DEPARTMENT OF HEALTH & HUMAN SERVICES

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February 28, 2011

Marlene Dortch
Secretary
Federal Communications Commission
Office of the Secretary
445 Twelfth Street, S.W.
Washington, DC 20554

Dear Ms. Dortch:

Re: In the Matter of *The United States Department of Health and Human Services' Substance Abuse and Mental Health Services Administration Petition for Permanent Reassignment of Three Toll Free Suicide Prevention Hotline Numbers,* in *Toll Free Service Access Codes*, CC Docket No. 95-155, WC Docket No. 07-271

This letter and attachments are filed on behalf of the United States Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA), by its attorneys, in order to update the record,[1] and to renew the request that the Federal Communications Commission (the "Commission") permanently reassign three toll-free suicide prevention hotline numbers[2] to SAMHSA.

The Commission has a stated interest in ensuring the continuous operation of the three toll-free suicide prevention hotlines.[3] In furtherance of that goal, the Commission has requested specific information regarding the administrative and financial resources needed to operate the

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[1] See, *U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration's Petition for the Permanent Reassignment of Three Toll Free Suicide Prevention Hotline Numbers, WC Docket No. 07-271, Toll Free Service Access Codes*, CC Docket No. 95-155, Memorandum Opinion and Order and Order on Review, 24 FCC Rcd 13022 (2009) (*Reassignment Order*). See also, Order and Request for Comment, January 14, 2011, WC Docket No. 07-271, CC Docket No. 95-155.

[2] The toll-free numbers 1-800-SUICIDE (1-800-784-2433), 1-888-SUICIDE (1-888-784-2433), and 1-877-SUICIDA (1-877-784-2432) are referred to collectively as "the suicide prevention hotlines."

[3] See, FCC's Order and Request for Comment, January 14, 2011, paragraph 6, p. 3.

suicide prevention hotlines. Accordingly, SAMHSA respectfully submits this letter and the attached information in response to the questions posed by the Commission.[4]

SAMHSA wishes to clarify and restate its role in supporting suicide prevention efforts nationwide, and particularly in the years since it began to operate the three toll-free numbers that were reassigned to SAMHSA by order of the FCC in 2007.[5] A recent filing by KBHC with the Commission included baseless assertions and inaccurate statements regarding SAMHSA's authority and role as a public health agency, as well as SAMHSA's specific actions and administration of the suicide prevention hotlines.

SAMHSA's Role in Suicide Prevention Efforts and Grant Programs Supporting Suicide Prevention Hotlines

SAMHSA is a public health agency created by Congress to address the mental health needs of the public.[6] Continuously since 2001, SAMHSA has offered federal funding of grants to support suicide prevention hotlines and a national network that permits callers nation-wide to connect to crisis centers.[7] In 2001, SAMHSA announced the availability of funding for a grant dedicated to improving hotline services offered by crisis programs.[8] In 2004, SAMHSA announced the availability of a new grant to continue and expand the services by establishing a series of toll-free numbers answered by a national network of crisis centers, under a federal grant award (cooperative agreement) for "Networking and Certifying Suicide Prevention Hotlines."[9]

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[4] See Attachment A which includes answers to the specific questions listed in the FCC's Order and Request for Comment, issued January 14, 2011. Please note that some of the operational data provided in the attachment were made available to SAMHSA by its grantee, Link2Health Solutions, Inc.

[5] See *Toll Free Service Access Codes*, CC Docket No. 95-155, Order, 22 FCC Fcd 651 (Wireline Competition Bureau 2007) (*800-SUICIDE Order*).

[6] Section 501 of the Public Health Service Act, as amended (42 U.S.C. §290aa).

[7] These SAMHSA grants made by SAMHSA's Center for Mental Health Services are authorized under section 520A of the Public Health Service Act, as amended. Under section 520A of the Public Health Service Act, SAMHSA is authorized to make grants or cooperative agreement to address priority mental health needs of regional and national significance. Accordingly, SAMHSA announces the availability of federal grant funds for its programs, and provides financial support to grantees and contractors. The grants process is one of open competition and peer review, while the contracts award process follows federal regulations.

[8] See Attachment B: SAMHSA Announcement of Funding Opportunity for FY 2001: Guidance for Applicants, No. SM 01-010, "Cooperative Agreements to Certify, Network, and Evaluate Crisis Programs that offer Hotline Services."

[9] See Attachment C: SAMHSA Notice of Funding Availability for FY 2004: Funding Opportunity Number: SM 04-013, "Networking and Certifying Suicide Prevention Hotlines."

In 2007, SAMHSA again announced the availability of funding for a grant program to Network, Certify, and Train Suicide Prevention Hotlines.[10] In 2004, the grant was awarded to the Mental Health Association of New York City. In 2007, the grant was awarded to Link2Health Solutions, Inc. (L2HS), a subsidiary of the Mental Health Association of New York City.

The National Suicide Prevention Lifeline

In 2005, SAMHSA and its grantee established the National Suicide Prevention Lifeline (Lifeline).[11] The network is intended to protect the nation's public health by ensuring that individuals in suicidal crisis have immediate access to crisis counselors using the same toll-free number from anywhere in the country. The Lifeline grantee administers several toll-free hotline numbers connecting callers in crisis to a network of 149 crisis centers located around the country.[12] SAMHSA is the subscriber of record for some of the hotline numbers, but others are maintained by L2HS, its legal grantee, to support specialized routing functions for the network.

The Lifeline is not simply a telephone service, or a network of toll-free numbers. The Lifeline program is a dynamic and specialized program engaged in constant and ongoing efforts to connect individual callers nation-wide in a seamless, quick, and efficient manner with the specialized mental health services offered by local crisis centers. While SAMHSA provides financial support for the toll-free numbers that comprise the Lifeline, SAMHSA also offers professional expertise in the area of crisis counseling, as well as ongoing enhancements to and evaluation of the services. The Lifeline is a unique resource which promotes public safety and public mental health through a combination of operational expertise and mental health expertise.

SAMHSA filed its petition for temporary reassignment of the suicide prevention hotlines in 2006, following KBHC's failure to pay telephone bills for services that it had incurred over a period of years. Since February 2007, when the FCC temporarily assigned 1-800-SUICIDE and the other two toll-free numbers to SAMHSA, SAMHSA has included those numbers in the

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[10] See Attachment D: Request for Applications for a Cooperative Agreement for "Networking, Certifying and Training Suicide Prevention Hotlines," RFA No. SM-07-009, 2007.

[11] The mission of the Lifeline is to prevent suicide by reaching and effectively serving all persons at suicidal risk in the United States through a network of crisis hotlines. The Lifeline is a network that links more than 140 independent crisis call centers nationwide using a series of toll-free numbers. When callers call these toll-free numbers at anytime from anywhere in the United States, they are routed to the nearest networked center, where helpers are trained to provide emotional support, assessment, crisis intervention and/or linkages to necessary community resources. The Lifeline is currently operated by SAMHSA and the Link2Health Solutions, Inc. under a cooperative agreement awarded in 2007. Since the FCC temporarily reassigned the three toll-free suicide prevention hotlines to SAMHSA, these numbers have been integrated into the Lifeline network.

[12] See Attachment E: List of the 149 crisis centers that comprise the Lifeline network. Each crisis center has a current and active agreement with Link2Health Solutions establishing the terms whereby calls will be routed and handled.

network of suicide prevention hotlines that it supports through the Lifeline. It has done so in pursuit of its mission to enhance public health and safety.

By incorporating the three suicide prevention hotlines into the Lifeline network in 2007, SAMHSA was able to preserve and enhance public access for callers to those lines. The number of callers is set forth in the attachments to this submission. It is the Lifeline network which is funded by SAMHSA, not a particular number. Further, the funding process occurs through a public and transparent process of announcements, applications, and review which results in the award of funding to entities capable of operating the Lifeline network in service of callers. The Lifeline network does not merely pay the phone bill for the toll-free numbers. Rather, it is actively engaged in monitoring the connections, supporting the crisis centers, and enhancing the services required on an ongoing basis. By filing this request, SAMHSA seeks to maintain the three suicide prevention hotline numbers as integral lines in the Lifeline network funded by SAMHSA, thereby maintaining those specialized and vital services to callers in need.

While the network directly connects callers to crisis centers, neither SAMHSA, nor its grantee, nor the Kristin Brooks Hope Center (KBHC) is structured to answer calls directly. It is the crisis centers that provide direct services to the public and form the backbone of the Lifeline network, answering calls on a daily, 24/7 basis.

The crisis centers are independently operated and funded, and each maintains its own local or state toll-free numbers and responds to crisis calls from their local communities or their states. Each of the crisis centers has signed a detailed agreement with L2HS to serve as the primary or backup center in answering calls originating from certain zip codes, counties, area codes, or states, from the national toll-free numbers administered in the Lifeline network. In order to participate in the network, crisis centers must not only have the staffing capacity to answer calls from their coverage areas, they must also be able to communicate with local emergency rescue services, and to provide callers with referral information for resources in the caller's locale.

The Lifeline grantee ensures that calls from the toll-free numbers are routed to the appropriate crisis center for aid. The routing system is complex, having been negotiated with each of the 149 crisis centers, and changing as crisis centers' circumstances change. The Lifeline grantee is actively engaged in overseeing the network to ensure quality at both the technological and the service-provision level, maintaining the highest possible level of services to the public in support of the public's health.

The Lifeline provides specialized services that are imperative for a system serving individuals in suicidal crisis, some of whom require the dispatch of emergency rescue services (typically with the caller's consent). For example, the Lifeline's Caller ID Retrieval System and Angel.com (described in Attachment A) were developed for the Lifeline and can only be used for calls routed through the Lifeline network. They would not work for 800-SUICIDE calls if that number is unbundled from the Lifeline system. Crisis centers use the Caller ID Retrieval

System when their own system does not allow them to capture the phone number—and potentially, the location—of a caller who is at imminent risk. Angel.com ensures adequate surge capacity for spikes in caller volume resulting, for instance, from a major media broadcast of a Lifeline number. Because these services are necessary and critical to protect the public safety, SAMHSA asserts that even if the three toll-free numbers at issue are reassigned to KBHC, and even if KBHC were to obtain resources adequate to operate them, KBHC could not protect public safety. In particular, SAMHSA notes as follows: (1) the crisis centers have current and valid agreements with the Lifeline, and are not obligated to enter agreements with KBHC; (2) KBHC has not demonstrated that it has the ability or capacity to provide centers with enhanced equipment such as Caller ID Retrieval and other systems which allow counselors to retrieve phone numbers of callers at imminent risk; and (3) KBHC has not shown it has the ability or capacity to address surges in calls so that callers in crisis will not hear a busy signal.

KBHC's Previous Claims Regarding SAMHSA Funding and the Appeal to the Departmental Appeals Board

KBHC's statement that SAMHSA provides financial support for other toll-free numbers without being the subscriber of record is correct; however, it omits the crucial fact that SAMHSA can only provide financial support to authorized grantees or contractors. KBHC is neither. KBHC may be eligible to apply for certain SAMHSA grants, but is not currently a grantee or contractor. Further, KBHC refers to prior financial support it received from SAMHSA. While this is partially accurate, the statement omits the context for that support, which derived from a SAMHSA grant (No. SM01-010) to "Certify, Network, and Evaluate Crisis Programs that Offer Hotline Services."[13/] The grant was awarded to the American Association of Suicidology in 2001 following an open competition and request for applications. KBHC was a subrecipient of federal funds based on KBHC's agreement with the American Association of Suicidology.[14/]

KBHC has insinuated that SAMHSA's denial of ongoing financial support to KBHC contributed to KBHC's inability to support hotlines under their control. In fact, grants always are limited in duration, and the term of the grant was specified in the public announcement. For the SAMHSA grant awarded in 2001, the three-year project period was listed in three places in the announcement.[15/] The terms of the prior award were published in the Federal Register, as well as on government websites, and made fully available to the public.

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[13] See Attachment B: SAMHSA Guidance for Applicants, "Cooperative Agreements to Certify, Network and Evaluate Crisis Programs that Offer Hotline Services," (2001).

