

ORIGINAL ARTICLE

Third-party callers to the national suicide prevention lifeline: Seeking assistance on behalf of people at imminent risk of suicide

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Abstract

Objective: To assist suicidal individuals, people in their social network are often directed to the National Suicide Prevention Lifeline (Lifeline). The study's objective was to provide information on third-party calls made out of concern for another person.

Method: Reports on 172 third-party calls concerning individuals deemed to be at imminent suicide risk were completed by 30 crisis counselors at six Lifeline crisis centers.

Results: Third-party callers were most likely to be calling about a family member or friend and were significantly more likely than persons at risk to be female and middle-aged or older. Counselors were able to collect information about suicide risk, and counselors and third-parties were nearly always able to identify at least one intervention to aid the person at risk. Emergency services were contacted on 58.1 percent of the calls, which represents a somewhat higher rate of emergency services involvement than previously reported on imminent risk calls placed by the person at risk. Characteristics of third-parties and persons-at-risk each predicted emergency service involvement, but counselor characteristics did not. Non-emergency interventions were implemented on 68.6 percent of calls.

Conclusions: Individuals calling the Lifeline when they are worried about someone are provided a range of interventions which can supplement, and at times replace, calling 911.

INTRODUCTION

Suicide continues to be a major public health problem in the United States, with rates increasing more than 35% between 1999 and 2019, the year for which the latest data are available (Drapeau & McIntosh, 2020). Suicide was the 10th leading cause of mortality in 2018, claiming over 48,000 lives. Moreover, in 2018 approximately 10.7 million adults had thought seriously about killing themselves (4.2% of adults), 3.3 million had made suicide plans (1.3%) and 1.4 million made a nonfatal suicidal attempt (0.6%) (Substance Abuse & Mental Health Services Administration, 2019, 2020). Enhancing help-seeking is a key strategy to address the rising rates of suicidal behavior. However, of concern is the finding that negative help-seeking attitudes are greatest among individuals with the greatest mental health needs (Hoge et al., 2004; Mackenzie et al., 2008; Mojtabai et al., 2002). Much evidence indicates that suicidal individuals negate, refuse, or avoid available help (“help negation effect”; e.g., Dean et al., 2001; Rudd et al., 1995). Furthermore, low perceived need for services has been reported as the most important reason that suicidal individuals do not seek help (Bruffaerts et al., 2011; Gould et al., 2012; Han et al., 2014).

Given the reluctance of many suicidal individuals to seek help for themselves, suicide prevention initiatives often encourage people in the social networks of at-risk individuals to seek help on their behalf. This is one underlying premise of gatekeeper training programs (e.g., Gould et al., 2013; Wyman et al., 2008) and public messaging that directs individuals to the National Suicide Prevention Lifeline (Lifeline) when they are worried about a friend or family member. Working with individuals calling on behalf of someone else (“third-party callers”) is as much a Lifeline priority as working with individuals calling on their own behalf (“direct callers”). It is believed that those who do not call on their own behalf may be at higher risk of suicide than those who do (Mishara et al., 2005). As such, a particular emphasis of Lifeline interventions is to collaborate with third-party callers to help individuals at imminent risk of suicide who have not themselves reached out to the Lifeline. Lifeline's policy for helping callers at imminent risk of suicide recommends that the crisis counselor “practice active engagement with persons calling on behalf of someone else (“third-party callers”) toward determining the least invasive most collaborative actions to best ensure the safety of the person at risk.” (Draper et al., 2015, p. 264). The Lifeline's Tip Sheet for Working with Third-Party Callers (National Suicide Prevention Lifeline, 2019) includes the following advice to crisis counselors:

1. gather sufficient information from the third party to gauge the safety and severity of the risk of the person of concern, including an evaluation of the source and validity of the information;
2. gather contact information and any identifying information about the person at risk that the third party is able to share;
3. coach the third-party caller on how they might best talk to the person at risk and how they might help the person connect to more help. This may include facilitating a three-way call with the third-party caller, the person reported to be at risk and the crisis counselor (or a treatment professional working with the person at risk); removing access to lethal means; maintaining close watch on the person at risk; escorting the person at risk to a emergency care facility;
4. reach out directly to the person at risk to offer assistance, when the third-party caller is unwilling or unable to take further steps to keep the person at risk safe;
5. Contact 911 if the risk is imminent and other solutions are not possible to keep the person at risk safe.

