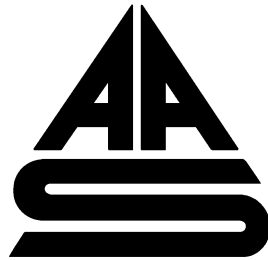

Organization Accreditation Standards Manual

Twelfth Edition



American Association of Suicidology



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VERSUS 8th EDITION
AMERICAN ASSOCIATION OF SUICIDOLOGY
ORGANIZATION ACCREDITATION STANDARDS**

12th Edition Changes

Two Components in Area 111 were extensively revised. Component 3 now called Outreach Service, Mobile Crisis Outreach Teams and Component 6 Internet Services (Online Emotional Support). Examiners will now offer as part of the AAS accreditation process accreditation for centers offering mobile crisis outreach teams and/or crisis chat and texting.

Crisis Chat & texting standards are available in Appendix 6. These separate accreditation standards are a result of an agreement between CONTACT USA & the American Association of Suicidology.

Organizations offering either Mobile Crisis Outreach Teams and/or Online Emotional Support will be accredited using these new standards and recognized for these specialized services above their basic accreditation.

11th Edition Changes

A Cultural Competence component has been added to Area 1 Administration and Organizational Structure. This addition is the major change made in the 11th Edition. The committee and other members of the AAS community believe there is a need to assure that organizations are responding “respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.”

10th Edition Changes

The accreditation committee has made some specific changes to the 10th edition of the Standards Manual related to online services to keep pace with the changing crisis service delivery environment. A Technology component has been added to Area I and Internet Services Component 6, Area III has been enhanced. In the appendix section at the back of the manual an example of policy and procedures for electronic communication has been included to assist organizations in preparing documentation for the operation of these services.

9th Edition Changes

To clarify and improve the Organization Accreditation Standards Manual, a 9th Edition was developed. The 9th edition continues to support the research reflected in the 8th edition as well as condensing the Rating Scale for each component from IV to III levels. The committee’s goal was to clarify the standards and make it easier to understand expectations.

Another change that emphasizes the importance AAS places on proactive intervention is in Area IV components 1 and 2. Both these components now have only one level. All organizations must meet the standard outlined in these components to become accredited.

8th Edition Changes

In October 2001 the federal Substance Abuse Mental Health Services Administration (SAMHSA) funded important research that examined the effectiveness of crisis centers. There were three primary researchers – John Kalafat, Ph.D. of Rutgers, Madelyn Gould, Ph.D. of Columbia and Brian Mishara, Ph.D. of the Centre for Research and Intervention on Suicide and Euthanasia (CRISE), University of Quebec at Montreal.

Among the results of interest to AAS were:

1. There is a need for more quality control and monitoring of crisis workers,
2. Crisis line worker selection criteria should include empathy, respect and the ability to establish good initial contact,
3. Training curriculum should include skills-building in the above areas,
4. Suicide risk assessments need to be given routinely on all calls to crisis centers to avoid missing potential suicidality.

A work group made up of the above researchers, the AAS Accreditation Committee and AAS Executive Director, Lanny Berman, Ph.D., made recommendations about how the AAS Accreditation standards 8th Edition should be revised to reflect these findings. Accordingly, changes were made in the standards.

ACKNOWLEDGEMENTS

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ACCREDITATION STANDARDS MANUAL

Preface

This is the Twelfth Edition of The American Association of Suicidology's Accreditation Standards Manual. The manual continues to build on the innovative work of the original American Association of Suicidology Committee on Accreditation first published in 1976, by incorporating the experiences of applying these standards during the process of conducting hundreds of site evaluations of crisis programs. This effort originated in a shared vision about the purpose and importance of defining basic standards to guide those who serve persons in crisis. This vision has been borne out in the work of Accreditation Examiners and responses of agency boards, staffs, funders, and various state officials to the accreditation process. American Association of Suicidology accreditation has stimulated self-evaluation and the improvement of suicide prevention and crisis intervention services.

Meanwhile, the crisis intervention field has matured into a more definable body of knowledge and practice. Both its growth and the clearer understanding of the crisis model have broadened the scope of services which can be assessed and accredited according to these AAS standards. These include: Suicide Prevention Centers, Crisis Intervention Centers, Online Emotional Support Services Shelters for Runaway/Pushed Out Youth and Domestic Violence Victims, Emergency Services of Community Mental Health Centers, Emergency Departments of General and Psychiatric Hospitals, and specifically focused education and outreach programs such as school based suicide prevention and mobile crisis outreach teams.

Two paradoxical themes characterize the crisis service delivery scene. There is an increasing human and economic need to focus on prevention programs and early intervention in life-threatening emergencies and other life crises. Also, in the broad field of mental health and psychiatric care, a dichotomy sometimes appears in the practice arena between traditional psychiatric emergency services, on the one hand, and suicide prevention and crisis intervention services, on the other.

The AAS Accreditation Standards Manual is intended to help bridge this gap. Our experience has taught us that the separation between these two aspects of comprehensive crisis service is, at best, artificial, and at worst, a disservice to persons experiencing a life crisis or psychiatric emergency.

ADMINISTRATIVE POLICIES AND PROCEDURES

Philosophy

The American Association of Suicidology accreditation process strives to recognize exemplary crisis programs, and to help other programs refine their services according to these standards.

The AAS Accreditation Examiner's role is both to evaluate and to assist the applying agency in reaching their highest potential according to these standards. This is one aspect of an ongoing collegial relationship with AAS.