[14] SAMHSA Grant No. SM54127

[15] See Attachment B: SAMHSA Guidance for Applicants, "Cooperative Agreements to Certify, Network and Evaluate Crisis Programs that Offer Hotline Services," (2001). The 3-year term of the project period is listed on pages 3, 4, and 9 of this announcement.

Further, the independent HHS Departmental Appeals Board (DAB) soundly rejected KBHC's claims regarding costs that it alleged were owed by SAMHSA. When the grant to the American Association of Suicidology ended, KBHC contested the disallowance of costs that it and the grantee had incurred under the grant. KBHC appealed to the DAB, arguing that it was entitled to $190,236 from SAMHSA. After hearing the appeal and reviewing KBHC's written evidence, the DAB upheld SAMHSA's decision disallowing the costs and finding that KBHC failed to meet its burden to document the costs claimed to the federal award and to show that the costs were reasonable, necessary, allocable, and adequately supported as required by federal regulations.[16/]

In light of the above, the statement that SAMHSA simply "chose" not to fund 800-SUICIDE is at best misleading. SAMHSA funds grants to support a network of suicide prevention hotlines and has done so since 2001. The terms of the grant competition are made public to ensure open competition, with information regarding the availability of federal funding published on government websites including terms, conditions, and duration of funding. As previously noted in the record, in 2004 SAMHSA announced a new grant competition for "Networking and Certifying Suicide Prevention Hotlines."[17/] Although KBHC was noted as a proposed subrecipient or subcontractor in an application filed by one party, that applicant did not receive the highest score, and therefore was not funded, following SAMHSA's standard grant review process using independent grant reviewers.

In 2007, SAMHSA announced the availability of funding for a new grant program to Network, Certify, and Train Suicide Prevention Hotlines.[18/] As occurred on each previous occasion, the availability of federal funding for this grant program was announced on the SAMHSA web site as well as listed on the HHS Grants Website (www.grants.gov) and in the federal-wide Catalog of Federal Domestic Assistance. KBHC did not apply for this grant, nor was it funded. Nevertheless, KBHC remains eligible to compete for federal grants and contracts for which it is qualified.

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[16] See, Attachment F: Decision of the HHS Departmental Appeals Board (Decision No. 2108), August 22, 2007.

[17] See, Attachment C: Notice of Funding Availability (NOFA) for a SAMHSA Grant for "Networking and Certifying Suicide Prevention Hotlines," (Funding Opportunity Number: SM 04-013), 2004.

[18] See, Attachment D: Request for Applications for a "Cooperative Agreement for Networking, Certifying and Training Suicide Prevention Hotlines," RFA No. SM-07-009 (2007).

The Financial Stability of a Provider of Services Should be Taken into Account When a Vital Public Health Service is Provided

KHBC's irresponsible claim that the FCC permitted an entity to "manufacture a financial risk" cannot withstand closer scrutiny. KBHC's past practices are a matter of record, while nothing gives any credence to KBHC's unfounded allegation that the financial risks were "manufactured" by any other party. In fact, SAMHSA urges the Commission to seek reliable documentation from KBHC to support its assertions regarding its financial health and ability to maintain the hotlines while paying for telephone services. The financial record of an entity asserting its ability to provide critical life-saving services to the public is important, beyond the ordinary responsibilities of a subscriber of record. Where, as in this case, there is no evidence supporting KBHC's assertions of improvement in its financial stability, its past track record is the only indicator the FCC has of future performance.

SAMHSA-funded evaluations have shown that seriously suicidal persons frequently utilize the lines, including individuals who are in the midst of making a suicide attempt.[20] A recent evaluation conducted by Columbia University that included calls to both 800-273-TALK and 800-SUICIDE showed that approximately 7.5% of callers to the National Suicide Prevention Lifeline are in the process of either making a suicide attempt, or engaging in behavior preparing to make a suicide attempt. Based on an average of 60,000 answered calls per month, an estimated 4,500 calls per month, or 150 a day, are from these "imminent risk" callers who are engaged in a suicide attempt or who have taken steps and have the means to complete a suicide attempt. In such situations, numerous components are necessary to minimize the likelihood of tragedy.

The telephony service must be able to deliver calls rapidly, efficiently, and reliably, and that may not be the least expensive service available. The crisis center must be prepared to receive the call and must be in ongoing communication with the network administrator regarding the volume of calls that can be appropriately handled. Such communications help optimize calls being routed to the center that is most likely able to handle the call volume at any given time, minimizing the routing time, which translates into the period of time that callers wait to speak to a counselor.

The Public Health and Safety Interest Warrants Permanent Reassignment of the Hotline Numbers to SAMHSA

SAMHSA does not now and has never viewed this matter as a dispute between SAMHSA and KBHC. Rather, this request for permanent reassignment of the toll-free numbers is an important tool to ensure access to a critical and unique public health resource. The use of these toll-free numbers in the public interest requires stable management and consistent operations. SAMHSA has shown that it is dedicated to doing so, within its legal authority.

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[20] See Attachment G: Gould MS, Kalafat J, Munfakh JLH, Kleinman M: An evaluation of crisis hotline outcomes, Part II: Suicidal Callers. Suicide and Life Threatening Behavior 2007;37(3): 338-352.

SAMHSA has consistently argued that the three toll-free numbers used as suicide prevention hotlines are a unique resource, to which public access and service must be preserved to promote and protect public health and public safety. We maintain that there is no more important basis to exercise discretionary authority than in the area of public health and safety. Each call to a suicide prevention hotline reflects an individual in a potentially life-threatening situation. SAMHSA's support for the hotlines, and the oversight it provides to the network operated by its grantee, reflect this position, and no other interest.

As a result of the foregoing, SAMHSA respectfully requests that the Commission grant the request for permanent reassignment of the three toll-free suicide prevention hotline numbers to SAMHSA.

Sincerely,

Rina Hakimian
Senior Attorney

Attachments: A - G

cc: Ann Stevens, Wireline Competition Bureau, FCC
Heather Hendrickson, Wireline Competition Bureau, FCC
Michelle Sclater, Wireline Competition Bureau, FCC

ATTACHMENT A

SAMHSA Responses to the FCC Request for Comment

1. **The total number of hotlines included in its network and, to the extent possible, the percentage of its costs allocated to each hotline number:**

   SAMHSA Response: The following table indicates the total cost from Lifeline's telecom provider for processing calls from each of the Lifeline's toll-free hotline numbers.

Lifeline Hotline Number	Total cost from Lifeline's telecom provider for processing calls in 2010
800-273-TALK	$605,852.14
800-SUICIDE	$234,681.30
888-SUICIDE	$2,434.39
888-628-9454 (Spanish Lifeline)	$2,057.83
877-SUICIDA	$48.86
800-564-2120 Idaho Back-up	$1,210.94
866-403-2668 Back-up Redirect	$1,541.72
All other Back Ups--13 Lines	$178.54
Total Amount	$848,005.72

2. **The average length of a suicide prevention call and the estimated cost per minute of that call:**

   SAMHSA Response – The following information was provided by the National Suicide Prevention Lifeline:

   Average call duration is 7.48 minutes. The cost per minute is $0.11. A breakdown of network calls, minutes and costs per month for 2010 is in the table below:

Jan - Dec 2010		
Calls	**Minutes**	**Cost**
80083	590421	65078
72602	546026	60181
86748	631150	69575
86246	614186	67711
88053	632139	69681
88098	632951	69770
89644	656677	72381
87673	675401	74440
83988	667465	73557
89156	697633	76887
86373	671872	74049
89213	677650	74690
1,027,877	**7,693,571**	**$848,000**

3. A detailed breakdown of the current monthly expenses to operate its (or its grantee's) suicide prevention network for 12 months, the total monthly cost of the network, including telecommunication/transmission costs, description of the goods and services utilized, their monthly cost, and other expenses necessary to operate the suicide prevention hotlines.

SAMHSA Response:

National Suicide Prevention Lifeline Average Monthly Operating Costs (2010)
Personnel $ 92,000
Other Than Personnel Services $189,700 (includes $71,000 for telecommunications)

The expenses for administrating and operating the Lifeline network relate to personnel expenses, occupancy and office support costs, equipment and travel expenses and vendor contracts to support a variety of network needs.

Personnel
In the area of personnel services, Lifeline's Project Director oversees all aspects of the service's operations, and the project's Administrative Coordinator also works with the entire Lifeline staff by providing office clerical, travel and budget management support. Lifeline's other 12 staff members work within one of three interdependent project divisions that are essential for better assuring that the service effectively reaches and serves callers in suicidal crisis. These divisions are:

1. The Information Technology (IT) Division, consisting of five staff members which manage the call routing database and monitor caller connectivity to centers, collect and analyze data to track service needs and trends, and provide web-based tools, communications and supports for network centers;

2. The Network Development (ND) Division, consisting of two staff members that grow and maintain capacity of the network to answer calls by recruiting and signing on new member centers, as well as support centers' local efforts to sustain funding; and

3. The Standards, Training and Practices (STP) Division, which consists of five staff members that provide resources, information and technical assistance to promote and implement best practices to network centers serving callers in emotional distress and/or suicidal crisis.

Expenses Other Than Personnel Expenses:

Other expenses include equipment to support staff and project operations.

Some of the essential technology tools maintained and provided by the IT Division to support crisis center work and protect public safety include the following:

1. Public Safety Answering Point (PSAP, a.k.a., 911 Call Center) Lookup tool. This tool is essential for crisis centers needing to provide emergency rescue services for callers outside the center's own local 911 area. The PSAP Lookup tool allows crisis centers to directly dial a 911 call center that is outside of their local area. With more than 5,000 PSAP's in the country, when a caller needs to be rescued and every second counts, this tool saves not only time, but lives.

2. Caller ID Retrieval System. Of all the tools provided by the Lifeline to its networked crisis centers, the Caller ID Retrieval System is the most frequently used. This essential tool is secure, password-protected, and user-friendly for member centers. In the event that a Lifeline caller is at imminent risk of suicide, crisis centers use this tool to securely retrieve Caller ID information. This is particularly important for centers whose own equipment does not allow counselors to retrieve phone numbers of callers at imminent risk who hang up before the counselor has had time to note the number. Crisis centers also use this tool to determine if a particular caller is on a cell phone or land line, which can be critical in determining whether a caller's location can be traced using his or her area code. Lifeline IT staff spent several hundred staff hours creating this tool, and continue to spend several hours a month maintaining it.

3. Cell Phone Locator. This tool is still in development and Lifeline hopes to have it available early in 2011. It will enable crisis centers to locate cell phones using Global Positioning Systems (GPS) or Cell Tower Triangulation.

4. Angel.com (surge call protection). Angel.com is the provider of digital call surge capacity services to assure that callers to the Lifeline network do not get a busy signal during extraordinary surge periods of call volume. Angel.com does not provide a specific breakdown of costs per requested function; they become bundled within what they bill as "fixed" rate cost to provide these functions. The fixed costs relate to a maximum of 2,500 minutes per month to provide the services listed below, with variable costs relating to additional features requested by Lifeline or expenses incurred from exceeding the 2,500 minute quota for the following special service features: call surge roll-over protection; special processing of Skype calls; Bridge phone routing services; and TTY call filtering for callers who are deaf or hard of hearing.

The Caller ID Retrieval System and Angel.com can only be used for calls routed through the Lifeline network and would not work for 800-SUICIDE calls if that number is unbundled from the system. These are necessary and critical to protect the public safety, particularly for callers at imminent risk of suicide.

Not including staff hours, the annual cost for the above four services (including the estimate for the Cell Phone Locator) is approximately $66,000. (This figure is included in the total expenses at the beginning of this section.)

Subcontractor/Vendor Expenses

Operating costs for the network includes office equipment and supplies to support staff work, rent/utilities and other occupancy expenses for the administrative team, and team travel costs to attend suicide prevention conferences and meetings. The largest proportion of operating expenses (nearly 50%) relate to subcontracts with organizations and vendors that perform vital functions for the network and its administrators. These subcontracts represent critical aspects of administrating a network, ranging from occupancy costs, payroll services, human resources supports, telephone vendor expenses, crisis center training expenses and telephonic language translation assistance.