Preliminary data from the Lifeline network of over 165 crisis centers indicate that approximately 25% of calls are from a third party (National Suicide Prevention Lifeline, 2011). Given nearly 2.2 million calls to the Lifeline in 2019 (personal communication, National Suicide Prevention Lifeline), there would have been approximately 550,000 third-party calls that year. This number is apt to increase given the increased visibility and accessibility of the Lifeline that would result from establishing a new three-digit number (988) for a national suicide prevention and mental health crisis hotline, as signed into law in October 2020 (National Suicide Hotline Designation Act of 2020; <https://www.congress.gov/116/plaws/publ172/PLAW-116publ172.pdf>). This makes the evaluation of services provided to third-party callers of critical import. However, to date, the evaluations of the Lifeline (e.g., Gould et al., 2016) have focused only on “direct” callers who call on their own behalf. There has been no evaluation of the interventions with third-party callers to the Lifeline network. Moreover, there is little existing information on third-party callers in the literature. Mishara et al. (2005) compared the effect of four suicide prevention programs in Quebec for family and friends who called on behalf of suicidal men who did not seek help for themselves. Follow-up with 131 third-party participants found that all four interventions resulted in reductions in suicidal ideation, suicide attempts, and depressive symptoms in the suicidal men about whom they were concerned. Mishara et al. (2005) also reported on the 1998 program development of the services to third-party callers that laid the groundwork for their intervention study. They reported that in the 1998 investigation of 321 third-party calls, women made up three-quarters of the callers, but over half of the third-party calls (51%) concerned a suicidal man. The vast majority (75%) of the calls gave the third-party callers information about how to help

the suicidal person. The remaining 25% of calls focused on the third party's expressing their own feelings. This is the extent of the existing research specifically focusing on third-party callers. To date, there is no information about the nature of the relationships between the third-party callers and the people they were calling about, the extent to which counselors are able to assess someone's suicide risk based on third-party reports, and the interventions that the counselors and third-party callers engaged in to enhance the safety of the persons at risk.

The current study addresses the sparsity of information about third-party calls to crisis hotlines by describing the demographics of the third-party callers and the persons at risk, the relationship between the third-party callers and the persons at risk, the source of the third-party callers' information about the persons at risk, the suicide risk characteristics of the persons at risk based on third-party reports, and the interventions implemented on third-party calls, with particular emphasis on interventions involving emergency services, their predictors, and their outcomes (e.g., whether the emergency service located the person at risk, and whether the person at risk was transported to a hospital). Our study focuses on third-party calls concerning a particularly high-risk group—individuals deemed by crisis counselors to be at imminent risk of suicide (Draper et al., 2015). Information on the characteristics of third parties and the individuals they call about, and on the types of assistance Lifeline counselors are able to offer third-party callers will provide an empirical foundation for the Lifeline's continuing efforts to enhance the safety of persons at risk of suicide who are not seeking help for themselves.

METHODS

Sample

Crisis centers

Building upon our previous data collection of imminent risk calls at eight Lifeline centers (Gould et al., 2016), crisis counselors at a new sample of eight Lifeline centers were recruited for the current study based on centers' responses to the Lifeline's 2015 Crisis Center Survey. Selection criteria included center's call volume, census region, and whether or not the center used volunteers to answer crisis calls. The goal was to select centers which were broadly representative of the diversity of Lifeline crisis centers overall. Also based on centers' responses to Lifeline's 2015 Crisis Center Survey, we selected only centers which had not made regular use of the Lifeline's on-line caller simulation training for crisis helpers ("Lifeline

Caller Simulation"). Lifeline had informed us of their plan to actively promote the Lifeline Caller Simulation during our study period. By selecting centers not already exposed to the training prior to this upcoming promotion effort, we anticipated that our sample would include sufficient variability in counselors' exposure to this training to allow us to examine its impact on counselors' interventions. Our evaluation of the Lifeline Caller Simulation is the focus of another paper. The recruitment of the eight centers focused on their ability to provide data on imminent risk callers calling on their own behalf. Six of the eight centers also provided data on third-party callers calling about someone deemed by the counselor handling the call to be at imminent risk. Two centers' protocols did not include assessing the suicide risk of individuals who were the focus of a third-party caller's concern, but who did not themselves participate in the call.

Crisis counselors

All counselors at participating centers responsible for answering calls to the Lifeline and the centers' local crisis lines were eligible for participation in the study. Of the 92 participating counselors, 30 (33%) ultimately completed questionnaires on at least one third-party imminent risk call. The remaining participating counselors did not answer a third-party imminent risk call during the data collection period. Of the 30 counselors, all were paid employees. Less than 14% of the counselors did not have bachelor's degrees, over 48% had bachelor's degrees as their highest level of education, and approximately 36.6% had graduate degrees. One-third were licensed clinicians/mental health professionals. Counselors had spent an average of 79.6 months working as telephone crisis counselor (range: 8–260 months), spent an average of 23 hours per week answering calls (range: 2–42 h), and handled an average of 7.5 suicide calls per week (range: 1–20).

