a half a century, when the federal government established the *Center for Studies of Suicide Prevention at the National Institute of Mental Health*. In recent decades, based on the considerable research into the many complexities of suicidal behavior, suicide prevention efforts have evolved to reflect the emerging knowledge base. Prevention strategies are now numerous and varied in scope. In the United States, the Los Angeles Suicide Prevention Center was founded in 1958 and was the first in the country to provide a 24/7 suicide prevention crisis line and use community volunteers in providing hotline service.

The *USDHHS-SAMHSA* recently released an updated comprehensive report called, *National Strategy for Suicide Prevention; Goals and Objectives for Action*. This report outlines a prospective strategy for suicide prevention that will undoubtedly inform local efforts in New Jersey.

⁸ Available at: http://www.cdc.gov/ViolencePrevention/suicide/statistics/leading_causes.html

⁹ Shneidman, E.S., (1998). *The Suicidal Mind*. Oxford University Press.

Suicide rates vary around the world and across the nation's 50 states. Review of the most recent data available from the *American Association of Suicidology* indicates that, among the 50 states, New Jersey has the second lowest suicide rate. Some research suggests that regions with lower rates of home gun ownership have lower rates of suicide, when other factors associated with suicide are controlled.¹⁰

On January 1, 2005, the *USDHHS-SAMHSA* and *Mental Health Association of New York City (MHA of NYC)* launched *The National Suicide Prevention Lifeline Network (Lifeline)*. *Lifeline's* mission is to, "prevent suicide by reaching and effectively serving all persons at suicidal risk in the United States through a network of crisis hotlines."¹¹

Lifeline's website states that there are more than 150 crisis centers* enrolled in *Lifeline's* network to date. Before being able to join and be a certified member of the *Lifeline* network, a hotline needs to first be accredited by an accrediting organization. *Lifeline* network member crisis centers are operated mainly by non-profit organizations that receive a small stipend as a certified member in the network.

Until recently, there was an insufficient evidence base regarding suicide crisis hotlines.¹² National studies, primarily of adults, now confirm that hotlines serve callers who are at serious risk for suicide, that significant decreases in suicidality were found during the course of the telephone session, with continuing decreases in hopelessness and psychological pain in the following weeks.¹³ Additionally, until recently, for youth, there was a dearth of information about the efficacy of telephone crisis services and whether they adequately address suicide risk.¹⁴ Current research of youth callers found significant decreases in suicidality and significant improvements in the mental state of the youth during the course of the calls.¹⁵

Terms, Definitions and Acronyms

Although it is common practice for the terms "crisis line", "hotline", "helpline" and "warm line" to be used interchangeably, it should be noted, the primary purpose of each of these types of phone lines differ. Additionally, not all calls received by a phone line fall within their primary purpose. Generally accepted definitions for these terms are:

Helpline provides phone based non-judgmental, active listening to help callers identify their problems and come to their own solutions.

¹⁰Simon, R.I., (2007) Gun Safety Management with Patients at Risk for Suicide. *Suicide and Life Threatening Behavior*, 37(5), 518 – 526.

¹¹ Draper, J. Mishara, B., Covington, D. et al (2010). Background Paper: National Suicide Prevention Lifeline Policy for Helping Callers at Imminent Risk of Suicide Research and Rational, pg 1.

* The National Suicide Prevention *Lifeline* Network defines a Crisis Center as a facility or call center.

¹² Suicide Prevention Resource Center and SPAN USA. David Litts, editor. *Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead*. 2010. Newton, MA: Education Development Center, Inc. Available at: www.sprc.org

¹³ Gould, M. S., Kalafat, J., Harrismunfakh, J. L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide & Life-Threatening Behavior*, 37(3), 338-52.

¹⁴ Gould, M.S., Greenberg, T., Velting, D.M., & Shaffer, D. (2003). Youth Suicide Risk and Preventive Interventions: A Review of the Past 10 Years. *American Academy of Child and Adolescent Psychiatry*, 42:4, 386-405.

¹⁵ King, R., Nurcombe, R., Bickman, L., Hides, L., & Reid, W. (2003). Telephone counseling for adolescent suicide prevention: Changes in suicidality and mental state from beginning to end of a counseling session. *Suicide and Life-Threatening Behavior*, 33, 400–411.

Hotline or **Crisis Line** or **Crisis Hotline** provides phone based services for individuals experiencing a crisis and may include domestic violence, poison control, etc. In New Jersey each designated screening center is required to operate a 24-hour hotline which shall be answered directly by a certified screener, crisis intervention specialist, or other clinical personnel under the supervision of the screener or crisis intervention specialist (*N.J.A.C.10:31-2.1*).

Suicide Prevention Hotline provides phone based services for individuals who are at risk of suicide or concerned about someone at risk of suicide. Suicide prevention hotline services may include a suicide risk assessment, crisis intervention counseling, and referral to community services as needed. They may operate 24/7 or may have limited hours.

Warm line provides phone based service for non-crisis situations. They are intended to provide support to individuals who are looking for support or would like to talk to a counselor.

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.

Previously the terms accreditation and certification had been used interchangeably, which created confusion. Currently, all major accrediting organizations use the term accreditation to avoid confusion.

Certification as a member of the National Suicide Prevention *Lifeline* Network (*Lifeline*) is obtained after a hotline has been accredited and has successfully completed the *Lifeline* application process.

AAS The **American Association of Suicidology** awards accreditation to crisis intervention programs. Suicide prevention is a key element throughout their vision, standards and philosophy.

AIRS The **Alliance of Information Referral Systems** is a professional organization that offers accreditation and certification to its members with a focus on information and referral systems.

CARF The **Commission on Accreditation of Rehabilitation Facilities** 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.

CUSA **CONTACT USA** provides accreditation to telephone crisis programs such as Helplines, Information and Referral, **CONTACT** Reassurance, Online Emotional Support and Certified Crisis Hotline Worker. Accreditation allows a hotline to link to the resources of a larger network of specialists dealing with similar problems.

COA The **Council on Accreditation** has developed Contextual Accreditation, a strategy to strengthen, measure, and validate an agency's effectiveness.

JCR The **Joint Commission Resources** is the arm of the Joint Commission, (formerly the **Joint Commission on Accreditation of Healthcare Organizations** or **JCAHO**) that provides accreditation, with a focus on hospitals.

Accreditation and Certification

Accreditation is a voluntary process and is based upon standards of care and best practices. To become accredited, a suicide prevention hotline is required to meet a number of standards. Depending upon the accrediting body, these standards vary. As noted previously, nationally there are numerous accrediting bodies. The two with a primary focus on suicide prevention are the American Association of Suicidology (*AAS*) and *CONTACT USA (CUSA)*. The accreditation process for both entities consists of on and off site activities and includes written documentation. Both *AAS* and *CUSA* have revised their standards to reflect the current evidence-based practices and in response to *SAHMSA* funded research that examined the effectiveness of crisis centers (hotlines).

AAS evaluates hotlines on seven basic areas of function, each with separate standards and *CUSA* uses seven areas of standardization. It is difficult to make direct links across the two organizations' standards of evaluation although within the subcategories the same general standards are considered.

AAS accreditation standards, in general, are more detailed and explicit in the required content of policies and procedures. *CUSA* accreditation standards, in general, require policies and procedures with less content requirements.¹⁶ A summary of the accreditation standards for *AAS Tenth Edition* and *CUSA 2012* is included as Appendix A.