Crisis Center Stipends

Other operating costs include annual network center stipends (see table below). All member centers receive a base stipend of $2,500 annually to help maintain their local operating costs that support Lifeline work and most of the centers receive $1,000 to ensure that staff is trained to assist military veteran callers. Five centers receive additional funds to provide special back-up service for the Department of Veterans Affairs' National Suicide Prevention Hotline service for veterans. In addition, 11 centers receive added compensation for serving Spanish callers in Lifeline's "Spanish Sub-network" and four centers receive stipends for providing special assistance to local American Indian populations.

To ensure that all Lifeline calls are answered, its call routing system includes a series of centers providing back-up supports within the network. Back-ups are necessary for those inevitable circumstances when all counselors at a center are busy assisting other callers, a major media broadcast of the network phone number leads to a sudden surge in calls, or a power outage or other technical problem prevents the primary center from receiving the calls. It is essential that

calls are answered, and that callers not receive a busy signal. It is also highly desirable that callers in crisis do not experience significant wait times. The first tier of back-up centers is generally within the same state as the initial center; the next tier consists of eight regional centers; the final tier is a national back-up center in Nebraska. More than 80% of all Lifeline calls are answered by the primary center, with over 95% of calls answered by the primary center or its back-up center in the network (total wait time is < 60 seconds). The Lifeline provides stipends for centers that provide back-up services.

Type	Annual Stipend	Centers	2010 Totals
Network Agreement	$2,500	149	$372,500
Spanish Amendment	$1,500	11	$ 16,500
Veterans Amendment	$1,000	128	$128,000
Veterans Back-Up Centers	$10,000	4	$ 40,000
American Indian Amendment	$2,500	4	$ 10,000
Regional Back-up Centers	Formula-based	8	$ 36,400
National Back-up Center	Formula-based. Also includes network's response to crisis e-mails and TTY/TDD service.	1	$ 54,600
Total			$658,000

These totals do not include an additional $810,000 in stipend awards that was allocated in FY 2010 through a one-year-only SAMHSA supplemental grant for the Lifeline.[21]

It is necessary, but not sufficient, for Lifeline to ensure technological connectivity and brief wait times. To help ensure the public safety of callers who are routed to a back-up crisis center, the Lifeline also provides non-local resource/referral information to all centers that have signed agreements to provide back-up services.

4. A projection of overall monthly expenses for the continued operation of its suicide prevention network.

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[21] This grant was intended to reinforce crisis center capacity to assist high risk individuals in their communities in light of the known negative mental health impacts of the economic downturn on individuals and families. Over 50 network centers were eligible to apply to the Lifeline in a competitive process for a stipend award of up to $50,000; 20 centers were eventually awarded with grants that ranged from $26,000 to $50,000 for the year. This amount was not included in the annual stipend total noted above as it is an atypical expense that is not expected to recur in subsequent years.

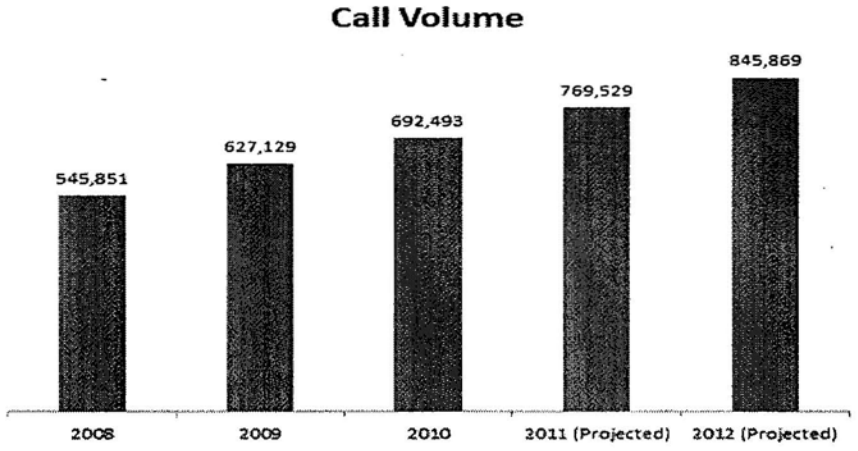
SAMHSA Response:

See response to #5, below.

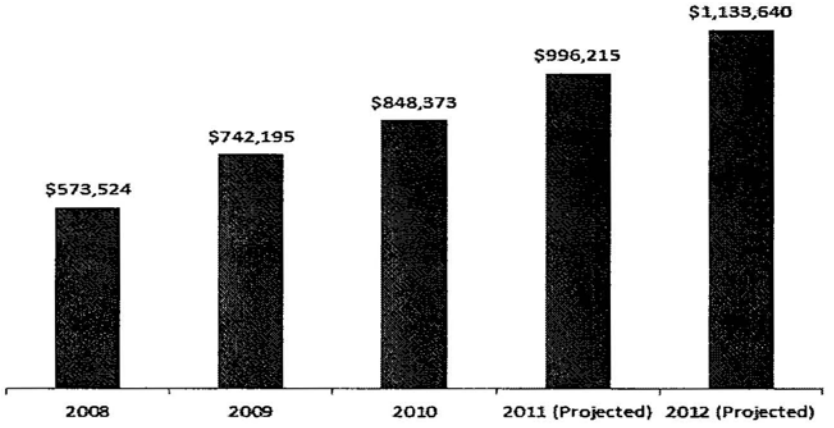
5. A projection as to whether the costs of operating its suicide prevention network will increase or decrease in the future, and, if so, why and by how much (for example, due to changes in call volume or future efficiencies in the network). Projected future costs for the next several years would be useful.

SAMHSA Response:

Every year, Lifeline calls have increased markedly. Based on past annual increases, a conservative estimate for volume growth would approximate 10-11% each year over the next two years (see bar graph below). Toll-free phone costs should be expected to grow at equal rates (over $996,000 total costs for FY 2011 and over $1.13 million in FY 2012). The bar graph below relates to past, current and projected numbers of *answered calls* by network centers, as opposed to actual number of calls placed to the network.



The following graph depicts toll-free telephone costs for the past few years and projected through FY 2012.



800-SUICIDE calls only. The graph showing answered calls above includes 800-SUICIDE calls. During 2010, the Lifeline crisis centers answered 219,637 calls that reached the network centers through the 800-SUICIDE number. The total cost from Lifeline's telecom provider (Patriot Communications) for processing the 800-SUICIDE calls in 2010 was $234,681.30. Estimating equivalent 10% growth rates for this number—if it were to be distinguished from the Lifeline and promoted separately—toll-free costs alone would approximate nearly $260,000 for FY 2011 and nearly $284,000 for FY 2012.

Given that Lifeline's network membership has grown at an average of 10 centers each year, it is anticipated that Lifeline will provide at least $25,000 in additional stipends for FY 2011 and another $25,000 (for a total of $50,000) in FY 2012. If any of the centers also provide specialized services for the network (e.g., Spanish language capacity or back-up assistance), additional stipend payments will be in order.

6. A description of the funding that will be used to operate its suicide prevention network in future years.

SAMHSA Response:

SAMHSA is dependent on Congressional appropriations to fund all of its initiatives, including the National Suicide Prevention Lifeline. Although it is not possible to predict the actions of the Legislative Branch, Congress has consistently appropriated suicide prevention funding for SAMHSA since 2001, and the President's FY 2012 Budget includes stable funding for the Lifeline and for suicide prevention programs in general. Based on this, SAMHSA plans to announce a competition to fund another grant to network, certify, and train suicide prevention hotlines in FY2012.

Fiscal Year	**Congressional Appropriation for SAMHSA's Suicide Prevention Programs**	**Congressional Appropriation for National Suicide Prevention Hotline**
2001	$ 3,000,000	$ 3,000,000
2002	$ 2,900,000	$ 2,900,000
2003	$ 5,620,000	$3,070,000
2004	$ 9,483,000	$3,052,000
2005	$16,436,000	$3,052,000
2006	$31,675,000	$3,021,000
2007	$36,190,000	$4,484,000
2008	$49,229,000	$5,082,000
2009	$48,136,000	$5,522,000
2010	$48,136,000	$5,522,000
2011 (Continuing Resolution)	$48,136,000	$5,522,000
	President's Budget for SAMHSA's Suicide Prevention Programs	President's Budget for National Suicide Prevention Lifeline
2012	$48,136,000	$5,522,000

7. If the commenter projects expenses associated with its network to increase, explain how it will fund any increased costs.

SAMHSA Response:

Since 2001, SAMHSA has made suicide prevention a priority and has funded grants to support suicide prevention hotlines. SAMHSA will continue to work through appropriate channels to determine whether and how additional funding can be dedicated to the grant to fund future increases in program expenses.

8. We also invite comment on any other factual data that the commenter believes is relevant to the Commission's decision, especially data relating to the suicide prevention hotlines' ability to protect public health and safety.

SAMHSA Response:

The national suicide prevention hotline network's ability to protect public health and safety depends on the rapid and efficient ability to route calls to network crisis centers that are ready and able to take the calls. Delays or problems in being able to deliver a call can have a profound impact.

The Lifeline not only optimizes the prompt delivery of all calls to crisis centers, but it provides tools and guidance on responding to those callers at imminent risk for suicide so that counselors have at their fingertips the tools needed to keep callers safe.

The issue of a well-staffed network administrator is also vital to public safety. Link2Health Solutions relies on many vendors to help administer and maintain the integrity of the hotline network, but it is the staff that performs duties that are essential to ensuring public safety, including communicating with the crisis centers on an ongoing basis. Link2Health Solutions will be filing a separate document with the FCC that describes in detail its staff functions within Lifeline's three divisions (Information Technology; Network Development; and Standards, Trainings, and Practices). These divisions work interdependently to help assure that the service effectively reaches and serves callers in crisis. It is true that not all tasks performed by Lifeline staff are necessary to ensure the public safety. However, the vast majority of their work is indeed necessary and critical to ensuring the provision of effective call connectivity, and the maintenance of a network with both the technological capacity to handle calls and the resources, tools, and skills to handle callers who are placing their lives in the hands of the network's counselors.

ATTACHMENT B:

SAMHSA ANNOUNCEMENT OF FUNDING OPPORTUNITY FOR FY 2001:

"COOPERATIVE AGREEMENTS TO CERTIFY, NETWORK, AND EVALUATE CRISIS PROGRAMS THAT OFFER HOTLINE SERVICES"

GUIDANCE FOR APPLICANTS, NO. SM 01-010

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Guidance for Applicants (GFA) No. SM-01-010
Part I - Programmatic Guidance

Cooperative Agreements to Certify, Network and Evaluate Crisis Programs That Offer Hotline Services

Short Title: Improve and Evaluate Crisis Hotline Services

Application Due Date:
May 21, **2001**

Bernard S. Arons, M.D.
Director, Center for Mental Health Services
Substance Abuse and Mental Health Services
Services Administration

Joseph H. Autry III, M.D.
Acting Administrator
Substance Abuse and Mental Health
Services Administration

Date of Issuance: April, 2001

Catalog of Federal Domestic Assistance (CFDA) No. 93.230
Authority: Section 520(a) of the Public Health Service Act, as amended
and subject to the availability of funds

Table of Contents

Agency....3
Action and Purpose....3
Who can Apply?....4
Application Kit....4
Where to Send the Application....5
Application Dates....5
How to Get Help....5
Cooperative Agreements....6
Funding Criteria....7
Post Award Requirements....7

Detailed Information on What to Include in Your Application
- Face Page....11
- Abstract....11
- Table of Contents....11
- Budget....11
- Program Narrative and Support Documentation....11
- Assurances....13
- Certifications....13
- Disclosure of Lobbying Activities....13
- Checklist....13

Project Narrative - Sections A through D Highlighted:
Category I....13
Category II....17

Confidentiality and SAMHSA Participant Protection....20

Appendix A: Guidelines for Assessing Consumer and Family Participation
Appendix B: Definitions of Racial groups and culture or origin.