No clinical training was provided as part of the current project. Participating counselors had all received Lifeline-approved trainings at their centers and had diverse histories of participation in supplementary trainings and experience providing systematic follow-up to suicidal callers. Either Applied Suicide Intervention Skills Training (ASIST, Gould et al., 2012) or training in safety planning protocols (other than those derived from ASIST) were completed by approximately 80% of counselors. Most counselors reported using safety planning protocols developed at their crisis centers, with smaller numbers reporting using protocols derived from ASIST, or from the Safety Planning Intervention developed by Stanley and Brown (2012). Approximately midway through data collection, 40% of the counselors made use of one or more modules of the

Lifeline Caller Simulation. The impact of this training is the focus of another paper.

Calls from third-party callers concerned about individuals at imminent risk of suicide

Over the course of data collection, which took place from December 2016 through October 2018 and spanned between 12 and 18 months at each center, counselors handled 172 calls from third-party callers concerned about individuals the counselors considered to be at imminent risk. Each counselor answered a median of three third-party calls (range = 1 to 39; interquartile range = 8). Due to the lack of identifying information collected on callers, we are unable to say whether our sample included more than one call from the same individual. The unit of analysis is therefore not the imminent risk third-party caller, but the imminent risk third-party call.

Procedures

Counselors were asked to complete an assessment similar to the one employed in our earlier imminent risk protocol evaluation (Gould et al., 2016). At the outset of data collection at each center, information on participating counselors' training and experience as a telephone crisis counselor was obtained from counselors and/or from their centers' supervisory staff (see *Counselor Questionnaire* below). Thereafter, for the duration of the data collection period, counselors were asked to provide information about each call from an individual they deemed to be at imminent risk of suicide or from a third party concerned about someone the counselor deemed to be at imminent risk. The primary means of data collection was for the counselor handling the call to complete our evaluation questionnaire using REDCap, a secure online data entry platform. According to center preference, at some centers where the centers' own record-keeping contained the data elements necessary for the evaluation or was programmed at the outset of data collection to do so, the data were transcribed from the counselor's record into REDCap by center supervisory staff. Because a goal of the study was to assess the extent to which counselors were adhering to the Lifeline policy on helping imminent risk callers, with which the counselors were expected to be familiar, counselors were not instructed by research staff in how to define imminent risk. Instead, counselors were instructed to use and to document on their questionnaires, their own understanding of this term. Counselors were instructed not to use the questionnaire as an interview, or to collect any data directly from the callers for study purposes. Instead, counselors were instructed to conduct the calls according to their center's protocols and their own clinical judgment and to describe their perception

of and intervention with the caller immediately after the intervention was completed.

Measures

The *Counselor Questionnaire*, developed for our earlier Lifeline evaluations (e.g., Gould et al., 2016), asked the counselors to describe their employment status at their center (whether paid employee, volunteer, and/or supervisor/trainer), how long they had been working/volunteering as a telephone crisis counselor, the average number of hours per week they spent answering crisis lines, the average number of suicide calls they handled per week, their highest level of education, whether they were licensed clinicians/mental health professionals, whether they had completed training in ASIST or in the use of any other Safety Planning protocols, and whether they made use of the Lifeline Caller Simulation during the study period.

The *Imminent Risk Form* expanded the questionnaire we employed in our earlier study (Gould et al., 2016) and contained questions relevant to the present analyses that fell into the following categories: (a) information about the third-party caller (including gender, age, location, relationship to the person at risk, and source of information about the person at risk); (b) demographics of the person at risk (including gender, age, and location); (c) suicide risk characteristics of the person at risk, including the components of suicidal "desire" (suicidal ideation, hopelessness, helplessness, feeling trapped, feeling alone, perceived burden, psychological pain, reasons for dying); suicidal "intent" (attempt in progress, plan to kill self, method chosen, preparatory behaviors, expressed intent to die, timeframe for acting on thoughts); and suicidal "capability" (history of suicide attempts, means available, current intoxication, history of substance abuse, exposure to someone else's death by suicide, recent dramatic mood change, being out of touch with reality, agitation/restlessness, aggression/anger, sleep problems, history of violence toward others, impulsive/reckless behavior) (Joiner et al., 2007); (d) interventions implemented by the third party or by the counselor working with the third party, and (e) outcomes of interventions involving emergency services (including whether emergency services were dispatched, whether the person at risk was located, transported to the hospital, and admitted to the hospital). The content of our assessment form was guided by Lifeline's guidelines and policies for helping callers at imminent risk of suicide, and suicide risk assessment standards (described in Draper et al., 2015), which have been disseminated to the Lifeline network of crisis centers. The answers to our questionnaire were entered online using REDCap after the call and did not require direct data collection from callers. Anonymity of the individuals at risk and of the third-party callers was maintained.