Overview of Existing New Jersey Crisis Hotline Services

A number of state government supported initiatives have been developed in New Jersey during the past decade. These initiatives provide greater access to mental health services for both the general population and for targeted at-risk groups. Some of these programs have explicit suicide prevention aims, whereas others serve broader aims but regularly encounter callers with ideation related to suicide by virtue of the personal and social context in which suicide occurs.

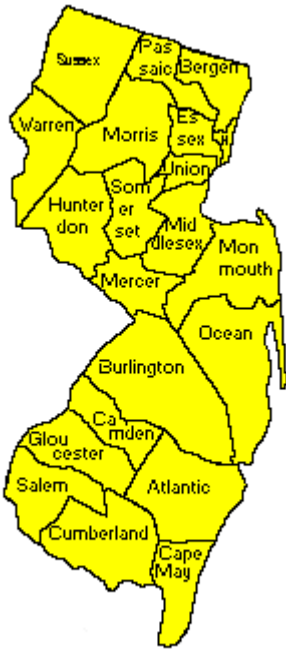
State Government Supported Programs:

Mental Health Association in New Jersey (MHANJ) is a non-profit agency and has been active since 1948. In New Jersey it provides mental health advocacy, education, training, and services for children and adults. *MentalHealthCares* information and referral service helpline, has been funded by the Department of Human Services since 2005, and operated by the *MHANJ*. This helpline provides mental health information and referral service, provider referral, case management and follow-up to callers and individuals who contact them via its internet website.

Services provided by *MHANJ* are Mental Health Information and Referral Services, Alcoholism Information Services and General Victim Services. Additionally it has the capability to “warm line” transfer a caller to Cop2Cop, Mom 2Mom, Vet2Vet and any other third party hotline/helpline.

¹⁶Kirkwood, A.D., Stamm, B.H., Hudnall, A.C., & Blampied, S.L. (2010). *Idaho Suicide Prevention Hotline: Analysis of Options for Decision Making*. Meridian, ID & Pocatello, ID: Idaho State University. Available from www.isu.edu/irh/publications.

MHANJ recently (September 2012) became a certified member of *Lifeline* to provide in-state backup coverage only. MHS is in the process of applying to become accredited by AAS.



Primary Coverage Area: N/A

Backup Coverage Area: New Jersey

Hours of Operation: 8 a.m. – 8 p.m. Monday – Friday

Accreditation: AAS in process

Certification: *Lifeline* affiliate

Staffing: Average 6 staff per shift, 8 full-time & 10 part-time.

Training: Minimum 12 hours

Call Volume: Average 2,000 monthly & 24,000 annually. Of total calls average 6,000 (25%) are youth

Suicide Related Calls: Annually 1,200 (5%)

NJ211 Addictions hotline (a subdivision of the NJ211 Partnership), funded in 2010 by the Department of Human Services and partnered with the United Way of New Jersey, is a statewide hotline available 24/7. Credentialed staff offer callers information on how to access the continuum of substance use services, such as detoxification units, residential based recovery services and outpatient programs.



Primary Coverage Area: New Jersey

Hours of Operation: 24/7

Accreditation: AIRS

Certification: Not Applicable

Staffing: On average 1-14 staff per shift, 24 total staff: 4 full-time & 20 part-time

Training: Minimum of 48 hours for new staff & 66 hours annual in-service

Call Volume: Average 9,000 monthly & 108,000 annually

Suicide Related Calls: Annually 100 (.09%) were at risk emergent/urgent

NJ 2-1-1 Addictions:

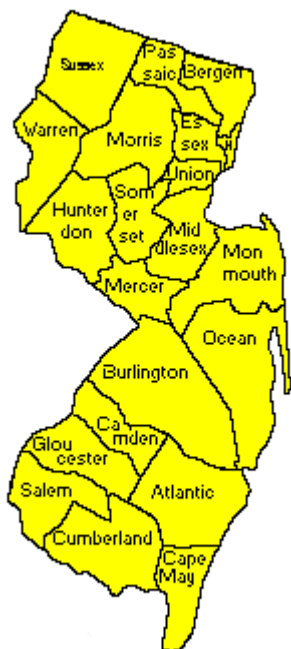
Staffing: On average 2-3 staff per shift, 16 total staff: 4 full-time & 12 part-time

Training: Minimum of 48 hours for new staff & 52 hours annual in-service

Call Volume: On average 1,100 monthly & 13,000 annually

Suicide Related Calls: Annually 100 (.77%) were at risk emergent/urgent, which includes suiciderelated and non-suicide-related crisis calls.

UMDNJ - University Behavioral Health Care's (UBHC) Access Center, with funding from a variety of public and private sources, operates several unique 24/7 hotlines targeted to distinct populations such as law enforcement and military personnel. These occupations and groups are at increased risk for suicide. *UMDNJ-UBHC* is accredited by *AAS* and *JCAHO*. *UMDNJ* recently (September 2012) became a certified member of *Lifeline* to provide in-state backup coverage only statewide noon to 8 p.m. Monday through Thursday.



Primary Coverage Area¹⁷: N/A

Backup Coverage Area: New Jersey

Hours of Operation: Noon – 8 p.m. Monday – Thursday

Accreditation: *JCAHO* & *AAS*

Certification: *Lifeline* affiliate

The *Cop2Cop* hotline is the first of its kind in the nation legislated into law to focus on suicide prevention and mental health support for law enforcement personnel. In 1998, P.L. 1998, c. 149, mandated the establishment of a statewide “law enforcement officer crisis intervention services” hotline. In 2000, the *UMDNJ-UBHC* was contracted to provide crisis intervention services to the law enforcement community and developed the *Cop2Cop* program.

It is staffed primarily by paid and volunteer retired police officers who are licensed Clinical Social Workers or who receive clinical training, and specially trained mental health professionals providing statewide coverage 24/7. Callers can speak to a “peer” officer who can help the often hesitant caller to access mental health services.

Staffing: Total 16 staff

Training: Minimum 20 hours new staff receive & 12 hours annual continuing staff training

Call Volume: Average 490 monthly & 5,888 annually

Suicide Related Calls: 318 (5.4%) at risk emergent/urgent, which includes suicide related and non-suicide related calls

¹⁷ For all 3 UMDNJ crisis lines.

Mom2Mom is a helpline for mothers of children with special needs. This helpline features peer support, telephone assessments, a network of referral services and support groups.

Peer supporters are mothers of special needs children trained in peer counseling and crisis support who offer peer support, explain resources, and explore the needs of the caller. Clinicians are available to do telephonic assessments to gauge the depression, anxiety, family and marital issues, etc., that may be impacting the caller.

Staffing: Total 12 staff

Training: Minimum 20 hours new staff receive & 12 hours annual continuing staff training

Call Volume: Average 680 monthly & 8,163 annually

Suicide Related Calls: 108 (1.32%) at risk emergent/urgent, which includes suicide related and non-suicide-related calls

Vet2Vet is a helpline providing peer counseling, clinical assessments, and assistance to returning veterans and their family members. *Vet2Vet* is administered by veterans who themselves have been consumers of VA mental-health services. The helpline provides access to a comprehensive support network of mental health professionals who specialize in issues specific to veterans returning to civilian life.

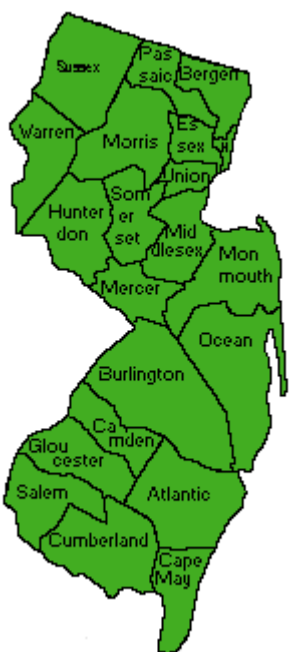
Staffing: Total 10 staff

Training: Minimum 20 hours new staff receive & 12 hours annual continuing staff training.