Agency

Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration, Center for Mental Health Services

Action and Purpose

The Substance Abuse and Mental Health Services Administration (SAMHSA),
Center for Mental Health Services (CMHS), announces the availability of Fiscal Year 2001 funds for "Certifying, Networking and Evaluating Crisis Centers."

The purposes of this program are to:
1) increase the number of crisis programs offering hotline services that are certified in suicide prevention in the U.S.,
2) increase the number of crisis centers/hotlines certified in suicide prevention which are networked through a single, toll-free, nationwide number, utilizing telecommunications technology that links callers to their geographically nearest crisis center. It is expected that approximately 200-300 of these crisis centers will be certified and networked over the project period of the award (3 years), and
3) to coordinate, collect and analyze data from crisis centers/hotlines in order to evaluate their effectiveness.

This Guidance for Applicants (GFA) solicits applications for two categories of cooperative agreements.

Category I:
Certification and Networking
Project Period: 3 years

For **Category I**, up to $2,550,000 is available per budget year, including direct and indirect costs. It is anticipated that **one** award will be made in this category.

The **Category I** recipient must carry out activities in each of the following three elements: 1) Certification of crisis centers/hotlines 2) Networking certified hotline services, and 3) Project evaluation

Category II:
Client and Community-Centered Outcomes Evaluation
Project Period: 3 years

For Category II, up to $450,000 is available per budget year, including direct and indirect costs. It is anticipated that **one** award will be made in this category.

The Category II recipient must carry out activities in design of data collection standards and in the collection and analysis of data and the production of final outcomes report

The Category I and II awardees share a common focus on operations and activities of hotline services. Because there is a strong probability that they will be working with the same crisis programs, they are encouraged to collaborate in areas of mutual interest and information sharing. For example, the Category I awardee will have valuable insights related to the needs and concerns of crisis programs as it relates to their participation in the evaluation activities. Likewise, the Category II awardee will have expertise to share with the Category I awardee in the design of data collection that will ensure a meaningful evaluation of outcomes.

Category I
Certification and Networking

Goal 1: To increase the number of crisis programs that operate hotline services that are certified in suicide prevention in the U.S.

Goal 2: To increase the number of crisis programs that operate suicide prevention hotlines which are networked through a single, toll-free, nationwide number, utilizing telephone switching technology that links callers to their geographically nearest crisis center. It is expected that approximately 200-300 of these crisis centers will be certified and networked over the project period (3 years).

Goal 3: To evaluate the organizational adherence to certification standards as well as the characteristics and quality of telephone intervention with suicidal callers over time.

Eligibility for **Category I** is limited to applicants who can perform the activities of certification and networking of hotline services.

Category II
Client and Community Centered Outcomes Evaluation

Goal 1 -To explore, identify and define client and community and centered outcomes in relation to crisis programs that operate suicide prevention hotline services.
Goal 2 - To develop documentation standards for hotline services that permit the full assessment of outcome measures identified in Goal 1;
Goal 3 - To coordinate, collect and analyze data from specifically identified crisis programs in order to evaluate identified outcome measures.

Eligibility for **Category II** is limited to applicants who have knowledge, skill, and experience with crisis centers and/or hotlines and experience and capability in data collection design, instrumentation and data analysis.

Note: A budget must be submitted for each year of support requested.

Continuation awards will depend on the availability of funds and progress achieved.

Who Can Apply?

Domestic not-for-profit organizations may apply, including:

- consortium/partnerships of organizations brought together for purpose of this GFA
- community-based organizations, including faith-based and consumer and family groups
- public or private universities
- hospitals
- units of State or local governments, Indian tribes and tribal organizations

Application Kit

Application kits have several parts. Part I is individually tailored for each GFA. Part II has general policies and procedures that apply to **all** SAMHSA grants and cooperative agreements. You will need to use both Parts I and II for your application.

The kit also includes the forms PHS-5161 and SF-424 which you will need to complete your application.

To get a complete application kit, including Parts I and II, you can:

Call the Center for Mental Health Services national clearinghouse, the Knowledge Exchange Network at (800) 789-2647 or

Download from the Knowledge Exchange Network website at www.mentalhealth.org or from the SAMHSA site at www.SAMHSA.gov

Where to Send the Application

Send the **signed** original and 2 copies of your grant application to:

SAMHSA Programs
Center for Scientific Review
National Institutes of Health
Suite 1040
6701 Rockledge Drive MSC-7710
Bethesda, MD 20892-7710*

*Change the zip code to 20817 if you use express mail or courier service.

Please note:

1. Use application form PHS 5161-1.
2. Be sure to type: "SM01-010, Improve and Evaluate Crisis Hotline Services" in Item Number 10 on the face page of the application form.

   Indicate whether you are applying for
   Category I - Certification and Networking
   or
   Category II - Client and Community-Centered Outcomes Evaluation.

Application Date

Applications must be received by May 21, 2001.

Applications received after this date must have a proof-of-mailing date from the carrier before May 14, 2001.

Private metered postmarks are not acceptable as proof of timely mailing. Late applications will be returned without review.

How to Get Help

For questions on *program issues*, contact:

Maria T. Baldi
Public Health Advisor
Division of Program Development, Special Populations, and Projects, Room 17C-26
Center for Mental Health Services, SAMHSA
5600 Fishers Lane
Rockville, MD 20857

(301) 443-2892
Email: Mbaldi@samhsa.gov

Robert DeMartino, M.D.
Associate Director for Program in
Trauma and Terrorism
Division of Program Development, Special
Populations and Projects, Room 17C-26
Center for Mental Health Services
SAMHSA
5600 Fishers Lane
Rockville, MD 20857
(301) 443-2940
E-Mail:**Rdemarti@samhsa.gov**

For questions on *grants management issues*, contact:

Steve Hudak
Division of Grants Management
Substance Abuse and Mental Health
Services Administration
5600 Fishers Lane
Rockville, Maryland 20857
Phone: 301-443-9666
Email: Shudak@samhsa.gov

Cooperative Agreements

These awards are being made as cooperative agreements because the complexity of the program requires substantive programmatic involvement of Federal staff.

The roles of Federal staff, and awardees are highlighted below.

Awardees Must:

- comply with the terms and conditions of the agreement
- accept guidance and respond to requests for information from CMHS
- ensure consumer or family participation on steering or other such work groups or committees that may be formed as part of this program
- author or co-author publications on project results for use by the field.
- implement specified activities, data collection, quality control, and prepare required SAMHSA reports.
- agree to provide SAMHSA with data required for GPRA.
- participate in a two-day annual Federal grantee meeting.

SAMHSA Staff Will:

- provide technical assistance on implementing project activities.
- monitor project activities and progress.
- provide guidance on project design and components, as needed.
- provide support services or assign outside consultants for training, evaluation, and data collection, if needed.
- author or co-author publications on program findings.
- provide technical assistance on ways to help disseminate and apply study results.
- conduct site visits if warranted or desired
- facilitate collaboration, as needed
- review quarterly reports, and
- make recommendations for continued funding.

The Advisory Board (Category II only):

The input of an Advisory Board is considered critical to the success of the Category II outcome evaluation. The Advisory Board must include members with extensive experience in the structure, operations and evaluation questions related to crisis centers and hotlines and could serve in the following functions:

The Advisory Board will:

- provide recommendations on the range of community and client-centered outcomes on which the outcome evaluation will be based
- review and provide recommendations on data collection interview and other pertinent protocols proposed for use at participating crisis programs
- review and provide recommendations regarding the client and community data that need to be collected by the participating crisis programs services in achieving the evaluation goals of the project
- develop and approve protocols related to caller anonymity, caller follow up, and referral with the needs of clients, the functioning of the service, and crisis workers, and the outcome evaluation in mind

Funding Criteria

Decisions to fund a grant are based on:

1. The strengths and weaknesses of the application as identified by the
   - Peer Review Committee and approved by the
   - CMHS National Advisory Council
2. Availability of funds

Post Award Requirements

1. Reports are required as follows (as described in the Terms and Conditions of Award to be issued upon award of funding):

- quarterly reports
- annual report
- final report summarizing accomplishments and outcomes
- compliance with GPRA
- financial status reports

2. Each awardee will be required to attend an annual 2-day Federal grantee meeting in the Washington, DC area. Attendees will include the project director and key personnel, and the annual budget must reflect adequate provisions for attendance at this meeting. Further details will be provided by the project officer upon award.

Background

For purposes of this GFA, a crisis center is a program that establishes immediate telephone communication between people who are emotionally distressed and individuals who have been trained to provide telephone assistance with the objective of diffusing the immediate crisis, ensuring the caller's safety, and assisting the caller to take the next immediate steps toward resolving the problem. Some are specialty centers focusing on crises related to domestic violence or rape, others see their mission as responding to the needs of all types of personal and family crises.

There are currently estimated to be over 500 operating "crisis centers" in the United States exclusive of military and employee assistance programs. For purposes of this GFA, crisis centers are programs that establish immediate telephone communication between people who are emotionally distressed and individuals who have been trained to provide telephone assistance with the objective of diffusing the immediate crisis, ensuring the client's safety, and assisting the client to take the next immediate steps toward resolving the problem. Some are specialty centers focusing on crises related to domestic violence or rape, others see their mission as responding to the needs of all types of personal and family crises.

Even more broadly defined is the national 211 Information and Referral Service (I&R) meant to serve as the link between people in need of health and human services assistance and the appropriate providers of such services. I&R specialists assess callers' needs and determine the service provider best equipped to handle their problems or crises, and whether a caller may be eligible for other programs. 211 provides information to callers on crisis intervention services, physical and mental health resources, work supports, support for older Americans and persons with disabilities, child, youth and family support and basic human needs.

In any type of serious personal crisis, the potential for suicidal thoughts and behaviors exists. In published surveys, 10 percent of calls to all types of crisis programs involve suicidality. Crisis centers also typically provide face-to-face client services and counseling. Hotline crisis services represent one of many possible effective interventions for suicidality.

"Hotline," a term describing a telephone service, may be directly associated with a single crisis center which also offers face-to-face client services or be a "hotline-only" service in which there are no associated face-to-face services. Such "hotline only" centers may be hundreds or thousands of miles from the location of the caller and often maintain databases of crisis services, local to the caller, to which that person can be referred if indicated.

"Suicide prevention hotlines" are programs that provide telephone crisis intervention services to individuals expressing suicidal thoughts or behaviors, or to others calling on behalf of such persons in crisis with the objective of exploring alternatives to self-harm. Suicide prevention workers establish and maintain contact with the individual while identifying and clarifying the focal problem, evaluate the potential for suicide, assess the individual's strengths and resources, and mobilize available resources including paramedic or police intervention and emergency psychiatric care as needed.

Though not all crisis centers have widely publicized "hotline" services, it is generally believed that most, if not all, centers field crisis calls from suicidal individuals. While face-to-face assessment and counseling in the work of crisis centers are to a large degree done by health professionals, the important work of telephone crisis intervention is done almost exclusively by trained volunteers. The use of trained volunteers in the role of telephone crisis workers has existed for many years and spawned the development of standards to guide them in their work. Especially with regard to caller suicidality, it is believed to be very important that the crisis workers be trained in the use of clinically indicated intervention techniques. Importantly, there are no

existing state or federal statutes nor professional accrediting requirements guiding these telephone activities at either the crisis center or "hotline only" centers. Some organizations in addressing this deficiency, have offered certification to centers that provide telephone intervention to suicidal callers.

Program Overview

The aims of this initiative are to:
1) increase the number of crisis centers/hotlines certified in suicide prevention, in other words, those having achieved defined standards in crisis worker training, service delivery, organizational administration and program evaluation among other potential criteria

2) increase the number of crisis programs offering hotline services that are certified in suicide prevention which are networked through a single, nationally accessible telephone number, utilizing telecommunications technology that links callers to their geographically nearest crisis center. It is expected that approximately 200-300 of these crisis centers will be certified and networked through this program over the project period (3 years), and

3) coordinate, collect and analyze outcome data from a number of specifically identified crisis programs in order to evaluate their effectiveness.