The project's protocol was approved by the Institutional Review Board of the New York State Psychiatric Institute and the Department of Psychiatry of Columbia University.

Statistical analyses

Analyses were performed on 172 Imminent Risk Forms completed by 30 crisis counselors on third-party calls at six centers. Analyses were performed in SPSS version 26 (Copyright 2009, IBM Corp.) and SAS version 9.4 (Copyright 2013, SAS Institute, Inc.). First, the demographic characteristics of the third-party callers and the persons at risk were described. Each third-party caller was linked to a person at risk they were calling about, so paired McNemar chi-square tests were employed to test the statistical differences between the third-party callers and persons at risk on dichotomous characteristics (e.g., gender and location) and the paired Wilcoxon test was used to test the difference in an ordinal characteristic (e.g., age). Second, descriptive statistics of the suicide risk characteristics of the persons at risk and the interventions on third-party calls were calculated. Next, we modeled the odds of any emergency services involvement (emergency services contacted by the counselor or third party) as a function of the characteristics of the third party, person at risk, and counselor, using mixed effect logistic regression models. A counselor-specific random intercept effect was included to account for variability shared by callers handled by the same counselor. Given the small number of centers and the skewed distributions of the number of counselors and calls by center, it was not possible to account for the variability shared by callers and counselors in the same center through

a random effect on a second level (i.e., nesting the counselor effect within the center effect). Instead, center was adjusted for by including it as a fixed effect predictor in all models. Each third party, person at risk, and counselor characteristic was tested individually as a fixed effect predictor of emergency services involvement. The predictor variables were either binary or categorical, with the exception of the number of months that the counselors worked as a crisis counselor, number of hours that the counselors answered calls per week, and number of suicide calls answered per week which were continuous variables. Binary and categorical variables had to have at least five percent in each response category and less than 50% missing responses to be included in the mixed effect logistic regression models.

RESULTS

Demographic description of third-party callers and persons at imminent risk

In the sample of 172 third-party imminent risk calls handled by the crisis centers, third-party callers were older and more likely to be female than the individuals at risk about whom they were concerned (see Table 1). Approximately two-thirds of the third-party callers and persons at risk were located within the center's main coverage area, and they were usually co-located either within or outside the center's main coverage area (92.5%).

Most third parties were calling either about a member of their family ($n = 80$; 46.5%; including primarily members of their nuclear family: $N = 70$; 40.7%), or about a friend

TABLE 1 Description of third-party callers and persons at risk

	Third-party caller $N = 172$ (%)	Person at risk (object of third party's concern) $N = 172$ (%)	Test statistic and p value
Gender			
Male	56 (32.6)	111 (64.5)	McNemar's $\chi^2 = 33.72$ $p < 0.0001$
Female	116 (67.4)	59 (34.3)	
Transgender	0	1 (0.6)	
Unknown	0	1 (0.6)	
Age ^a			
High school student or younger	17 (13.0)	27 (20.6)	Wilcoxon Test $Z = 3.83$ $p < 0.0001$
Young adult	56 (42.7)	72 (55.0)	
Middle-aged	55 (42.0)	28 (21.4)	
Senior	3 (2.3)	4 (3.1)	
Location ^b			
Within center's state or area	90 (67.7)	84 (63.2)	McNemar's $\chi^2 = 2.50$ $p = 0.115$
Outside center's state or area	43 (33.3)	49 (36.8)	

^aInformation on age of both the third-party caller and person at risk was available for 131 calls.

^bInformation on the location of both the third-party caller and person at risk was available for 133 calls.

($n = 70$; 40.7%). The remaining types of people ($n = 22$; 12.8%) about whom third parties placed calls included their child's friend, or a professional contact such as a client, patient, student, or co-worker.

The most common source of the third party's information about the person they were calling about was face-to-face contact with that person, a source endorsed for more than a third of the third-party imminent risk calls ($n = 63$; 36.6%). Other common sources of information were text messaging ($n = 37$; 21.5%), telephone calls ($n = 32$; 18.6%), and social networking websites ($n = 26$; 15.1%). Less frequent sources were second-hand reports ($n = 15$; 8.7%) or other sources ($n = 3$; 1.7%) (e.g., online games, suicide note). For 13.4% of the third-party calls, the source of the information about the person at risk was unknown. Family members were more likely than friends or others (57.5%, 15.7%, and 27.3%, respectively) to base their information on face-to-face contact with the person at risk ($\chi^2 = 29.03, p < 0.001$).