Call & Chat Volume: Average 286 monthly & 3,441 annually

Suicide Related Calls & Chats: 34 (.99%) at risk emergent/urgent, which includes suicide related and non-suicide related calls

The *2NDFLOOR* youth helpline is funded by the Department of Children & Families. *2NDFLOOR* provides a single, universal, toll-free, confidential and anonymous interactive helpline for New Jersey's youth population, a TTY phone line to support New Jersey youth who are hearing impaired, and an interactive website. There is a dedicated Spanish language line that operates daily from 4 to 10 p.m. Other language services are provided through a language line.



Primary Coverage Area: New Jersey

Hours of Operation: 24/7

Target Group: Youth age 24 & under

Accreditation: AAS

Certification: Not Applicable

Staffing: On average 1-6 staff & volunteers per shift, 70 total staff: 3 full-time, 22 part-time & 45 interns

Training: Minimum 6 hours

Call Volume: Average 1,666 per month. Approximately 200,000 annually

Suicide Related Calls: Annually 29 (.0145%)

2NDFLOOR performs risk assessments; provides local resources and referral information, works collaboratively with family members and their Youth Advisory Council members, comprised of teens from various school districts who serve as peer leaders. The agency responds to youth regardless of the topic, in a safe, non-judgmental

manner providing confidentiality and anonymity to callers. 2NDFLOOR is accredited by AAS.

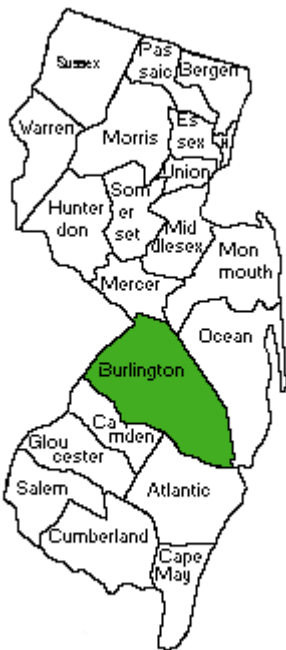
In addition to suicide prevention, the agency provides a Teen Hotline, Alcoholism Information, Child Abuse Counseling, Drug Information & Counseling, Sex Information, Mental Health Information & Referral, Sexually Transmitted Disease Information and General Crisis Hotline.

Designated Screening Service programs - Pursuant to N.J.S.A. 30:4-27.1 et seq., enacted in 1987, all 21 New Jersey counties have at least one *Designated Screening Service* program. All hotline calls to the state's Designated Screening Service program are available 24/7 and are answered at all times directly by clinical personnel. These programs are designed to provide psychiatric crisis stabilization services, 24/7, in every geographic area in the state of New Jersey. In addition to the 24/7 hotline, other crisis services provided include crisis intervention, assessment and stabilization; mobile outreach; and screening for hospitalization. The 24/7 hotlines operated by these programs serve a critical suicide prevention function in the New Jersey mental health system.

Designated Screening Service programs are funded primarily by the New Jersey Department of Human Services (DHS) and represent one of the DHS's largest investments in community based crisis mental health services.

Non-State Government supported programs:

CONTACT of Burlington County is a non-profit organization. Its primary coverage area is Burlington County with a 2010 census population of 448,734. It is accredited by *CONTACT USA* and is a member of AAS, AIRS, the *New Jersey Coalition Against Sexual Assault (NJCASA)*, the *Rape, Abuse, Incest National Network (RAINN)*, the *American Foundation for Suicide Prevention (AFSP)*, and the *United Way of Burlington County*.



Primary Coverage Area: County Burlington

Backup Coverage Area: N/A

Hours of Operation: 24/7

Accreditation: CONTACT USA

Certification: Lifeline

Staffing: Not Available

Training: Meets CONTACT USA requirements

Call Volume: Average 2,083 monthly & 25,000 annually

Suicide Related Calls: Annually 50 (.2%)

The agency provides outreach and education; a Reassurance Call program, a daily outreach telephone call to senior citizens who live alone; and information and referral services. In addition, it offers a KidsLine Program, for youth who are home alone after school; as well as a Rape Care/Sexual Assault response program for Burlington County; PetFriends, which provides support for owners in grief after the loss of a pet; a TeenLine, and a peer telephone helpline. CONTACT is also the 2-1-1 provider for the county. In 2008 the agency was designated as the 2-1-1 South Regional Center for ten counties in southern New Jersey (Atlantic,

Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem), and in 2009 it began accepting calls in Burlington County for *the National Suicide Prevention Lifeline Network*.

CONTACT of Mercer County is a non-profit organization primarily serving Mercer County with a total 2010 census population of 366,513 in the 609 area code. The 609 area code coverage area consists of all of Mercer and Cape May counties and portions of Atlantic, Burlington, Hunterdon, Middlesex, Monmouth, Ocean and Somerset counties. Afterhours crisis calls on the suicide prevention line are automatically diverted to *Lifeline*.



Primary Coverage Area: Mercer County & Area Code 609

Backup Coverage Area: N/A

Hours of Operation: Monday – Sunday, 7 a.m. – 11 p.m.

Accreditation: CONTACT USA

Certification: *Lifeline*

Staffing: 1 staff per shift, 1 full-time & 80 part-time volunteers

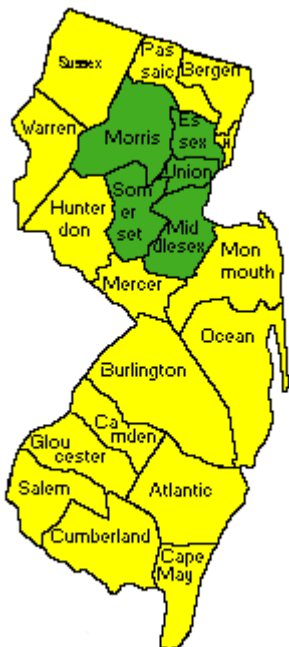
Training: Meets CONTACT USA requirements

Call Volume: Average 900 monthly & 11,000 annually.

Suicide Related Calls: Annually 300 (2.7%)

It provides a CrisisChat program; co-facilitates a monthly survivors group, provides telephone reassurance services and operates a Retired Senior Volunteer Program (RSVP).

CONTACT We Care is a non-profit organization. According to the 2010 census the population for youth under the age of 18 is 710,163 and for adults age 18 and over it is 2,239,600. Afterhours crisis calls on the suicide prevention line are automatically diverted to *Lifeline*.



Primary Coverage Area: Essex, Middlesex, Morris, Somerset, Union Counties

Backup Coverage Area: New Jersey

Hours of Operation: Monday – Sunday, 7 a.m. – 11 p.m.

Accreditation: CONTACT USA

Certification: *Lifeline*

Staffing: 2 staff per shift, 1 full-time, 3 part-time & 120 volunteers

Training: Meets CONTACT USA requirements

Call Volume: Average 1,000 monthly & 12,000 annually

Suicide Related Calls: Annually Adults & youth 641 (5.7%). Adults 628 (5.6%). Youth age 18 & under 13 (.11%)

In addition to the suicide prevention hotline, CONTACT We Care also provides a texting service, Mental Health I & R, Teen Hotline, General Crisis Hotline, Outreach Program, Texting Services & Suicide Prevention Training.