Data collection instruments will be subject to review and approval by the Office of Management and Budget. This clearance will result in delays of approximately 6 months in commencing actual data collection. This delay should be taken into account in the planning of project timelines. It will be the responsibility of the grantee to prepare all materials for the OMB clearance submission using guidance provided by the SAMHSA OMB Reports Clearance Officer.

Existing research literature on crisis center/hotline services has failed to reveal that they reduce the overall suicide rate in the communities they serve. These findings are in stark contrast to the experience of clients and crisis workers who attest to the effectiveness of services delivered by crisis programs. Certainly, the "rescue" services that crisis programs provide is arguably the most visible and immediate manifestation of their potential to prevent suicide. There are several categories of explanations for this apparent discrepancy:

A. Problems with the intervention:
A.1. Accepted crisis intervention techniques are not being faithfully implemented
A.2. Individuals that would be best served by being referred to specialized therapeutic services are not being referred
A.3. At-risk individuals are being referred consistently, but not to services best suited to their needs

B. Problems with access to the program:
B.1. Gaining access to the crisis program is difficult, preventing those at risk from utilizing it
B.2. The service is easy to access, but those most at-risk are not using it or unaware of its availability.
B.3. Individuals are not able to access language appropriate interventions or crisis workers with a familiarity of the community and social context of which the individual is a part.

C. Problems with follow-through:
The crisis intervention is appropriate and well suited to the individual's needs, but the individual does not follow through with the intervention plan.

D. Problems with the research: "Effectiveness" evaluations of suicide prevention crisis programs have generally been limited to an examination of the program's effect on the overall suicide rate in the community. Important beneficial and community outcomes of these services have not been identified and evaluated sufficiently.

This initiative seeks to address some of these issues:

Problem A. The training standards that are generally a component of certifying a crisis program in suicide prevention (see American Association of Suicidology: *Organization Certification Standards Manual for Crisis Intervention Programs*, Washington, DC, 1995) encourage a consistent, clinically accepted approach to assessing the lethality of and intervening with suicidal callers. These interventions may involve referral of the caller to specialized services. Certified crisis programs train their workers to recognize clients appropriate for referral to specialized services and attempt to identify community resources that are best suited to their needs. Certification standards also set benchmarks for the provision of walk-in, outreach and follow-up services when they are offered by a crisis program.

Problem B. A single, nationally available, easy to remember, toll-free telephone number linked to crisis programs should improve public access to suicide prevention services. A single number also would permit pooling of resources to more effectively advertise the service and to heighten the impact of public information campaigns, thereby increasing its use.

Though toll-free crisis hotlines do now exist, they generally connect the client to a crisis worker at a centralized location, which may be at a great distance from the client. Databases available to the crisis worker may permit referral of the suicidal individual to a local treatment facility, but it is unlikely that specific knowledge of that facility can be offered.

Clinical rationale supports a preference for crisis center/hotline services that serve their geographic community. Geographic proximity of the caller to the crisis worker makes it more likely that the worker is familiar with the social and cultural values, conflicts and dilemmas with which the caller is faced. It may also make it more likely that the crisis worker can offer up-to-date referral information and have personal knowledge of and experience with the range of available resources in the community.

Current technology permits instant telephone routing of calls from a central access number, for instance a toll-free line, back to the community, or the nearest community from which the call originated.

Problems C. & D. Despite their existence over many years, hotlines have not been systematically evaluated for their potential beneficial effect on other aspects of the client and his/her community in addition to the numbers or rate of suicide. For instance, changes in:

- psychological or social characteristics of clients over time,

- vocational functioning of clients (e.g., days of work lost)
- suicidal behaviors in client and community-at-large
- successful follow-through with intervention plan
- emergency room and other medical services utilization by clients
- community attitudes towards suicide and crisis programs

have not been evaluated and might be theorized to be affected by the presence of a suicide prevention hotline in a community. However, this list is not intended to serve as definitive outcome measures to be used in the Category II evaluation. In fact, an important element of the Category II proposal is identification of these measures.

The relative consistency in several important facets of crisis programs afforded by certification will permit the evaluation of community and client centered outcome measures across locations, as well as more in depth examination of the role and effectiveness of certification and networking in the quality of services delivered. Utilization of standardized telephone response protocol as well as a standardized data collection mechanism will enhance the likelihood that outcomes can be accurately evaluated.

This initiative therefore calls for certification of 200-300 crisis centers/hotlines in the management of callers expressing suicidal thoughts or behaviors. These certified programs are to be networked through telephone technology that permits national access to crisis center/hotline services through a single toll-free number. The technology will permit calls to be directed immediately to a telephone prevention worker who is located at the geographically nearest location to the caller.
Networking will also entail the development of systems to permit certification, and networking at this scale gives the opportunity for utilizing response protocols and data collection standards that will permit the evaluation of client and community centered outcomes that have not previously been pursued.

Detailed Information on What to Include in Your Application

In order for your application to be **complete and eligible**, it must include the following in the order listed. Check off areas as you complete them for your application.

❑ ***1. FACE PAGE***
Use Standard Form 424. See Appendix A in Part II for instructions. In signing the face page of the application, you are agreeing that the information is accurate and complete.

❑ ***2. ABSTRACT***
Your total abstract may not be longer than **35 lines.** In the first 5 lines or less of your abstract, write a summary of your project that can be used in publications, reporting to Congress, or press releases, if funded.

❑ ***3. TABLE OF CONTENTS***
Include page numbers for each of the major

sections of your application and for each appendix.

❑ ***4. BUDGET FORM***

Standard Form 424A. See Appendix B in Part II for instructions.

❑ ***5. PROGRAM NARRATIVE AND SUPPORT DOCUMENTATION***

These sections describe your project. The program narrative is made up of Sections A through D. **More detailed information of A-D follows #10 of this checklist.** Sections A-D may not be longer than 15 pages.

☐ **Section A - Project Description**

☐ **Section B - Implementation Plan**

☐ **Section C - Management and Staffing Plan**

☐ **Section D - Program Evaluation (Category I)**

☐ **Section D - Dissemination (Category II)**

☐ **Section E - NOT REQUIRED**

The support documentation for your application is made up of sections F through I.
There are no page limits for the following sections, except for Section H, the Biographical Sketches/Job Descriptions.

☐ **Section F-** Literature Citations
This section must contain complete citations, including titles and all authors, for any literature you cite in your application.

☐ **Section G -** Budget Justification, Existing Resources, Other Support

Fill out sections B, C, and E of the Standard Form 424A. Follow instructions in Appendix B, Part II.

☐ **Section H-** Biographical Sketches and Job Descriptions

-- Include a biographical sketch for the project director and for other key positions. Each sketch should not be longer than **2 pages**. If the person has not been hired, include a letter of commitment from him/her with the sketch.

-- Include job descriptions for key personnel. They should not be longer than **1 page**.

-- ***Sample sketches and job descriptions are listed in Item 6 in the Program Narrative section of the PHS 5161-1.***

☐ **Section I-** Confidentiality and SAMHSA Participant Protection (SPP) Also please see Part II.

The seven areas you need to address in this section are outlined after the Project Narrative description in this document.

❑ ***6. APPENDICES 1 THROUGH 3***

- Use only the appendices listed below.
- **Don't** use appendices to extend or replace any of the sections of the Program Narrative (reviewers will not consider them if you do).
- **Don't** use more than **10 pages** (plus all

instruments) for the appendices.

Appendix 1: Letters of Support
Provide relevant letters of support from collaborators. These may include entities who are providing in kind resources, and/or others as deemed relevant by the grantee in each category, and should indicate the kind/extent/purpose of the collaboration.

Appendix 2: Memorandums of Agreement
Category II applicant, please provide Memorandums of Agreement for all of the crisis programs who will participate in data collection activities that will permit evaluation of outcome measures.

Appendix 3: Data Forms
Please attach any data collection forms which are intended for use.

❑ ***7. ASSURANCES***
Non- Construction Programs. Use Standard form 424B found in PHS 5161-1.

❑ ***8. CERTIFICATIONS***
See Part II for instructions.

❑ ***9. DISCLOSURE OF LOBBYING ACTIVITIES***
Please see Part II for lobbying prohibitions.

❑ ***10. CHECKLIST***
See Appendix C in Part II for instructions.

Project Narrative– Sections A Through D

Highlighted

Your application consists of addressing sections A through I. **Sections A through D, the project narrative parts of your application, describe what you intend to do with your project.** Below you will find detailed information on how to respond to sections A through D.

- Sections A through D may not be longer than 15 pages.
- **A peer review committee will assign a point value to your application based on how well you address these sections.**
- The number of points after each main heading shows the maximum points a review committee may assign to that category.
- Reviewers will also be looking for cultural competence.

Cultural competence means attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations. This includes an understanding of a group's or member's language, belief, norms and values, as well as socioeconomic and political factors which may have significant impact on their psychological well-being, and incorporating those variables into assessment and treatment.

- Following each review criterion are statements in bullet form. These statements do not have weights, they are provided to invite attention to important areas within the review criterion.

There are two sets of review criteria, one set for **Category I** and one set for **Category II**.

Review Criteria for Category I

Certification and Networking

CMHS' aim in this project is to provide certification of 200-300 crisis centers/hotlines in the management of callers expressing suicidal thoughts or behaviors. These certified programs are to be networked through telephone technology that permits national access to crisis center/hotline services through a single toll-free number. The technology will permit calls to be directed immediately to a telephone prevention worker who is located at the geographically nearest location to the caller.

Section A:
Project Description (20points)

This element of the application will be scored based upon:

- the extent to which the applicant demonstrates understanding of the needs and the goals of the program and demonstrates how the proposed project, if fully successful, will contribute to achieving these goals.
- the extent to which any proposed project collaborators or stakeholders express support for the project. Letters of Support should be included in Appendix 1, entitled "Letters of Support from Collaborating Organizations." These may include providers of in-kind support, crisis project managers, 211 agencies, or any key stakeholder deemed critical to the success of the program.
- the extent to which the proposed program's goals and objectives are tied to the identified stakeholder needs
- the extent to which the applicant describes potential barriers to implementing the project and the adequacy of methods to overcome them.
- description of how the project will contribute to the field and address community needs.
- description of the project's plan to address the language and cultural needs of clients
- description of how this project will make use of, collaborate or interact with the newly approved 211 nationwide Information and Referral service(s)

Section B: Implementation Plan (40 points)

This should include a description of the goals and objectives of the implementation plan.

Certification Activities

- describe and justify the selection of the certification program to be used in the project. At a minimum it must be based on clinically accepted tenets and sets standards for crisis worker training, nature and quality of services delivered and their integration into the community, organizational and administrative structure and nature and quality of program evaluation mechanisms.
- describe the plan, if any, for providing technical assistance to crisis programs who

do not reach certification standards

- describe a systematic, geographically and culturally diverse plan for identifying and enrolling crisis programs in the certification program. How will your project ensure a variety of programs that serve racial/cultural groups are represented?

- describe the project's plan for ensuring adequate enrollment of crisis programs into the network (200-300 over 3 years).

- describe the process by which a crisis program will be enrolled in certification. What are the eligibility criteria for programs to be considered for participation in this initiative?

- What plan, if any, does the project propose to address the costs to crisis programs associated with certification?

Networking Activities

- describe the process by which a crisis program will be enrolled in the network. What are the eligibility criteria for programs to be considered for participation in this initiative?

- What plan, if any, does the project propose to address the costs to crisis programs associated with networking?

- What additional resources will be required of the crisis program and the applicant to build and maintain the network. How will that change over the course of the project period?

- describe the plan to publicize the existence of the network to the public, how and why it should be used, and how it can be accessed. How will the project reach age/gender/race/ethnic groups at risk for suicide that traditionally underutilize hotline services?

- describe plans to develop and maintain or make available an up-to-date human resources directory that will be available to the networked centers

- describe the plan to collect a base set of information from all participating crisis programs. What information do you propose to collect? Attach at Appendix 3 any data forms that are planned for use.