Suicide risk characteristics of persons at imminent risk based on third-party reports

Based on the information provided by third-party callers, counselors were able to ascertain the presence of suicidal desire (92.4%), intent (90.7%), and capability (82.0%) in the persons at risk, with all three components of suicide risk assessed as present in 70.9% of calls. The presence of suicidal desire was largely accounted for by the coding of suicidal ideation (90.7% of persons at risk). Information on each of the remaining seven desire items was unavailable for approximately one-half to three-quarters of calls, indicating the counselors' difficulty in ascertaining these risks based on the third-party's reports. The presence of suicidal ideation largely reflected expressed intent to die on the part of the person at risk (84.9%). A substantial proportion of third parties also reported that the persons at risk had plans to kill themselves (62.8%) and had chosen a method (52.3%). Nearly half of the persons at risk either had an attempt in progress (18%) or planned on acting on their suicidal thoughts within a few hours (37.6% of calls without an attempt in progress; or 30.8% of all calls). Information on the one remaining intent item was unavailable for more than 50% of calls. There was more variability in the coding of the 12 capability items than in the desire and intent items, with available means (46.5%), recent dramatic mood change (39.5%), agitation/restlessness (36.6%), impulsive/reckless behavior (29.7%), and history of suicide attempts (27.3%) being the most frequently reported by the third-party callers. Information on the remaining seven capability items was unavailable for more than 70% of calls.

TABLE 2 Interventions on Third-Party Imminent Risk Calls ($N = 172$)

Intervention	<i>N</i> (%)
Counselor...	
Emergency intervention	
Contacted emergency services	45 (26.2)
Auxiliary intervention	
Provided third party with information on emergency services	22 (12.8)
Non-emergency interventions	
Contacted mobile outreach	48 (27.9)
Encouraged third party to have person at risk contact Lifeline	17 (9.9)
Provided third party with information on local resources (clinic/ER)	12 (7.0)
Provided third party with information on mobile outreach	8 (4.7)
Contacted person at risk	4 (2.3)
Took other steps	9 (5.2)
Third party agreed to...	
Emergency intervention	
Contact emergency services	57 (33.1)
Auxiliary intervention	
Join a three-way call with emergency dispatch ^a	8 (4.7)
Non-emergency interventions	
Maintain watch on person at risk	18 (10.5)
Speak with person at risk ^a	13 (7.6)
Escort person at risk to a hospital/ED	12 (7.0)
Involve another third party ^a	12 (7.0)
Collaborate with mobile outreach	9 (5.2)
Remove access to lethal means	8 (4.7)
Encourage person at risk to contact the Lifeline ^a	6 (3.5)
Participate in some other intervention ^b	17 (9.9)

^aThese four interventions were not included on the instrument but were written in by counselors under "third party agreed to participate in some other intervention."

^bOther steps the third party agreed to take, as written in by the counselors, but not specified in the table above, included the third party agreeing to contact the person at risk's treatment professional, the third party agreeing to encourage the person at risk to go to an ED, and the third party's agreeing to make a report on social media (e.g., reporting a post in Facebook) regarding their concern for the person at risk.

Interventions on third-party calls on behalf of person at imminent risk

Crisis counselors and third-party callers were able to collaborate on the implementation of measures to ensure the safety of individuals at risk on nearly all calls. Crisis counselors alone took some action on 53 calls (30.8%),

third parties alone agreed to take some action on 76 calls (44.2%), both agreed to take some action on 42 calls (24.4%), and no steps were taken by either party on only 1 (0.6%) of the 172 third-party imminent risk calls. The most common interventions implemented by counselors on third-party imminent risk calls were contacting a mobile outreach team (e.g., to conduct a face-to-face or telephone evaluation, or to provide follow-up services) (27.9%) or contacting emergency services (e.g., 911, police, sheriff, ambulance, EMS) (26.2%) (see Table 2). Counselors sometimes obtained contact information for the person at risk (32.7% of calls) in order to implement these interventions, but rarely (2.3%) took the step of reaching out to the person at risk themselves. The most common action the third-party callers agreed to take to assist the person at risk was contacting emergency services, with approximately one third of them doing so. However, third-party callers also agreed to take other steps to ensure the safety of the person at risk, as presented in Table 2. One or more non-emergency interventions on the part of the counselor or third-party were implemented on 118 calls (68.6%), including 71 calls (41.3%) with non-emergency interventions exclusively.