Results from the Suicide Prevention Hotline Survey

All of the helplines/hotlines respond to various crisis calls and provide an extensive array of other support services. These include:

- Mental health information and referral services
- Teen Hotline
- Teen-to-Teen Hotline
- General Crisis Hotline
- Outreach & Education
- Texting Services
- Online Chat
- Suicide Prevention Training
- Insurance Eligibility Screening
- 2-1-1
- Rape Crisis
- Reassurance calls
- PetFriends Grief Support for pet owners

Call Volume

There is a wide range of crisis call volume. This is due, in part, to the area covered by the respondents, with service areas ranging from a single county to state-wide coverage. Additionally, some of the hotline/helplines focus on specific populations. Lastly, not all call data was available. Where available, the call data reported included the total number of all calls received, the number of calls that were identified as at risk or emergent/urgent and then the number of calls that were suicide related. Not all calls identified as at risk or urgent/emergent are suicide related.

Of the data available for suicide related hotline calls:

- *2NDFLOOR* Youth Helpline reported of its total 196,499 calls, 29 were suicide related. Most calls are less than 5 minutes in length, where crisis calls usually are longer than 30 minutes.
- *CONTACT We Care* reported of the 11,224 total calls 641 or 5.7% were suicide related.
- *CONTACT of Burlington* reported of the 25,000 total calls 50 or .2% were suicide related.
- *MHA-NJ* reported of the 24,000 total calls 1,200 or 5% were suicide related.
- *NJ 2-1-1* reported of the 108,000 total calls 100 or .09% were at risk emergent/urgent¹⁸.
- *NJ 2-1-1 Addictions Hotline* reported of the 13,000 total calls 100 or .77% were at risk emergent/urgent.
- *Cop2Cop* reported of the 5,888 total calls 318 or 5.40% were at risk emergent/urgent.
- *Mom2Mom* reported of the 8,163 total calls reported 108 or 1.32% were at risk emergent/urgent.
- *Vet2Vet* reported of the 3,441 total calls & chats 34 or .99% were at risk emergent/urgent

During state fiscal year 2011, the state's 23 designated screening service programs provided over 88,000 episodes of emergency mental health care, with 70,000 of these episodes provided to adults and the remainder to children under age 18. In general, statewide, the programs report that approximately 33% of all service episodes are suicide related.

¹⁸ "At risk emergent/urgent" calls include suicide related and non-suicide related crisis calls, e.g. family violence, etc.

Lifeline Call Volume

The call volume reported by *Lifeline* for New Jersey and contained in this report is for the three crisis call centers that were, at that time, the only certified members of *Lifeline*. There is a Spanish sub-network included, connecting Spanish speaking callers to a bilingual counselor. A Veterans Suicide Prevention Hotline was added in 2007. The network includes a regional and national back-up system.

The *Lifeline* network connects a caller to a local crisis call center based on the caller's area code. Calls not answered within 30 seconds are then routed to the next closest crisis call center.

The call data includes all calls, anyone calling for any reason and includes all ages. The only calls with an identifier are those calls to the Veteran or Spanish-speaker hotlines. Hence, crisis calls that were specifically suicide related and youth or adult identified were not available.

As reported by *Lifeline*, nationally the highest call volume is between the hours of 8 p.m. and midnight. For those call centers in the *Lifeline* network New Jersey has limited coverage, with only the Burlington crisis call center providing 24/7 coverage to Burlington County. From 11 p.m. until 7 a.m. Monday through Sunday, the other 20 counties crisis calls are responded to by the regional or national *Lifeline* centers.

For calendar year 2011 *Lifeline* reported of the New Jersey based certified *Lifeline* members:

- There were a total of 19,310 calls
- 17% were answered in-state
- 60% were answered out-of-state
- 3% were answered by the *Spanish Lifeline*
- 19% were answered by the *Veterans Lifeline*

Burlington County, the only 24/7 crisis call center, had a total of 559 calls and was the county with the highest in-state call response at 70%. Only 10% of its calls were answered out-of-state, 20% were answered by the *Veterans Lifeline* and no calls were answered by the *Spanish Lifeline*.

For January 1, 2012 through June 30, 2012 *Lifeline* reported the following:

- A total of 11,354 calls
- 17% were answered in-state
- 68% were answered out-of-state
- 2% were answered by the *Spanish Lifeline*
- 13% were answered by the *Veterans Lifeline*

Burlington County had a total of 307 calls and is the county with the highest in-state call response at 78%. Only 7% of its calls were answered out-of-state, 15% were answered by the *Veterans Lifeline* and 1% of their calls were answered by the *Spanish Lifeline*.

Lifeline's total calls for New Jersey in calendar year 2010 were 13,909; for 2011 it was 19,310 and for the first six months of 2012 it was 11,354.

Lifeline recently certified the Mental Health Association in New Jersey and the *University of Medicine & Dentistry in New Jersey (UMDNJ)* crisis call centers as members of the *Lifeline* Network. Both will provide backup coverage statewide only during specific days and hours.

Staffing & Training

2NDFLOOR Youth Helpline

On an average day, 1-6 staff and volunteers are required to operate the helpline. The agency has a total of 70 staff; 3 full-time, 22 part-time and 45 interns. Staff training includes youth specific topics such as bullying, self-harm, depression and anxiety. Training requirements conform to AAS standards.

MHANJ

Staffing consists of 8 full time and 10 part time staff, 6 staff for each shift. Staff members receive a minimum of 12 hours training.

NJ 2-1-1

Staffing consists of a total of 24 staff, four full-time and 20 part-time staff. The average number of hotline staff on a shift ranges from 1 to 14. New staff members receive a minimum of 48 hours of training, existing staff members receive 66 hours of annual in-service training.

NJ 2-1-1 Addictions

Staffing consists of a total of 16 staff, 4 full-time and 12 part-time staff. The average number of hotline staff per shift is 2-3. New staff members receive a minimum of 48 hours of training; existing staff receive 52 hours of annual in-service training.

CONTACT of Burlington County

Staffing data was not available. Training requirements conform to *CONTACT USA* requirements.

CONTACT of Mercer County

Staffing consists of 1 full-time and 80 part-time volunteer staff with 1 staff person for each shift. Training for all staff complies with *CONTACT USA* requirements.

CONTACT We Care

Staffing consists of 120 volunteers, 1 full-time and 3 part-time paid staff. Training for all staff complies with *CONTACT USA* requirements.

UMDNJ-UBHC

Cop2Cop

Total number of staff is 16 with new staff members receiving 20 hours of training and existing staff receiving 12 hours of annual continuing training.

Mom2Mom

Total number of staff is 12 with new staff members receiving 20 hours of training and existing staff receiving 12 hours of annual continuing training.

Vet2Vet

Total number of staff is 10 with new staff members receiving 20 hours of training and existing staff receiving 12 hours of annual continuing training.

Full-time paid staff for the New Jersey based crisis call centers ranges from 1 to 27. The three *CONTACT* agencies maintain a large volunteer staff, ranging from approximately 80 to 150. Staff training for new employees of New Jersey based crisis call centers, including volunteers, ranges from 6 to 46 hours. Annual on-going training ranges from a minimum of 6 to 66 hours.