Section C: Management and Staffing Plan (20 points)

Management Plan

Describe plans for managing your overall project including:

- a timely and feasible project schedule and timeline.

- describe the experience and expertise that will be brought to bear to manage the fiscal and organizational complexities of a Federal grant program

- applicant's capability and experience with managing collaborative activities with other agencies or organizations. What is applicant's experience in collaborating with the kinds of programs envisioned for enrollment into the network?

- the adequacy and availability of facilities and equipment.

- the real and potential stakeholder in-kind resources.

- evidence of an ongoing plan to achieve project sustainability after federal funding expires.

Staffing Plan

Describe plans for staffing your overall project including:

- Qualifications and experience of the proposed Project Director and directors of networking, certification and program evaluation activities as well as other key personnel. Describe the qualifications and experience of these key figures, whether or not they are employed directly by the applicant organization.

- the extent to which the qualifications and experience of the proposed project director and other key personnel are appropriate to the proposed activities; if any key staff have not been selected at the time of application, the duties and requirements of the position should be described.

- a staff pattern that is appropriate and adequate for the project. Please prepare a table outlining the staffing structure across those organizations that will play a role in carrying out the activities of the program.

- Capability, experience, and evidence of commitment of proposed consultants and subcontractors.

Section D: Program Evaluation (20 points)
The applicant should propose an experienced evaluation team to work closely with crisis program staff to develop and conduct the evaluation plan. The evaluation team should also solicit input from consumer constituencies in developing the evaluation plan.

- describe the qualifications and experience of the project's evaluation staff. If the evaluation staff has not yet been selected, position description(s) listing the minimum qualification and experience requirements should be attached in Section H.

- describe plans to evaluate the effectiveness of certification in producing consistent high quality telephone crisis services. For example, such things as the clinical appropriateness of the intervention including assessment of lethality, clinical referral, and use of consultants should be evaluated. What other aspects of service delivery should be evaluated?

- How will the project utilize web technology in streamlining the provision, collection, and analysis of data?

- describe the plan for evaluating the adherence of participating crisis centers to certification standards over time.

- how does networking impact the aspects of service delivery that you will be evaluating? Are there functions of crisis programs that are particularly influenced by networking? How will that receive attention in your evaluation?

- describe the plan for tracking call response characteristics, such as call response time and geographic proximity of clients to responding crisis workers

- what are your plans to provide regular feedback to participating crisis centers/hotlines on the progress finding of the program evaluation?

- what is the plan for determining if racially/ethnically appropriate services are being delivered by participating crisis programs?

- propose an evaluation of other factors that might be expected to impact the quality of services delivered (e.g. staffing patterns, crisis worker turnover, training-retraining practices)

Note: although the **budget** for the proposed project is not a review criterion, the Peer Review Committee will be asked to comment on the budget after the merits of the application have been considered.

Review Criteria for <u>Category II</u>

Client and Community Centered Outcomes Evaluation

CMHS's aim in this program is to fund a sophisticated outcome study of telephone hotline services with specific attention to their role in the prevention of suicide and suicidal behaviors. As described earlier, previous studies of these services have failed to find them successful in reducing the community suicide rate. This initiative intends to open the door to thinking of the crisis program and the hotline service it operates in a broader sense, studying other potential aspects of a program's impact in its community, in addition to suicide and suicidal behaviors, that may serve a community's goal of suicide prevention.

The program goals for Category II are to:
1) explore, identify and define community and client-centered outcomes in relation to crisis programs that operate suicide prevention hotline services;
2) develop documentation standards for hotline services that permit the full assessment of outcome measures identified in Goal 1; and
3) coordinate, collect and analyze data from crisis programs in order to evaluate identified outcome measures.

Issues particular to the clientele, crisis workers, and the nature of hotline services make evaluations of their effectiveness particularly challenging. The ability to evaluate outcomes is influenced by the extent and nature of anonymity, the ability to follow-up with clients, the ability to assess and collect certain kinds of information, and for those reasons, as well as others, it will be necessary to work with a number of crisis programs to collect the quantity, quality, and breadth of information sufficient to perform an adequate outcome evaluation. It is expected that the awardee will work with several crisis programs closely in order to fulfill CMHS's stated goals for this initiative. The number of programs that must participate in order to perform a scientifically and statistically adequate outcome evaluation may be influenced by the size

and nature of the hotline services, a program's standards/protocols to collect information, the service's ability to modify current practices in order to fulfill the evaluation needs, etc.

Section A:
Project Description (20 points)

- state the goals and objectives of the project
- and how the implementation plan will address these goals
- identify the crisis programs with which you will partner in carrying out this work
- describe your rationale for choosing the crisis programs you have identified. Be sure to include the following:
  a) description of program's service in the community
  b) certification status
  c) participation in network
  d) ability/willingness to modify documentation/protocols
  e) documentation of data gathering
  f) previous activities in research/evaluation
  g) length of service in community
- What are your needs regarding type, quality and quantity of data supplied by the crisis program in order to perform a scientifically and statistically adequate outcome evaluation?
- What plan, if any, does the project propose to address the costs to crisis programs associated with data collection?
- describe the plan for identifying participant and control groups if required by the evaluation proposal, for example, will data be collected and compared from certified and non-certified crisis centers? From the networked and non-networked centers?
- describe potential barriers to implementing the project and methods to overcome them
- describe how the project will contribute to the field and address community needs

Section B: Implementation Plan
(40 Points)

Describe process by which outcome measures will be identified and how data collection, interview and anonymity protocols, referral protocols and follow-up procedures will be developed and completed.

<u>Outcomes, Standards, Protocols</u>
Describe how outcome measures will be identified.

- identify potentially evaluable and community outcomes that will lead to a fuller understanding of the role of crisis programs in suicide prevention. How will the feasability and value of these potential outcomes be determined? What is the process by which the actual outcome measures to be used in the outcome study will be determined?
- if applicable, describe the work of any advisory committee you will convene. Who will be the key groups represented on such a board?
- in order to evaluate certain /community outcomes, it may be necessary to implement

standards and/or protocols on aspects of the crisis program. These might include anonymity, follow-up, clinical referral practices, and response to chronic and "validity questionable" callers. Using the set of outcome measures you have identified above, describe what standard/protocols/activities would be required of crisis programs involved in the evaluation.

Quality Control, Data Collection and Analysis

- describe the plan for ensuring quality of data being collected
- describe the methodology to be used in evaluating the identified outcome measures.
- propose a plan for data collection from the crisis programs that will participate in this evaluation. Consider electronic means including web-based data entry and program-centered databases. Include memorandums of agreement from those who agree to participate (Appendix 2).
  Attach at Appendix 3 any data forms that are proposed for use.
- describe the process by which you will ensure that certification standards will be crafted/adapted to permit a thorough and innovative outcome evaluation.

Section C: Project Management and Staffing Plan (30 points)

Describe the plan for management of the project and staffing plan.

Management Plan

- describe the comprehensiveness of your plan to accomplish the project goals in terms of : (1) the length of the project period (2) adequacy and availability of resources (e.g., staffing, consultants, collaborating entities; facilities, equipment)
- describe the plan for management and support of any advisory board or work group which is established
- what is the experience and expertise that will be brought to bear to manage the fiscal and organizational complexities of a Federal grant program?
- describe the extent to which any proposed collaborators demonstrate support of your project. How will the support of these entities aid in the success of your project? These should be included in Appendix 1, entitled "Letters of Support from Collaborating Organizations." These might include organizations involved in similar activities, or providers of in kind-resources, for example, and should indicate the kind/extent/purpose of the collaboration.
- describe existing resources of your organization that would support success of the proposed activities and how you will leverage your institutional resources and existing activities to aid in achieving functional

goals. Indicate what additional resources (materiel, information processing capacity, etc.) Would be recruited in order to conduct the proposed activities. Also, identify areas in which additional expertise is required and indicate plans to recruit or develop such expertise (e.g., staff hiring, training, collaborations, recruiting consultants).

Staffing Plan

Describe the staffing plans of your project

- identify the individual who will function as the Project Director and describe their qualifications for assuming this role. Their qualifications should be explained in terms of their training and expertise in research, prior leadership and administrative experience, their familiarity with crisis centers and/or experience in data collection, design, instrumentation and data analysis.

- describe the extent to which qualifications and experience of the proposed project director and other key personnel are relevant to accomplishing the goals of this project. If any key staff have not been selected, the duties and requirements of the position should be described. Position descriptions for key staff should be included as Section H.

- Describe the capabilities, experience and commitment of any proposed consultants and/or subcontractors.

- describe the extent to which key personnel reflect the diversity of the population/communities to be served

Section D: Dissemination (10 points)

Describe a plan for dissemination of findings of the project.

This element of the project will be scored based upon:

- the adequacy of plans and process for disseminating the products and findings generated by the project;

- the adequacy of plans to provide regular feedback to participating crisis centers/hotlines on progress of evaluation.

- propose a plan for feedback to the field via talks, peer review articles

NOTE: Although the **budget** for the proposed project is not a review criterion, the Peer Review Committee will be asked to comment on the budget after the merits of the application have been considered.

Confidentiality and SAMHSA Participant Protections (SPP)

You must address 7 areas regarding confidentiality and SAMHSA participant protection in your supporting documentation. However, no points will be assigned to this section.

This information will:

√ Reveal if the protection of participants is adequate or if more protection is needed.

√ Be considered when making funding decisions.

Some projects may expose people to risks in many different ways. In Section I of your application, you will need to:

- Report any possible risks for people in your project.
- State how you plan to protect them from those risks.
- Discuss how each type of risk will be dealt with, or why it does not apply to the project.

The following 7 issues must be discussed:

❶ Protect Participants and Staff from Potential Risks:

- Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects.

- Discuss risks which are due either to participation in the project itself, or to the evaluation activities.

- Describe the procedures that will be followed to minimize or protect participants against potential health or confidentiality risks. Make sure to list potential risks in addition to any confidentiality issues.

- Give plans to provide help if there are adverse effects to participants, if needed in the project.

- Where appropriate, describe alternative treatments and procedures that might be beneficial to the subjects.

- Offer reasons if you do not decide to use other beneficial treatments.

❷ Fair Selection of Participants:

- Describe the target population(s) for the proposed project. Include age, gender, racial/ethnic background. Address other important factors such as homeless youth, foster children, children of substance abusers, pregnant women, or other special population groups.

- Explain the reasons for using special types of participants, such a pregnant women, children, institutionalized or mentally disabled persons, prisoners, or others who are likely to be vulnerable to HIV/AIDS.

- Explain the reasons for including or excluding participants.

- Explain how you will recruit and select participants. Identify who will select participants.

❸ Absence of Coercion:

- Explain if participation in the project is voluntary or required. Identify possible reasons why it is required. For example, court orders requiring people to participate in a program.

- If you plan to pay participants, state how participants will be awarded money or gifts.

- State how volunteer participants will be told that they may receive services and incentives even if they do not complete the study.

❹ Data Collection:

- Identify from whom you will collect data. For example, participants themselves, family members, teachers, others. Explain how you will collect data and list the site. For example, will you use school records, interviews, psychological assessments, observation, questionnaires, or other sources?

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation and research or if other use will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in Appendix No. 3, "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that you plan to use.

❺ Privacy and Confidentiality:

- List how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.
- Describe:
  -How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private. For example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse records according to the provisions of Title 42 of the Code of Federal Regulations, Part II.

❻ Adequate Consent Procedures:

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Include how the data will be used and how you will keep the data private.
- State:
  - If their participation is voluntary.
  - Their right to leave the project at any time without problems.
  - Risks from the project.
  - Plans to protect s from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

  Note: If the project poses potential physical, medical, psychological, legal, social, or other risks, you should get written informed consent.

- Indicate if you will get informed consent from participants or from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include sample consent forms in your Appendix 4, titled "Sample Consent Forms."

If needed, give English translations.