Interventions involving emergency services on behalf of person at imminent risk

Emergency services were contacted on 100 of 172 third-party imminent risk calls (58.1%). The third-party callers contacted emergency services on approximately one-third of calls, while the crisis counselors did so on approximately one-quarter of calls. This difference was not significant ($p = 0.266$). There were two calls on which both the counselor and third party

contacted emergency services. On 53 calls (53% of calls with an emergency services intervention, or 30.8% of all calls), contacting emergency services was the only intervention endorsed. On the remaining 47 calls with an emergency services intervention (47% of calls with an emergency services intervention, or 27.3% of all calls), one or more non-emergency interventions, such as having the third party wait with the person at risk, or enlisting a mobile crisis team to follow-up, were also implemented. One or more additional, non-emergency interventions were implemented on 35 of 45 calls (77.8%) where the counselor contacted emergency services, but only on 14 of 57 calls (24.6%) where the third party made the emergency services call.

Crisis centers had more information about the outcomes of emergency services interventions if the counselor had contacted emergency services than if the third party had done so (see Table 3). Even when the counselor had contacted emergency services, information about whether emergency services ultimately located the person at risk was available less than half of the time (44.4%, or 20 of 45 calls). If the third party had initiated the contact with emergency services, the center knew whether emergency services had been dispatched <10% of the time.

The odds of emergency services being contacted (by either the crisis counselor or the third party) were significantly lower if the third party was middle-aged or older in contrast to high school or younger, or young adult (see Table 4). The odds of contacting emergency services were significantly lower if the third party was a family member (in contrast to a friend or acquaintance) of the person at risk, and if the third party's information was based on face-to-face contact, which was more common for family members. The odds of contacting emergency services were greater if the person at risk was reported to be in the midst of a suicide attempt or planned to

TABLE 3 Outcomes of emergency services involvement on third-party imminent risk calls

Outcome		Emergency services contacted by counselor ($N = 45$)	Emergency services contacted by third party ($N = 57$)
Emergency services dispatched?	Yes	36/45 (80.0%)	5/57 (8.8%)
	No	6/45 (13.3%)	0
	Don't Know	3/45 (6.7%)	52/57 (91.2%)
Emergency services located person at risk?	Yes	20/36 (55.6%)	1/5 (20.0%)
	No	1/36 (2.8%)	0
	Don't Know	15/36 (41.7%)	4/5 (80.0%)
Emergency services transported person at risk?	Yes	10/20 (50.0%)	0
	No	3/20 (15.0%)	0
	Don't Know	7/20 (35.0%)	1/1 (100%)
Person at risk admitted to hospital?	Yes	1/10 (10.0%)	n/a ^a
	No	0	n/a ^a
	Don't Know	9/10 (90.0%)	n/a ^a

^aNot applicable because there were no "yes" answers to the previous question.

TABLE 4 Relationship of emergency services involvement with third-party, person-at-risk, and counselor characteristics

	Emergency services contacted	No emergency services contacted	OR (95% CI)	<i>p</i>
Third-party characteristics				
Gender of third party				
Male (<i>N</i> = 56)	33 (58.9)	23 (41.1)	1.22 (0.61–2.46)	0.573
Female (<i>N</i> = 116)	67 (57.8)	49 (42.2)		
Age of third party ^a				
High school or younger (<i>N</i> = 19)	15 (78.9)	4 (21.1)	0.36 (0.17–0.75)	0.006
Young adult (<i>N</i> = 72)	48 (66.7)	24 (33.3)		
Middle-aged (<i>N</i> = 62)	28 (45.2)	34 (54.8)		
Senior (<i>N</i> = 3)	2 (66.7)	1 (33.3)		
Location of third party				
Within area (<i>N</i> = 100)	55 (55.0)	45 (45.0)	1.50 (0.64–3.54)	0.353
Outside area (<i>N</i> = 55)	32 (58.2)	23 (41.8)		
Source of third party's information				
Face-to-face contact (<i>N</i> = 63)	28 (44.4)	35 (55.6)	0.42 (0.21–0.86)	0.017
No face-to-face contact (<i>N</i> = 87)	59 (67.8)	28 (32.2)		
Person-at-risk characteristics				
Gender of person at risk				
Male (<i>N</i> = 111)	68 (61.3)	43 (38.7)	0.83 (0.41–1.66)	0.590
Female (<i>N</i> = 59)	31 (52.5)	28 (47.5)		
Age of person at risk ^a				
High school or younger (<i>N</i> = 29)	17 (58.6)	12 (41.4)	0.51 (0.22–1.18)	0.113
Young adult (<i>N</i> = 78)	47 (60.3)	31 (39.3)		
Middle-aged (<i>N</i> = 32)	14 (43.8)	18 (56.3)		
Senior (<i>N</i> = 4)	1 (25.0)	3 (75.0)		
Location of person at risk				
Within area (<i>N</i> = 88)	44 (50.0)	44 (50.0)	0.66 (0.27–1.65)	0.371
Outside area (<i>N</i> = 50)	34 (68.0)	16 (32.0)		
Relationship of person at risk to third party				
Friend (<i>N</i> = 70) ^b	50 (71.4)	20 (28.6)	0.32 (0.16–.67) 1.53 (0.45–5.16)	0.003 0.494
Family (<i>N</i> = 80)	34 (42.5)	46 (57.5)		
Other (<i>N</i> = 22)	16 (72.7)	6 (27.3)		
Suicide risks ^c				
Plan to kill self				
Yes (<i>N</i> = 108)	70 (64.8)	38 (35.2)	3.88 (0.92–16.51) 2.24 (0.51–9.88)	0.066 0.286
No (<i>N</i> = 12) ^b	3 (25.0)	9 (75.0)		
DK (<i>N</i> = 52)	27 (51.9)	25 (48.1)		
Attempt in progress				
Yes (<i>N</i> = 31)	25 (80.6)	6 (19.4)	6.55 (2.23–19.22) 2.98 (1.43–6.18)	0.0007 0.004