Minimum training requirements include the following:

- Suicide risk assessment
- Emergency service linkages
- Listening/engagement
- Dealing with difficult callers
- Information and referral/resources

Youth specific services

New Jersey has had the lowest state-level adolescent suicide rate in the country for more than a decade.¹⁹ Additionally, there have been continuous youth suicide prevention efforts across various agencies and systems. Data from the 2011 New Jersey Student Health Survey reports for high school students since 1995:

- consideration of suicide dropped from 21.8% to 12.9%
- suicide planning fell from 16.3% to 10.9%
- suicide attempts dipped from 9.2% to 6.0%²⁰

The *2NDFLOOR* Youth Helpline is the Department of Children & Families’ primary suicide prevention hotline for all youth in the state of New Jersey. It began initially as a resource for youth aged 10-19 in 2003 serving three counties. It expanded its services in 2008 to youth ages 10-24, its hours to 24/7, and its coverage area to all 21 New Jersey counties. It was accredited in July 2011 by the *American Association of Suicidology (AAS)* as a suicide prevention hotline.

Table 3 provides a break down of *2NDFLOOR* calls by age and gender for the latest available year.

Table 3

Age	Gender			Grand Total	Percent of Total
	Female	Male	Unknown		
0 to 6	255	181	29	465	0.39%
7 to 9	776	577	79	1,432	1.19%
10 to 12	5,206	3,251	181	8,638	7.16%
13 to 15	14,913	8,542	379	23,834	19.75%
16 to 17	4,017	2,534	113	6,664	5.52%
18+	2,142	2,059	142	4,343	3.60%
Unknown	17,774	16,415	41,121	75,310	62.40%
Grand Total	45,083	33,559	42,044	120,686	100.00%
Percent Total	37.36%	27.81%	34.84%		

This interactive hotline is staffed by counseling professionals and specially trained volunteers providing immediate helpline response and linkage to information and services. Prior to its accreditation as a suicide prevention hotline, from July 2009-June 2011, over 33% of the calls received were in those areas identified as risk factors that are associated with suicidal behavior.

¹⁹ Guild, P.A., Freeman, V.A., Shanahan, E. *Promising Practices to Prevent Adolescent Suicide: What We Can Learn from New Jersey*. Cecil G. Sheps Center for Health Services Research. University of North Carolina at Chapel Hill.

²⁰ *Report on the 2011 New Jersey Student Health Survey of High School Students*. (May 2012) Conducted by the Bloustein Center for Survey Research, Edward J. Bloustein School of Planning and Public Policy. Available at <http://www.nj.gov/education/students/yrbs/index.html>

Research indicates youth and young adults are more likely to use the internet, text messaging or use other forms of social media for mental health, sexual health or wellness information.²¹ As part of its youth oriented response *2NDFLOOR* provides a message board and email options in addition to the crisis line. For calendar year 2011, it reported a total of 286,227 website sessions.

Other New Jersey based hotlines provide youth friendly services. These include *CONTACT We Care* with texting, a teen hotline and email; *CONTACT of Mercer* and *NJ 2-1-1* with online chat. *CONTACT of Burlington* has a TeenLine and is expecting its online chat to be available in 2013. Conversations with these agencies revealed that they have seen an increase in their youth contacts since implementing these services.

Of the data available for youth suicide related calls to hotlines for a 12 month period:

- *2NDFLOOR* reported of 118,095 youth calls, 29 or .025% were suicide related. *CONTACT We Care* reported of the 11,224 total calls about 13 or .11% were youth related suicide calls.

Of the data available for youth calls to hotlines for a 12 month period:

- *CONTACT of Mercer* reports 70% of its chats are from youth/young people engaged in or thinking about self harm such as cutting behaviors and suicidal ideation.
- *MHA-NJ* reported approximately 6,000 or 25% of its total calls were from child/youth/young adult.
- For State Fiscal Year 2011, the 23 designated screening centers provided slightly over 17,000 episodes of emergency mental health care involving children, ages 18 and younger.

Findings of the Suicide Prevention Hotline Survey

The purpose of this report was to “review the effectiveness and sufficiency of services provided by the New Jersey based suicide prevention hotlines.” The following conclusions are based upon the data provided by the seven agencies surveyed that offer crisis call services in New Jersey.

Data and Call Volume

Follow up conversations with the organizations indicate there is an increasing crisis call volume (this includes all calls) from previous years with data from *Lifeline* confirming this trend. Related to call volume and data is the various methods of data collection and reporting. Again, conversations with the organizations indicate their desire for a standard process of data collection and reporting. Throughout this process it was difficult, at best, to collect data and information. Crisis call data collection methods and reporting i.e. different age ranges, time periods etc., vary, based on available resources. Some organizations had sophisticated data collection and reporting systems which allowed them to provide data that other organizations could not hindering the analysis of any information received. Improving their capacity and standardizing the collection of data can improve the analysis of the information.

²¹ Keys, S.G., (March 2010) SAMHSA/CMHS Garrett Lee Smith Tribal Grantee Meeting. *Using New Media Strategically in Suicide Prevention Efforts*. Available at <http://www.sprc.org/news-events/conference/using-new-media-strategically-suicide-prevention-efforts>

Staffing, Training, Accreditation and Certification

All of the organizations provided training specific to cultural competence and all had some Spanish language ability, although the ability to provide services in other languages was varied. Some had access to a TTY line and some did not. All of the organizations strive to provide culturally competent services, in the language the caller is most comfortable speaking, with an individual who may require the use of a TTY line and to any population who may be at risk. It was not possible to review this area more thoroughly; although it was evident all of the organizations were maximizing available resources.

In general, differences were noted in organizations accredited by *CUSA* and *AAS*. These differences do not imply one accrediting organization is better than the other; only that there are differences and they should be considered when developing a hotline.

The composition of staff for *CUSA* accredited organizations was largely volunteers, whereas those organizations accredited by *AAS* were primarily paid professional staff. The *CUSA* standards and training requirements are more of a general helping model which may be better suited to an organization that has a large volunteer staff, from various backgrounds and minimal formal professional training as a counselor. The *AAS* standards and training requirements are a more therapy-like counseling model, which appear better suited for light counseling and for individuals with professional counseling training.

The organizations accredited by *CUSA* are primarily funded by foundations and private funding, with little or no government funding. *AAS* accredited organizations are primarily funded by government. Until recently, only the *CUSA* accredited organizations were members of *Lifeline* and *AAS* accredited organizations were not.

The *CUSA* accredited *Lifeline* members provide a significant service with limited funding and with staffing that is primarily volunteers. In general, a crisis call center's capacity was limited by its funding, language capacity, and the ability to collect and analyze more data to better understand community needs, and prioritize resources.

Until September 2012 there was only one *Lifeline* member providing in-state back-up coverage for the entire state, within limited hours. However, beginning in September 2012 the *Lifeline* network has the following coverage in New Jersey²²:

- Three in-state *Lifeline* members will provide statewide backup coverage Monday-Thursday between noon- 8 p.m.
- Two in-state *Lifeline* members will provide statewide backup coverage Monday-Friday between 8 a.m. - noon and Fridays between 8 a.m.- 8 p.m.
- One in-state *Lifeline* member will provide statewide backup coverage Monday-Sunday 7 a.m. - 8 a.m. and Monday-Sunday 8 p.m.(should this be a.m.??) - 11 p.m.

With the addition of the two in-state backup *Lifeline* members, New Jersey should see an increase in the number of calls that answered in-state. However, as reported by *Lifeline*, in general the highest call volume (peak hours) is between the hours of 8 p.m. and midnight; hours the two new *Lifeline* members

²² Please see the Overview of Existing New Jersey Crisis Hotline Services for more detail regarding coverage areas and times.

will not be operational. With the exception of Burlington County, there is no in-state *Lifeline* member providing primary or backup coverage Monday-Sunday 11 p.m. -7 a.m.