Note - Never imply that the participant waives or appears to waive any legal rights; may not end involvement with the project; or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both the treatment intervention and for the collection of data. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

❼ Risk/Benefit Discussion:

- Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

APPENDIX A

Guidelines for Assessing Consumer and Family Participation

Applicants should have experience or track record of involving mental health consumers and their family members. The applicant organization should have a documented history of positive programmatic involvement of recipients of mental health services and their family members. This involvement should be meaningful and span all aspects of the organization's activities as described below:

* Program Mission. An organization's mission should reflect the value of involving consumers and family members in order to improve outcomes.

* Program Planning. Consumers and family members are involved in substantial numbers in the conceptualization of initiatives including identifying community needs, goals and objectives, and innovative approaches. This includes participation in grant application development including budget submissions. Approaches should also incorporate peer support methods.

* Training and Staffing. The staff of the organization should have substantive training in and be familiar with consumer and family-related issues. Attention should be placed on staffing the initiative with people who are themselves consumers or family members. Such staff should be paid commensurate with their work and in

parity with other staff.

* Informed Consent. Recipients of project services should be fully informed of the benefits and risks of services and make a voluntary decision, without threats or coercion, to receive or reject services at any time.

* Rights Protection. Consumers and family members must be fully informed of all of their rights including those designated by the President's Advisory Commission's Healthcare Consumer Bill of Rights and Responsibilities: information disclosure, choice of providers and plans, access to emergency services, participation in treatment decisions, respect and non-discrimination, confidentiality of healthcare information, complaints and appeals, and consumer responsibilities.

* Program Administration, Governance, and Policy Determination. Consumers and family members should be hired in key management roles to provide project oversight and guidance. Consumers and family members should sit on all Boards of Directors, Steering Committees and Advisory bodies in meaningful numbers. Such members should be fully trained and compensated for their activities.

* Program Evaluation. Consumers and family members should be integrally involved in designing and carrying out all research and program evaluation activities. This includes determining research questions, designing instruments, conducting surveys and other research methods, and analyzing data and determining conclusions. This includes consumers and family members being involved in all submission of journal articles. Evaluation and research should also include consumer satisfaction and dis-satisfaction measures.

APPENDIX B.

Racial groups, for the purposes of this announcement, are defined as:

- **American Indian or Alaska Native–a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.**
- **Asian–a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.**
- **Black or African American–a person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."**
- **Native Hawaiian or Other Pacific islander–a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.**
- **White–a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.**

Hispanic or Latino culture or origin, for the purposes of this announcement, is defined as:

- **Hispanic or Latino–a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin" can be used in addition to "Hispanic or Latino."**

ATTACHMENT C:

SAMHSA NOTICE OF FUNDING AVAILABILITY FOR FY 2004:

"NETWORKING AND CERTIFYING SUICIDE PREVENTION HOTLINES," FUNDING OPPORTUNITY NUMBER: SM 04-013

Billing Code: 4162-20-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Funding Opportunity Title: Notice of funding availability (NOFA) for a Grant for Networking and Certifying Suicide Prevention Hotlines

Announcement Type: Initial

Funding Opportunity Number: SM 04-013

Catalog of Federal Domestic Assistance (CFDA) Number: 93.243

Due Date for Applications: July 21, 2004

[Note: Letters from State Single Point of Contact (SPOC) in response to E.O. 12372 are due September 20, 2004.]

SUMMARY: The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, announces the availability of FY 2004 grant funds for Networking and Certifying Suicide Prevention Hotlines. A synopsis of this funding opportunity, as well as many other Federal Government funding opportunities, is also available at the Internet site: www.grants.gov.

For complete instructions, potential applicants must obtain a copy of SAMHSA's standard Infrastructure Grants announcement [INF-04 PA (MOD)], and the PHS 5161-1 (Rev. 7/00) application form before preparing and submitting an application. The INF-04 PA (MOD) describes the general program design and provides instructions for applying for all SAMHSA Infrastructure Grants, including the Networking and Certifying Suicide Prevention Hotlines

grant. Additional instructions and specific requirements for this funding opportunity are described below.

I. Funding Opportunity Description:

Authority: Section 520A of the Public Health Service Act, as amended and subject to the availability of funds.

Networking and Certifying Suicide Prevention Hotlines grant program is one of SAMHSA's Infrastructure Grants. In general, SAMHSA's Infrastructure Grants provide funds to increase the capacity of mental health and/or substance abuse service systems to support effective programs and services. This particular grant will provide funding to manage a toll-free national suicide prevention hotline network utilizing a life affirming number which routes calls from anywhere in the United States to a network of local crisis centers that can link callers to local emergency, mental health and social service resources. Grant funds must also be used to increase the number of crisis centers certified in suicide prevention.

The goals of the Networking and Certifying Suicide Prevention Hotlines grant program are to:

1) Increase the number of crisis programs offering hotline services which are networked through a single, nationally accessible telephone number, utilizing telecommunications technology that links callers to their geographically nearest crisis center. It is expected that there will be at least one crisis program offering hotline services in all 50 states;

2) Increase the number of crisis centers/hotlines certified in suicide prevention, e.g., having

achieved defined standards in crisis worker training, service delivery, lethality assessments, organizational administration and program evaluation; and

3) Evaluate, collect and analyze data regarding such issues as: as the use of the national suicide prevention number (including variations by state and area code); reasons for callers' use of the service; the nature and appropriateness of services provided; outcomes of the intervention (i.e., referrals made to emergency, mental health and social services resources); and the technical efficiency and effectiveness of the telephone service that is provided to callers. The evaluation must address the effectiveness of intervention services provided by crisis centers within the network as compared to crisis centers not in the network.

To achieve these goals, the applicant will be required to engage in the following activities:

1) Network Centers: The applicant must demonstrate a capacity to network centers using telephone technology that permits national access to crisis centers or hotline services through a single toll-free number. This number will be selected by SAMHSA and maintained by the applicant. SAMHSA will choose a number that is easy to remember and is life affirming. The applicant will use this telephone number to establish and maintain the hotline network. At the end of the grant period, SAMHSA will determine whether if it will continue to retain the number or release it to the grantee. This determination will be made no later than six months prior to the end of the grant period. The technology utilized must permit calls to be directed immediately to a telephone

suicide prevention worker who is within geographic proximity to the caller. The network must have the capacity to assist local crisis centers in identifying the telephone numbers of callers at imminent risk of suicide in need of emergency rescue who are unable or unwilling to provide a telephone number or location (e.g. caller ID, ANI, or call tracing). The applicant must describe in their proposed approach the type of call routing system to be used (i.e. carrier driven advanced business networking or a customized service hosted by a carrier but maintained through the applicant organization or through subcontracts). The applicant should clearly explain why they are proposing a particular approach. This discussion should include the following information: review literature that discusses determination of peak usage periods in order to determine the size of the network, average call drop rates and how the proposed approach seeks to reduce call drops, the cost benefits to the approach, and the specific features of the approach that will enhance the hotline network, and provide crucial data to the individual crisis centers and to SAMHSA.

In addition to establishing the telephone network, the applicant must clearly demonstrate the capability to provide training and technical assistance to the individual crisis centers on utilizing the network technology, provide assistance to obtain or upgrade equipment at the local crisis centers in order to participate in the network, provide incentives to the local crisis centers to maintain their certification, continue participation in the network and provide call outcome data to the applicant who will then aggregate data from all centers, analyze and report it to SAMHSA.

2) Certification of Crisis Hotlines: The applicant must increase the number of crisis hotlines certified in suicide prevention. Crisis centers participating in the network should be certified in suicide prevention by the American Association of Suicidology (AAS), or if not certified by AAS, have met accreditation standards accepted by AAS as equivalent, such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), or Contact USA. The applicant should have experience with, or partner with, an organization that has experience with certification of crisis centers in suicide prevention.

3) Resource Database Development: The applicant must develop a Resource Database that can be accessed via the Internet by all crisis centers, regardless of their participation in the network. This resource database will quickly provide the hotline center with local information on emergency, mental health, and social service resources within 50 miles of the caller's geographical area. The applicant should either have, or partner with, an organization that has a documented history of developing such a comprehensive resource database. The applicant may also propose to use other currently existing databases.

4) Program Evaluation: The applicant must conduct an evaluation of the grant project that accurately documents the population served by the toll-free crisis line service, including variations in usage by state and area code; the reason(s) for callers' use of the service; the nature and appropriateness of the service that was provided; the outcome(s) (i.e., referrals made to emergency, mental health, and social service resources); and the technical efficiency and effectiveness of the telephone service that is provided to callers using the

toll-free crisis service. The applicant should either have, or partner with, another organization that has a documented history of successful evaluation efforts.

5) Sustainability: The applicant must propose a sustainability plan that ensures that the program can be self-supporting when Federal funding ends. The applicant must demonstrate experience in sustaining similar initiatives through blended public and private funding.

6) Financial Management: The selected applicant must demonstrate existence of an adequate financial management system (reference 45 CFR Part 74, Subpart C), and be capable of administering Federal awards. Specifically, the applicant must maintain and follow adequate policies and procedures that safeguard assets and determine cost allowability, maintain an accounting system capable of segregating grant income and expenditures, maintain effective accountability and control over grant funds, maintain accounting records supported by source documentation, maintain an adequate procurement system (including ability to administer subcontracts, if applicable), and maintain property control.

The activities described above fall within the following categories of allowable activities listed in the INF-04 PA (MOD): provider/network development, development of interagency coordination mechanisms, data infrastructure development, and evaluation. Activity in the other categories of allowable activity defined in the INF-04 PA (MOD) are allowed only to the extent that the applicant can demonstrate that they are critical to the effective implementation of the activities that are required for this grant.

Background:

There are currently estimated to be over 500 operating "crisis centers" in the United States, exclusive of military and employee assistance programs. Some are specialty centers focusing on crises related to domestic violence or rape. Others see their mission as responding to the needs of all types of personal and family crises. The primary objective of the crisis center is to diffuse the immediate crisis, ensure the caller's safety, and assist the caller to take the next immediate steps toward resolving the problem. In any type of serious personal crisis, the potential for suicidal thoughts and behaviors exist. In published surveys, 10 percent of calls to all types of crisis programs involve suicidality. Hotline crisis services represent one of many possible effective interventions for suicidality.

"Hotline" crisis services may be directly associated with a single crisis center, which also offers face-to-face client services, or be a "hotline-only" service in which there are no associated face-to-face services. Such "hotline-only" centers may be hundreds or thousands of miles from the location of the caller and often maintain databases of crisis, mental health, and social services local to the caller to which that person can be referred if indicated. "Suicide prevention hotlines" are staffed with suicide prevention workers who establish and maintain contact with the individual while identifying and clarifying the problem, evaluating the potential for suicide, assessing the individual's strengths and resources, and mobilizing available resources including paramedic or police intervention and emergency psychiatric care as needed.

"Suicide prevention hotlines" may be stand-alone "hotline only" services, may operate out of community agencies, or be part of organized health and mental health care delivery systems. While suicide prevention hotlines have been in existence for more than forty years, access to

such services in many areas has been either highly variable or non-existent. The multiplicity of phone numbers for local hotlines made national, state or regional public education campaigns impossible. This led to support for a single, toll free, nationally accessible telephone number for suicide prevention, utilizing telecommunications technology that links callers to their geographically nearest crisis center.

Though not all crisis centers have widely publicized "hotline" services, it is generally believed that most, if not all, centers field crisis calls from suicidal individuals. While face-to-face assessment and counseling in the work of crisis centers are to a large degree done by health professionals, much of the important work of telephone crisis intervention is done by trained volunteers. The use of trained volunteers in the role of telephone crisis workers has existed for many years and spawned the development of standards to guide them in their work. Workers responding to suicidal callers should be trained in the use of clinical intervention techniques. The certification of crisis centers in suicide prevention is a crucial component of this grant. Many crisis centers do not operate out of organized health delivery systems, such as hospitals or community mental health centers. State laws and regulations governing the use of terms such as "crisis center", "crisis line", or "hotline" either do not exist or vary widely. The majority of crisis center workers are volunteers who do not fall under any state licensing laws for mental health professionals. Thus, voluntary certification for meeting nationally recognized suicide prevention standards is virtually the only form of external, task specific quality control that exists for many crisis centers. The success of the network is ultimately tied to the adherence of participating crisis centers to nationally recognized standards for suicide prevention.