(Continues)

TABLE 4 (Continued)

	Emergency services contacted	No emergency services contacted	OR (95% CI)	<i>p</i>
No (<i>N</i> = 63) ^b	23 (36.5)	40 (63.5)		
DK (<i>N</i> = 78)	52 (66.7)	26 (33.3)		
Time frame for acting on suicide thoughts ^d				
<few hours (<i>N</i> = 53)	40 (75.5)	13 (24.5)	14.49 (4.04–51.98)	<0.0001
>few hours (<i>N</i> = 22) ^b	5 (22.7)	17 (77.3)	3.59 (1.10–11.72)	0.035
DK (<i>N</i> = 66)	30 (45.5)	36 (54.5)		
Counselor characteristics				
ASIST training				
Yes (<i>N</i> = 71)	38 (53.5)	33 (46.5)	0.53 (0.25–1.11)	0.901
No (<i>N</i> = 98)	59 (60.2)	39 (39.8)		
Safety planning training				
Yes (<i>N</i> = 114)	70 (61.4)	44 (38.6)	1.65 (0.68–4.01)	0.269
No (<i>N</i> = 55)	27 (49.1)	28 (50.9)		
	Mean (SD)	Mean (SD)		
Number of months experience as crisis counselor	70.20 (80.83)	83.40 (77.16)	0.99 (0.993–1.001)	0.161
Hours per week answering calls	24.67 (11.58)	23.36(10.78)	1.01 (0.98–1.05)	0.511
Number of suicide calls answered per week	7.77 (3.70)	7.93 (3.69)	1.00 (0.90–1.11)	0.998

^aAge was dichotomized: high school or younger/young adult versus middle-aged/senior; High school/young adult was the reference group.

^bReference group

^cSuicide risks with at least five percent in each response category and <50% “don’t know” responses were included in these analyses.

^dTime frame for acting on thoughts was not asked whether the response to an attempt in progress was “yes.”

act on suicidal thoughts within a few hours. When the counselors could not determine definitively whether or not a suicide attempt was in progress, or whether the time frame for acting was less than a few hours, then the odds of contacting emergency services were also significantly increased compared to calls where these risk factors were ruled out. None of the counselor characteristics was significantly associated with emergency services being contacted.

DISCUSSION

This paper has described 172 “third-party calls” to the National Suicide Prevention Lifeline—calls made out of concern for another person who was deemed by a crisis counselor to be at imminent risk of suicide based on the third-party caller's report. Just as females have been found to be more likely than males to seek help on their own behalf (Calear et al., 2014), our findings indicate that females are more likely than males to seek help on behalf of others, with females commonly seeking help on behalf of suicidal males in their social network. Similarly, just as adolescents and young adults are

more reluctant than adults to seek help for themselves (Jagdeo et al., 2009), our findings indicate that youth are less likely than middle-aged persons to seek help for someone else, with older adults commonly seeking help for younger people. In the present study, most third-party callers were calling about either a member of their nuclear family or a friend, with whom they had either face-to-face contact or communication via text messaging or telephone calls. Our findings thus underscore the importance of family and friends as key gatekeepers for suicidal individuals (Hom et al., 2015).

Crisis counselors had difficulty in ascertaining the presence of many suicide risk factors based on the third party's report, as reflected by the large number of missing codes for the majority of the suicide risk items. However, crisis counselors were still able to estimate the imminence of the suicide risk based on some key suicide risk factors, such as an attempt in progress and a timeframe for acting on suicidal thoughts of only a few hours. Moreover, information on clinically meaningful indicators of suicide desire, intent, and capability was obtained. Thus, our findings indicate that it can be feasible for crisis counselors to obtain usable information on the suicide risk and safety of individuals who are not calling on their

own behalf but whose suicide risk assessment is based on third-party reports alone.