Prevailing thought regarding suicide prevention hotlines

Studies and practices regarding crisis hotlines that were reviewed for this report revealed the following findings:

- Significant decreases in suicidality and significant improvements in the mental state of youth during calls to hotlines.²³
- Seriously suicidal individuals are reaching out to telephone crisis services.²⁴
- Clinical effectiveness of the crisis intervention is consistent with the significant decreases in suicidality found during the course of the telephone session,²⁵ and the continuing decrease in callers' hopelessness and psychological pain in the weeks following the crisis intervention.²⁶
- Significant reductions in callers' psychological pain and hopelessness from the end of the call to follow-up.²⁷
- A need for consistent thorough assessment of a callers risk using evidence-based risk Suicide Risk Assessment Standards.²⁸

CONTACT USA, *AAS* and *Lifeline* standards criteria have been revised to incorporate these findings into their policies and procedures.

Current practices and standards of the New Jersey Surveyed Crisis Hotlines and follow up conversations with the respondents revealed the following:

- All of the hotlines and helplines have a policy for callers at imminent risk of suicide.
- All of the hotlines and helplines routinely utilize a screening/assessment instrument for callers.
- All of the hotlines and helplines are accredited or are in the process of accreditation.
- All of the hotlines and helplines are available 24/7 or have a system in place to respond to callers during those hours when they are not operational.
- All of the hotlines and helplines provide local resources and referrals to callers. All of the hotlines and helplines meet or exceed the staff training requirements of their accrediting body.
- All of the hotlines and helplines have a quality assurance process.
- Ten of the 11 providers routinely follow up with suicidal callers for those who provide contact information.
- Seven providers can transfer calls via a "warm line."

²³ King, R., Nurcombe, R., Bickman, L., Hides, L., & Reid, W. (2003). Telephone counseling for adolescent suicide prevention: Changes in suicidality and mental state from beginning to end of a counseling session. *Suicide and Life-Threatening Behavior*, 33, 400–411.

²⁴ Gould, M. S., Kalafat, J., Harrismunfakh, J. L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide & Life-Threatening Behavior*, 37(3), 338-52.

²⁵ Gould, M. S., Kalafat, J., Harrismunfakh, J. L. (2005) *Hotline Evaluation and Linkage Project*. Available at: http://www.samhsa.gov/Grants/2007/SummaryGould_Kalafat.pdf

²⁶ Gould, M. S., Kalafat, J., Harrismunfakh, J. L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide & Life-Threatening Behavior*, 37(3), 338-52.

²⁷ Ibid.

²⁸ Joiner, T., Kalafat, J., Draper, J., Stokes, H., Knudson, M., Berman, A., & McKeon, R. (2007). Establishing Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention *Lifeline*. *Suicide and Life-Threatening Behavior*, 37(3), 353–365.

Ways to improve NJ Crisis Hotline Services

- Strengthen the linkage between crisis hotlines and local community crisis intervention services.
- Uniform definitions, uniform data reporting, available technology.
- Enhance cultural competence including language, the deaf community and sexual orientation
- Enhance the use of the internet, text messaging and/or other social media.
- For *Lifeline*:
 - Provide statewide, in-state primary and/or backup coverage Monday-Sunday between
 - 11 p.m. – 7 a.m.
 - In its data collection, capture suicide-related calls instead of tracking simply the total number of calls received, no matter reason. Also, to the extent possible, capture demographic data of callers.

Looking ahead

DCF and DHS are committed to continued collaboration, whether through the issuance of a Request for Proposals or providing additional resources to existing contracted providers, to bolster the capacity of the network of New Jersey suicide prevention hotlines. Enhancing the strong network of existing service providers is critical to keeping New Jersey's service infrastructure strong and responsive, so that New Jersey residents are able to access appropriate prevention services during times of need.

Appendices

Appendix A Summary of Accreditation

Item	AAS	CUSA
Basic Eligibility Criteria:	<ul style="list-style-type: none"> ○ Offer crisis intervention services as primary focus or principal component of services offered ○ Must be an AAS organization member ○ Must be operational 24/7 	<ul style="list-style-type: none"> ○ Must have been in operation for at least one full year ○ Agree to the minimum CUSA operational standards ○ Must be operational during advertised hours
Accreditation/ Reaccreditation Cycle:	<ul style="list-style-type: none"> ○ First accreditation:3 years ○ Reaccreditation:5 years 	<ul style="list-style-type: none"> ○ First accreditation:5 years ○ Reaccreditation:5 years
Steps to Accreditation:	<ul style="list-style-type: none"> ○ Accept accreditation requirements ○ Complete pre-screening questionnaire ○ Provide organization documents per accreditation manual ○ Complete on-site visit and earn a passing score 	<ul style="list-style-type: none"> ○ 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:	<ul style="list-style-type: none"> ○ No time frame provided 	<ul style="list-style-type: none"> ○ Six (6) months
Accreditation Standard/ Requirements:	<ul style="list-style-type: none"> ○ 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 	<ul style="list-style-type: none"> ○ 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:	<ul style="list-style-type: none"> ○ 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 	<ul style="list-style-type: none"> ○ 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:	<ul style="list-style-type: none"> ○ Attitudinal Outcomes ○ Knowledge Outcomes ○ Skill Outcomes 	<ul style="list-style-type: none"> ○ Attitudinal Outcomes ○ Knowledge Outcomes ○ Skill Outcomes

Appendix B

Data Summaries

DATA SUMMARY 2NDFLOOR Youth Helpline

Funding & Services Areas	
Year established	2003 Youth Helpline, 2011 accredited as a suicide prevention hotline
Primary funding sources	Government
Service Area	Statewide
2010 Census ages10-24 population	1,726,672
Staffing	
Total number of staff	3 full time 22 part time
Total number of volunteers	45 interns
Average number Staff/Volunteers per shift	1-6
Staff Training	6 hours minimum
Hotline Information	
Average number of monthly calls	1,666
Average number of annual calls	200,000
Annual number of all suicide related calls	29 .0145%
Risk assessment administered	Yes
TTY	Yes
Method(s) used to serve non-English callers	Language line
Other Services	
Other services	Teen Hotline, Alcoholism Information, Child Abuse Counseling, Drug Information & Counseling, Sex Information, Mental Health Information & Referral, Sexually Transmitted Disease Information and General Crisis Hotline
Specified target groups	Youth & young adults ages 10-24

DATA SUMMARY CONTACT of Burlington County

Funding & Services Areas	
Year established	1972
Primary funding sources	Private, Foundation
Service Area <i>Lifeline</i>	Burlington
NJ 2-1-1 Service Area	Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem County
2010 Census Burlington County population	449,149
Adults age 18 & over	344,906
Youth age 17 & under	104,243
Staffing	
Total number of staff	Not Available
Total number of volunteers	Not Available
Average number Staff/Volunteers per shift	Not Available
Staff Training	Exceeds CONTACT USA requirements
Hotline Information	
Average number combined monthly calls	2,083
Average number combined annual calls	25,000
Annual number of all suicide related calls	50 (.2% of all calls)
CY 2011 Out-of State <i>Lifeline</i> calls	559
Total number 2011 <i>Lifeline</i> suicide related calls	Not Available
Annual number of youth suicide related calls	Not Available
Risk assessment administered	Yes
TTY	No
Method(s) used to serve non-English callers	Language Line
Other Services	
Other services	KidsLine, Reassurance, Information & Referral, Rape Care/sexual Assault, PetFriends, TeenLine, Outreach & Education and 2-1-1.
Specified target groups	

DATA SUMMARY CONTACT We Care, Inc.