Definitions:

Crisis center: A program that establishes immediate telephone communication between people who are emotionally distressed and individuals who have been trained to provide telephone assistance to diffuse the crisis, ensure the caller's safety, and assist the caller to take next steps toward resolving the problem.

Hotline crisis services: A telephone service directly associated with a single crisis center.

Suicide prevention hotline: A program that provides telephone crisis intervention services to individuals expressing suicidal thoughts or behavior, or to others calling on behalf of such persons in crisis, with the objective of exploring alternatives to self-harm.

II. Award Information:

1. **Estimated Funding Available/Number of Awards:** It is expected that up to $2.2 million will be available to fund one award in FY 2004. It is expected that only one Category 2-Comprehensive Infrastructure Grant, as defined in the INF-04 PA (MOD), will be awarded. The maximum allowable award is $2.2 million in total costs (direct and indirect) per year for three years. **Proposed budgets cannot exceed the allowable amount in any year of the proposed project**. The actual amount available for the award may vary, depending on unanticipated program requirements and the quality of the applications received. Annual continuations will depend on the availability of funds, progress in meeting program goals and objectives, and timely submission of required data and reports.

2. **Funding Instrument:** Cooperative Agreement

Role of the Grantee:

- Comply with the terms of the award and all applicable grant rules and regulations, and satisfactorily perform activities to achieve the goals described below;
- Seek SAMHSA approval for key positions to be filled. The key positions include: project director, networking/telephony director, certification director, evaluation director, database director;
- Seek SAMHSA approval of proposed approach to networking of hotlines prior to implementing proposed design and accept SAMHSA-recommended modifications to approach;
- Consult with and accept guidance from CMHS staff on performance of activities to achieve goals described below;
- Respond to requests for information from CMHS;
- Agree to provide SAMHSA with data required for the Government Performance and Results Act (GPRA);
- Manage the toll free telephone number selected by SAMHSA through the end of the grant period and relinquish control of the telephone number to SAMHSA or to another organization, if required;
- Produce required SAMHSA reports.

Role of SAMHSA staff:

- Maintain overall responsibility for monitoring the conduct and progress of the suicide prevention hotline networking and certification program;
- Approve proposed key positions/personnel

- Review proposed approach and request modifications to approach and/or approve the approach;
- Make recommendations regarding continued funding;
- Provide guidance and technical assistance on project design;
- Approve all proposed subcontracts;
- Review quarterly reports and conduct a site visit, if warranted;
- Review and approve the evaluation plan, including the sites selected to participate in the evaluation;
- Approve data collection plans and institute policies regarding data collection;
- Recommend consultants for assisting with the resource database, evaluation, and data collection, if needed; and
- Provide technical assistance, as needed, on sustainability and to assist in disseminating the resource database to non-networked crisis centers.
- Provide a toll free number that is easy to remember, life affirming and test marketed.

III. Eligibility Information

1. Eligible Applicants: Eligible applicants are domestic public and private nonprofit entities. For example, State, local or tribal governments; public or private universities and colleges; community- and faith-based organizations; and tribal organizations may apply. The statutory authority for this program precludes grants to for-profit organizations.

2. Cost Sharing or Matching is not required.

3. **Other:** Applicants must also meet certain application formatting and submission requirements, or the application will be screened out and will not be reviewed. These requirements are described in Section IV-2 below, as well as in the INF-04 PA (MOD).

IV. Application and Submission Information

1. **Address to Request Application Package:** Complete application kits may be obtained from the National Mental Health Information Center at 1-800-789-2647. When requesting an application kit for this program, the applicant must specify the funding opportunity title (Networking and Certifying Suicide Prevention Hotlines) and the funding opportunity number (SM 04-013) for which detailed information is desired. All information necessary to apply, including where to submit applications and application deadline instructions, is included in the application kit. The PHS 5161-1 application form is also available electronically via SAMHSA's World Wide Web Home Page: http://www.samhsa.gov (Click on 'Grant Opportunities') and the INF-04 PA (MOD) is available electronically at http://www.samhsa.gov/grants/2004/standard/Infrastructure/index.asp.

When submitting an application, be sure to type "SM 04-013 Networking and Certifying Suicide Prevention Hotlines" in Item Number 10 on the face page of the application form. Also, SAMHSA applicants are required to provide a DUNS Number on the face page of the application. To obtain a DUNS Number, access the Dun and Bradstreet web site at www.dunandbradstreet.com or call 1-866-705-5711.

2. **Content and Form of Application Submission:** Appendices 3 and 5, referenced in the INF-04 PA (MOD) in Section IV-2, are not required and should not be included in the application. Additional information including required documents, required application components, and application formatting requirements is available in the INF-04 PA (MOD) in Section IV-2.

Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications

SAMHSA's goal is to review all applications submitted for grant funding. However, this goal must be balanced against SAMHSA's obligation to ensure equitable treatment of applications. For this reason, SAMHSA has established certain formatting requirements for its applications. ***If you do not adhere to these requirements, your application will be screened out and returned to you without review.***

- ❑ Use the PHS 5161-1 application.
- ❑ Applications must be received by the application deadline. Applications received after this date must have a proof of mailing date from the carrier dated at least 1 week prior to the due date. Private metered postmarks are not acceptable as proof of timely mailing. Applications not received by the application deadline or not postmarked at least 1 week prior to the application deadline will not be reviewed.
- ❑ Information provided must be sufficient for review.
- ❑ Text must be legible.
    - Type size in the Project Narrative cannot exceed an average of 15 characters per inch, as measured on the physical page. (Type size in charts, tables, graphs, and footnotes will not be considered in determining compliance.)

- Text in the Project Narrative cannot exceed 6 lines per vertical inch.

- ❑ Paper must be white paper and 8.5 inches by 11.0 inches in size.
- ❑ To ensure equity among applications, the amount of space allowed for the Project Narrative cannot be exceeded.
    - Applications would meet this requirement by using all margins (left, right, top, bottom) of at least one inch each, and adhering to the page limit for the Project Narrative stated in the specific funding announcement.
    - Should an application not conform to these margin or page limits, SAMHSA will use the following method to determine compliance: The total area of the Project Narrative (excluding margins, but including charts, tables, graphs and footnotes) cannot exceed 58.5 square inches multiplied by the page limit. This number represents the full page less margins, multiplied by the total number of allowed pages.
    - Space will be measured on the physical page. Space left blank within the Project Narrative (excluding margins) is considered part of the Project Narrative, in determining compliance.
- ❑ The page limit for Appendices stated in the specific funding announcement cannot be exceeded.

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, the information provided in your application must be sufficient for review. Following these guidelines will help ensure your application is complete, and will help reviewers to consider your application.

- ❑ The 10 application components required for SAMHSA applications should be included. These are:
  - Face Page (Standard Form 424, which is in PHS 5161-1)
  - Abstract
  - Table of Contents
  - Budget Form (Standard Form 424A, which is in PHS 5161-1)
  - Project Narrative and Supporting Documentation
  - Appendices
  - Assurances (Standard Form 424B, which is in PHS 5161-1)
  - Certifications (a form in PHS 5161-1)
  - Disclosure of Lobbying Activities (Standard Form LLL, which is in PHS 5161-1)
  - Checklist (a form in PHS 5161-1)
- ❑ Applications should comply with the following requirements:
  - Provisions relating to confidentiality, participant protection and the protection of human subjects, as indicated in the specific funding announcement.
  - Budgetary limitations as indicated in Sections I, II, and IV-5 of the specific funding announcement.
  - Documentation of nonprofit status as required in the PHS 5161-1.
- ❑ Pages should be typed single-spaced with one column per page.
- ❑ Pages should not have printing on both sides.
- ❑ Please use black ink, and number pages consecutively from beginning to end so that information can be located easily during review of the application. The cover page should be page 1, the abstract page should be page 2, and the table of contents page should be page 3.

Appendices should be labeled and separated from the Project Narrative and budget Section, and the pages should be numbered to continue the sequence

- ❑ Send the original application and two copies to the mailing address in the funding announcement. Please do not use staples, paper clips, and fasteners. Nothing should be attached, stapled, folded, or pasted. Do not use heavy or lightweight paper, or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments such as posters will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

3. Submission Dates and Times: Applications must be received by July 21, 2004. You will be notified by postal mail that your application has been received. Additional submission information is available in the INF-04 PA (MOD) in Section IV-3.

4. Intergovernmental Review: Applicants for this funding opportunity must comply with Executive Order 12372 (E.O.12372). E.O.12372, as implemented through Department of Health and Human Services (DHHS) regulation at 45 CFR Part 100, sets up a system for State and local review of applications for Federal financial assistance. Instructions for complying with E.O. 12372 are provided in the INF-04 PA (MOD) in Section IV-4. A current listing of State Single Points of Contact (SPOCs) is included in the application kit and is available at www.whitehouse.gov/omb/grants/spoc.html.

5. Funding Restrictions: Funds for the Networking and Certification of Suicide Prevention Hotlines grant may **not** be used for implementation pilots, as stated in the INF-04

PA (MOD). Additional information concerning funding restrictions is available in the INF-04 PA (MOD) in Section IV-5.

V. Application Review Information

1. Evaluation Criteria: Applications will be reviewed against the Evaluation Criteria and requirements for the Project Narrative specified in the INF-04 PA (MOD). The following information describes exceptions or limitations to the INF-04 PA (MOD) and provides special requirements that pertain only to the grant for Networking and Certifying Suicide Prevention Hotlines.

Note that implementation pilots referenced in the INF-04 PA (MOD) may **not** be included in this grant program.

Applicants must discuss the following requirements in their applications, in addition to the requirements specified in the INF-04 PA (MOD):

1.1 In "Section A: Statement of Need":

a. The target population for this program is the total potential number of suicidal persons who may seek help through hotline services in the United States. The applicant should address the needs of this target population in Section A of the Project Narrative.

b. Applicants may disregard the 4th bullet in Section A that requests applicants to show that the identified need for the proposed project is consistent with the State's priorities. This requirement does not apply because the scope of this grant program is nationwide.

1.2. In "Section B: Proposed Approach":

Applicants must address the goals and activities of the grant for Networking and Certifying Suicide Prevention Hotlines identified in Section I of this NOFA when responding to the bullets in Section B of the INF-04 PA (MOD).

1.3. In "Section D: Evaluation and Data":

All SAMHSA grantees are required to collect and report certain data, so that SAMHSA can meet its obligations under the Government Performance and Results Act (GPRA). The Networking and Certifying Suicide Prevention Hotlines grantee will be required to report on the increase in the number of hotline centers included in the network and the increase in the number certified in suicide prevention. Applicants must document their ability to collect and report on these measures in "Section E: Evaluation and Data" of their applications

2. **Review and Selection Process:** Information about the review and selection process is available in the INF-04 PA (MOD) in Section V-2.

VI. Award Administration Information: Award administration information, including award notices, administrative and national policy requirements, and reporting requirements are available in the INF-04 PA (MOD) in Section VI. SAMHSA's standard terms and conditions are available at http://www.samhsa.gov/grants/2004/useful_info.asp . Note that the Networking and Certifying Suicide Prevention Hotlines grantee will be required to provide quarterly

progress/financial reports in addition to annual progress/financial reports. The quarterly reporting format, including crisis center call data, is under development by SAMHSA.

VII. Agency Contact for Additional Information: For questions about program issues, contact: Brenda Bruun, SAMHSA/CMHS, Division of Prevention, Traumatic Stress and Special Programs, 5600 Fishers Lane, Room 17C-26, Rockville, MD 20857; 301-443-4669; E-mail: bbruun@samhsa.gov. For questions on grants management issues, contact: Gwendolyn Simpson, SAMHSA/Division of Grants Management, 5600 Fishers Lane, Room 13-103, Rockville, MD 20857; 301-443-4456; E-mail: gsimpson@samhsa.gov.

Dated: _____

Signed: Daryl Kade
Director, Office of Policy, Planning and Budget
Substance Abuse and Mental Health Services Administration