Overall, nearly 60% of the third-party calls yielded an emergency service contact by either the counselor or third party, which was somewhat higher than the percentage of emergency services contacted for imminent risk callers who call on their own behalf (approximately 46%) (Gould et al., 2016). When crisis counselors intervene directly with imminent risk callers, they are often able to reduce the imminent risk enough by the end of the call so that emergency services are not necessary (Gould et al., 2016). While direct interventions with suicidal individuals are not possible on third-party calls, and no immediate impact of the call on the person at risk can be ascertained, counselors were nonetheless able on over 40% of calls to identify steps that they or the third-party callers could take to mitigate the at-risk individual's suicide risk without involving emergency services. Thus, it appears that crisis counselors working with third-party callers are adhering to Lifeline's policy to initiate the "least invasive, most collaborative actions" whenever possible (Draper et al., 2015, p. 264). Having the third party contact emergency services appeared to have been implemented as a last resort, when no other interventions appeared feasible: one or more additional less invasive interventions, such as having the third-party keep watch on the person at risk, or coordinating follow-up by a mobile crisis team, were implemented on only 25% of calls where the third party contacted emergency services, compared with nearly 80% of calls where the counselor initiated emergency services contact. Emergency services contact was associated with meaningful clinical and contextual factors: use of emergency services was more likely when the third party was young, when they were friends or acquaintances in contrast to family, when they did not have face-to-face contact with each other, and when the person at risk was either in the midst of a suicide attempt or planned to engage in suicidal behavior within a few hours.

Our study revealed deficiencies in the linkages between crisis centers and local law enforcement, mobile crisis teams, and treatment facilities within their state, county, or other local coverage area, as reflected by the center's lack of information about the outcomes of rescue interventions implemented. Following the crisis counselors' contacting emergency services, information about whether emergency services ultimately located the person at risk was available less than half of the time. If the third party had initiated the contact with emergency services, the center was unlikely even to know whether emergency services had been dispatched. On the rare occasion when the center knew that the emergency service had been dispatched or the person at risk was located, the center usually did not know whether the person had been transported or admitted to the hospital. Enhancing continuity of care for suicidal individuals has been a major priority for the Substance Abuse and Mental Health Services

Administration (2020) and is a goal of the U.S. National Strategy for Suicide Prevention (U.S. Department of Health & Human Services, 2012). Future efforts need to focus on centers' developing and utilizing collaborative relationships with other community services, as recommended by the Lifeline to enhance the continuity of care and safety for callers at imminent risk (Draper et al., 2015).

There are several limitations of the current study. In light of the need to address the imminent suicide risk of the person on whose behalf the third-party was calling, there was no ethical or feasible way for us to obtain third-party callers' consent for study participation, including participation in a follow-up assessment. Therefore, all of our data were de-identified, based on counselor self-report, and limited to the single time point of the crisis intervention. We relied on the crisis counselor's clinical judgment as to who was at imminent risk. We have no way of assessing whether the counselors were correct in their assessment of the callers' risk, or whether the interventions they chose were the most appropriate or effective ones. Another limitation was our inability to explore the impact of different family relationships (e.g., nuclear family versus extended family, or parent versus child) on the types of interventions that were implemented due to our relatively small sample size. Lastly, our sample of crisis centers may not be representative of the Lifeline network of centers despite their diversity in staffing and census region. While we selected centers that used volunteers and paid staff to answer crisis calls, all the counselors who completed questionnaires about third-party calls were paid employees. Despite these limitations, our study provides an unprecedented amount of systematic data on third-party calls, which to date have been little studied.

Our finding that crisis counselors were able to work collaboratively with third-party callers to implement measures to ensure the safety of the persons at risk on nearly all calls informs the promotion of the future three-digit number (988) that has been designated for use as the national suicide prevention hotline (<https://www.congress.gov/116/plaws/pub1172/PLAW-116pub1172.pdf>). In contrast to a third-party calling 911, which only dispatches an emergency service—frequently involving the police—calling the Lifeline yields alternative and adjunctive interventions. With the help and guidance of the Lifeline counselors, third-party callers also agreed to ensure the safety of the person at risk by maintaining watch on the person at risk, speaking with the person at risk, escorting the person at risk to a hospital or ED, getting another third party involved, collaborating with mobile outreach, removing access to lethal means, and encouraging the person at risk to contact the Lifeline. Given suicidal individuals' greater willingness to disclose suicidal thoughts to family or friends over mental health professionals (e.g., Arria et al., 2011), the Lifeline's equipping family and friends with appropriate skills to

assist suicidal individuals is of utmost importance. This is the first study to provide information on crisis counselors' active engagement with third parties to ensure the safety of suicidal individuals who are reluctant to seek services for themselves.

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