Funding & Services Areas	
Year established	1975
Primary funding sources	Private, Foundation
Service Area	Essex, Middlesex, Morris, Somerset, and Union Counties
2010 Census for this service area	2,949,763
Adults age 18 & over	2,239,600
Youth age 17 & under	710,163
Staffing	
Total number of staff	1 Full Time. 3 Part Time
Total number of volunteers	120
Average number Staff/Volunteers per shift	2
Staff Training	Meets CONTACT USA requirements
Hotline Information	
Average number combined monthly calls	1,000
Average number combined annual calls	12,000
Annual number of all suicide related calls	641 (5.7% of all calls)
Annual number of youth suicide related calls	13 (2% of suicide related calls)
CY 2011 Out-of State <i>Lifeline</i> calls	9,444
Total number 2011 <i>Lifeline</i> suicide related calls	Not Available
Risk assessment administered	Yes-ASIST
TTY	No
Method(s) used to serve non-English callers	<i>Lifeline</i> Spanish language line
Other Hotline Services	
Other services	Mental Health I & R, Teen Hotline, General Crisis Hotline, Outreach Program, Texting Services & Suicide Prevention Training
Specified target groups	

DATA SUMMARY CONTACT of Mercer County

Funding & Services Areas	
Year established	1975
Primary funding sources	Mercer County
Service Area	Mercer County & 609 Area Code
2010 Census Mercer County Only	366,789
Adults age 18 & over	283,807
Youth age 17 & under	82,982
Staffing	
Total number of staff	1
Total number of volunteers	80
Average number Staff/Volunteers per shift	1
Staff Training	Meets CONTACT USA requirements
Hotline Information	
Average number combined monthly calls	900
Average number combined annual calls	11,000
Annual number of all suicide related calls	300 (2.7% of all calls)
Annual number of youth suicide related calls	Not Available
CY 2011 Out-of State <i>Lifeline</i> calls (Mercer County only)	727
Total number 2011 <i>Lifeline</i> suicide related calls	Not Available
Risk assessment administered	Yes
TTY	No
Method(s) used to serve non-English callers	<i>Lifeline</i> Spanish language line
Other Services	
Other services	Monthly survivors group, General Crisis, RSVP, Telephone Reassurance and CrisisChat.
Specified target groups	

DATA SUMMARY Mental Health Association in New Jersey, Inc.

Funding & Services Areas	
Year established	1948
Primary funding sources	Government
Service Area	Statewide
2010 Census Statewide	8,801,624
Staffing	
Total number of staff	18
Total number of volunteers	0
Average number Staff/Volunteers per shift	6
Staff Training	12 hours minimum
Hotline Information	
Average number of monthly calls	2,000
Average number of annual calls	24,000
Annual number of all suicide related calls	1,200 (5% of all calls)
Annual number of youth suicide related calls	Not Available
Risk assessment administered	Yes
TTY	Yes
Method(s) used to serve non-English callers	Language Line
Other Services	
Other services	Mental Health information & Referral, Alcoholism Information, General Victim
Specified target groups	

DATA SUMMARY New Jersey 2-1-1 Partnership

Funding & Services Areas	
NJ 2-1-1 Partnership Year established	1981-Initial 2005-Statwide
Primary funding sources	Government
Secondary funding sources	Private
Service Area	Statewide
2010 Census Statewide	8,801,624
Staffing	
NJ 2-1-1 Partnership Total number of staff	24
Total number of volunteers	0
Average number Staff per shift	1-14
Staff Training	48 hours minimum
Hotline Information	
Average number of monthly calls	9,000
Average number of annual calls	108,000
Annual number of at risk emergent/urgent calls	100 Urgent/Emergent (.09% of all calls)
Annual number of all suicide related calls	Not Available
Annual number of youth suicide related calls	Not Available
Risk assessment administered	Yes
TTY	Yes
Method(s) used to serve non-English callers	Language Line
Other Services	
Other services	Addictions Helpline, Disaster Preparedness & Response and on line CrisisChat
Specified target groups	None

DATA SUMMARY New Jersey 2-1-1 Addictions

Addictions Funding & Services Areas	
Year established	November 2011
Primary funding sources	Government
Service Area	Statewide
2010 Census Statewide	8,791,894
Staffing	
Total number of staff	16
Total number of volunteers	0
Average number Staff/Volunteers per shift	2-3
Staff Training	48 hours minimum
Hotline Information	
Average number of monthly calls	1,100
Average number of annual calls	13,000
Annual number of at risk emergent/urgent calls	100 Urgent/Emergent (.77% of all calls)
Annual number of all suicide related calls	Not Available
Annual number of youth suicide related calls	Not Available
Risk assessment administered	Yes
TTY	Yes
Method(s) used to serve non-English callers	Language Line
Other Services	
Other services	Disaster Preparedness & Response and on line CrisisChat
Specified target groups	

DATA SUMMARY UMDNJ-UBHC Cop2Cop

Funding & Services Areas	
Year established	2000
Primary funding sources	Government
Service Area	Statewide
Staffing	
Total number of staff	16
Total number of volunteers	0
Average number Staff/Volunteers per shift	Not Available
Staff Training	20 hours new staff &12 hours ongoing
Hotline Information	
Average number of monthly calls	490
Average number of annual calls	5,888
Annual number of at risk emergent/urgent calls	318 (5.4% of all calls)
Annual number of all suicide related calls	Not Available
Risk assessment administered	Yes
TTY	No
Method(s) used to serve non-English callers	Translation service-Auracom
Other Services	
Other services	Community Support Groups
Specified target groups	Law enforcement officers & family

DATA SUMMARY UMDNJ-UBHC Mom2Mom

Funding & Services Areas	
Year established	
Primary funding sources	Government
Service Area	Statewide
Staffing	
Total number of staff	12
Total number of volunteers	0
Average number Staff/Volunteers per shift	Not Available
Staff Training	20 hours new staff &12 hours ongoing
Hotline Information	
Average number of monthly calls	676
Average number of annual calls	8,123
Annual number of at risk emergent/urgent calls	108 (1.32% of all calls)
Annual number of all suicide related calls	Not Available
Annual number of youth suicide related calls	Not Available
Risk assessment administered	Yes
TTY	No
Method(s) used to serve non-English callers	Translation service-Auracom
Other Services	
Other services	Community Support Groups
Specified target groups	Mothers of children with special needs

DATA SUMMARY UMDNJ-UBHC Vet2Vet

Funding & Services Areas	
Year established	
Primary funding sources	State & Private
Service Area	Statewide
Staffing	
Total number of staff	10
Total number of volunteers	0
Average number Staff/Volunteers per shift	Not Available
Staff Training	20 hours new staff &12 hours ongoing
Hotline Information	
Average number of monthly calls & chats	286
Average number of annual calls & chats	3,441
Annual number of at risk emergent/urgent calls	34 (.99% of all calls)
Annual number of suicide related calls	Not Available
Risk assessment administered	Yes-General symptom severity, suicide risk assessment, depression & anxiety
TTY	No
Method(s) used to serve non-English callers	Translation service-Auracom
Other Services	
Other services	On line chat
Specified target groups	Veterans & family

Appendix C Suicide Prevention Hotline Survey

We ask that you complete the survey to the best of your ability. If it is easier and more expedient to provide information from your most recent annual report, please do so.

If the Hotline is part of a larger Agency, Please provide the following information:

Agency Name: _____
Executive Director: _____
Address: _____

Phone Numbers: _____
Website: _____ Email: _____

PROGRAM INFORMATION

Name of Program: _____
Address: _____
Contact Person: _____
E-mail of contact person: _____
Business Telephone: _____
Service Area: _____

If different than above please provide the following for the person completing this survey:

Name: _____
Email: _____
Telephone: _____ Cell: _____

Our program/organization is accredited by (check all that apply):

AAS AIRS CONTACT USA CARF
 JCR COA Other-Please Identify: Not accredited

Is your hotline a member of the *Lifeline* Network? Yes No
If not, are you interested in membership to the *Lifeline* Network? Yes No
If there is no interest in *Lifeline* Network membership, please provide a short explanation (e.g. cost, outside agency scope of services)

Date hotline program was established: _____

Current Annual Budget: _____

List major funding sources:

1 _____
2 _____
3 _____
4 _____

OPERATIONS

1. Check all services provided. Double-check those considered major or objectives:

<input type="checkbox"/> Suicide Prevention Hotline <input type="checkbox"/> Teen Hotline <input type="checkbox"/> Alcoholism Information Service <input type="checkbox"/> General Victim Services <input type="checkbox"/> Drop In Center <input type="checkbox"/> Compassionate Friends <input type="checkbox"/> Child Abuse Counseling <input type="checkbox"/> Drug Information Service <input type="checkbox"/> Sex Information <input type="checkbox"/> Mental Health I & R <input type="checkbox"/> Mobile outreach <input type="checkbox"/> Vet 2 Vet <input type="checkbox"/> Cop 2 Cop <input type="checkbox"/> Other Please identify: _____	<input type="checkbox"/> Rape Crisis Counseling <input type="checkbox"/> Survivors of Suicide Support Group <input type="checkbox"/> Sexually Transmitted Disease Info <input type="checkbox"/> Face to Face Counseling <input type="checkbox"/> General Grief Support Groups <input type="checkbox"/> General Crisis Hotline <input type="checkbox"/> Teen to Teen Hotline <input type="checkbox"/> Substance Abuse Counseling <input type="checkbox"/> Outreach Program <input type="checkbox"/> Domestic Violence <input type="checkbox"/> 211 <input type="checkbox"/> Mom 2 Mom
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2. Does the agency have dedicated staff, policies & procedures and supervisory personnel, specific to the suicide prevention hotline? Yes No

3. Does your hotline operate 24/7? Yes No
 If not, are calls forwarded to another location? Yes No
 Please list location(s): _____

4. Which of the following best describes your hotlines linkages with other local Agencies/Organizations:
 - Formal (e.g. Memorandum of Understanding)
 - Informal (e.g. referral to local services)
 - None (e.g. do not routinely refer to local services)

5. Does your hotline routinely follow up with suicidal callers? Yes No
 If yes, please describe: **Provide the percentage or number of follow up calls one month later for those who provide contact information.** _____

6. Does your hotline have a policy for callers at imminent risk of suicide? Yes No
 If yes, please attach a copy.

7. Does your hotline have the ability to warm-line transfer a call? Yes No
 If yes, please check all that apply:
 Cop 2 Cop Mom 2 Mom Vet 2 Vet
 Other (Please list): _____

STAFFING AND TRAINING

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

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

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

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

10. Total hotline Staff: _____ Full Time _____ Part-Time _____ Volunteer _____

Hotline Staff with Degrees in Mental Health Disciplines:

Total: _____ Full Time _____ Part-Time _____ Volunteer _____

11. a. **Suicide hotline workers only** (place # of staff in appropriate box)

Status	Non-Mental Health Professional	Mental Health Professional (Bachelor's Level)	Mental Health Professional (Master's or above)
Full-time			
Part-time			
Volunteer			

- b. **Suicide hotline supervisors only** (place # of staff in appropriate box)

Status	Non-Mental Health Professional	Mental Health Professional (Bachelor's Level)	Mental Health Professional (Master's or above)
Full-time			

Part-time			
Volunteer			

12. Please indicate the average number of workers for your hotline on each shift.

QUALITY ASSURANCE

13. Does your hotline have a quality assurance structure? Yes No

If your hotline has a quality assurance structure (check all that apply):

- Checking documentation
- Checking compliance with policies and procedures
- Monitoring of staff's responses to callers

14. If your hotline routinely 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

15. a. Supervision for hotline staff occurs (check all that apply):

- Weekly Monthly Quarterly Other
- As Needed (please describe) _____

b. Supervision of hotline staff is provided by (check all that apply)

Status	Non-Mental Health Professional	Mental Health Professional (Bachelor's Level)	Mental Health Professional (Master's or above)
Full-time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Part-time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Volunteer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. 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

TECHNOLOGY AND DATA

17. Does your hotline use any of the following to manage incoming calls?

- Automated Attendant Automatic Call Distribution
- Answering Machine None of the above

18. Does your hotline forward overflow calls to another location? Yes No

If yes, Please list location(s): _____

19. Does your hotline utilize a 911 locator? Yes No
20. Do you have a dedicated line for the *Lifeline* Network? Yes No
 If not, would you consider establishing a dedicated line if the funds were provided to you to do so? Yes No
 If not, please explain why: _____

21. 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: _____

22. Do you have a texting or social media component? Yes No
 If yes please check all that apply:
 Texting On line chat
 Other (Please identify) _____

23. 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, please describe any limitations (e.g. shared computers, dial-up connection below):

24. What kind of data are you collecting? (check all that apply)
 Personal/Demographic Geographic
 Symptoms Referrals
 Other screening/assessment information

25. How does your hotline 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): _____

26. Please note below all language capabilities your hotline's staff can provide directly to callers.

Languages	Dedicated Line (Note Hours of Operation)	No Dedicated Line (Note Capacity)
Spanish		
Other(s)		

27. Do you have access to translation services for all languages? Yes No

If yes, indicate name of language service.

28. Do you have a TTY line?
Is it a dedicated line?
If yes, please indicate the number

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

29. Call Volume
Average # Monthly Calls _____ Average # Annual Calls _____

30. If available please provide the following data for the most recent calendar year. Please identify year.

Year: _____

Youth/Young Adult 24 & under	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total Calls													
Total Conversations													
Total Abandoned													
Total Talk Time in Minutes													
Average Wait Time in Seconds													
Total Website Sessions													

Adult 25 and Older	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total Calls													
Total Conversations													
Total Abandoned													
Total Talk Time in Minutes													
Average Wait Time in Seconds													
Total Website Sessions													

Caller Age-as reported by caller	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
0-6													
7-9													
10 to 12													
13 to 15													
16 to 17													
18 to 24													
25 and older													
Grand Total													

Call Categories	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Suicidal													
Friend Suicidal													
Mental Health other than suicide													
Substance Use/Abuse													
Bullying													
Other													
Total Conversations													

Calls by age and gender (for the latest available year)

Age	Gender			Grand Total
	Female	Male	Unknown	
0 to 6				
7 to 9				
10 to 12				
13 to 15				
16 to 17				
18 to 24				
25 and older				
Unknown				
Grand Total				

Please provide the following information for ages 0 to 24

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
# calls answered in New Jersey													
% calls answered in New Jersey													
# calls answered in other state													
% calls answered in other state													

Please provide the following information for ages 25 and older

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
# calls answered in New Jersey													
% calls answered in New Jersey													
# calls answered in other state													
% calls answered in other state													

31. Please provide any suggestions you may have to improve the sufficiency and effectiveness of New Jersey’s Suicide Prevention Hotlines.

32. Please feel free to discuss any trends you have seen concerning calls.