The Accreditation Standards Manual is designed to assist the policy boards, administrators, and professional staff of various agencies to evaluate their crisis programs by measuring them against minimum standards of service. The standards defined in this manual are based on the values of the American Association of Suicidology, and the beliefs that:

Suicide prevention is everybody's business. Each major area of standards is sufficiently important that minimum performance should be met. Therefore, excellence in some areas will not compensate for deficiency in others. For example, a crisis program that does not perform basic services in suicide prevention will not be accredited by AAS.

One of the core values of AAS is that every person has the basic right to assistance in life-threatening or other crises. This value reflects the basic philosophy that an active intervention, including active engagement and active rescue and follow up should be implemented if a client's life is in danger even when the client will not or cannot assent. Because we also value a client's privacy and self-determination, ideally the intervention is done with the client's consent. Active intervention describes the entire spectrum of actions taken to reduce the suicidal ideation and behavior of the at risk individual. Active intervention includes both the collaborative relationship (active engagement) and also, when necessary, more aggressive interventions which may include the involvement of third parties, such as law enforcement, friends and family (active rescue), in cases involving imminent life threatening behavior. When possible, consent from the at risk individual will be obtained. When that is not possible, the intervention will occur without the client's consent or knowledge only after all other options have been exhausted.

Some examples of proactive approaches for intervention and support of suicidal clients include; using caller ID, tracing, and calling police or ambulance, making follow up calls to suicidal callers and third party callers who are suicidal. (**Appendix 5**)

These standards reflect the above statement. Organizations that do not or cannot operate in this manner will not be eligible for accreditation.

A single agency can rarely provide the comprehensive services necessary to assure this right. Therefore, a comprehensive community crisis program necessarily requires interagency coordination and collaboration among groups such as voluntary and governmental mental health agencies, police, emergency medical services, and self-help groups.

The purpose of accreditation is neither to exclude programs nor to stifle, frustrate, or punish agencies. Rather, minimum standards are meant to stimulate agencies to strive for higher levels of functioning-to teach optimum standards of services, not to become complacent with having met minimum standards. To this end the accreditation process focuses on self-evaluation, learning and sharing as ways to improve service.

The accreditation process represents the American Association of Suicidology's value system for crisis programs, which the standards define and identify as objectively observable elements of service.

The following example illustrates crisis intervention practice based on this philosophy:

At 11:00 p.m. police call the 24-hour telephone crisis program. A team of professional crisis workers (one a psychiatric nurse with a master's degree, the other a volunteer with a B.A. in psychology) is dispatched to make an outreach visit to the home of a man whom the police and the man's family believe to be acutely suicidal, non-cooperative and in need of assessment for possible involuntary hospitalization. The man has refused police and family recommendations for treatment. The outreach team spent one and one-half hours interviewing the man and his family in the home. He is finally persuaded to go voluntarily to the emergency department of a community hospital where he will be examined by psychiatric liaison staff for possible hospitalization. Following assessment of the man and his family situation, he is kept overnight in the emergency department holding bed. Outpatient therapy is initiated the following morning for the man and his family at the community mental health center with which the hospital has an interagency service contract for follow-up of such mental health emergency cases. The family is also given the telephone number of the 24-hour telephone and outreach crisis program.

Advantages of Accreditation

AAS accreditation bears practical rewards. Besides the humanistic value of assuring minimum standards of service for persons in crisis, there are other advantages:

- AAS accreditation validates service delivery programs that are performing according to nationally recognized standards.
- AAS accreditation examiners offer consultation tailored to the needs of an individual program, its staff and board.
- AAS accredited centers are given a unique ID and PASSWORD to view crisis centers' best practices on the AAS website.
- The increased visibility and credibility of an AAS accredited program provide opportunities for modeling of program excellence to other agencies and professionals.
- AAS accreditation provides a morale boost for staff working in the field of crisis intervention.
- AAS accredited programs have additional credibility with funding agencies and insurance companies.
- Programs seeking AAS accreditation have access to criteria for systematic, ongoing self-evaluation.
- People in life-threatening and other crises who obtain service from AAS-accredited programs are assured that staff has seriously examined their commitment to provide service according to recognized standards.

For those who share our value system and its implications for practice, we invite you to examine these standards and to join the AAS effort to improve the quality of crisis programs.

Others have said about the accreditation process:

“An advantage has been credibility. When we address funding sources or present our trainings and workshops the fact that we are nationally accredited is stated and understood by the participants as a standard by which we are glad to have been measured. It has been a point of pride by our funding sources and is often mentioned in any recognition we receive. We have also benefited from the networking opportunities that attending AAS sponsored events and conferences have afforded our staff and volunteers. In the staff development area it would be hard to put a dollar value to the benefits of accreditation across disciplines and job areas.”

Frank R. Campbell Ph.D., Executive Director
Baton Rouge Crisis Intervention Center, Inc. (Baton Rouge, LA)

“... one of the greatest benefits of AAS accreditation is the wonderful consultation we received from our site surveyor. It was so helpful to get an outside, objective look at our systems and procedures. She gave us some very helpful suggestions, which we have implemented ... Additionally, many of our callers have commented that they feel much more comfortable telling others to call us knowing that there is an outside organization that assures that we are providing high quality services.”

Lesley Levin, Executive Director

Behavioral Health Response (St. Louis, MO)\

“AAS accreditation assures funders and other community stakeholders that the services provided by our Crisis Line adhere to current, nationally recognized “best praactice” standards of care, and a commitment to quality improvement.”

Karen Kipling, M.Ed., Director, Care Crisis Response Services
Volunteers of America Western Washington (Everett, WA)

Eligibility Criteria

The American Association of Suicidology (AAS) has been accrediting crisis intervention programs since 1976 in the United States, Canada and recently internationally.

Programs seeking accreditation must offer crisis intervention services either as their primary focus or as a principle component of their service. The following types of programs may be included:

A suicide prevention and crisis center whose primary function is the provision of crisis services,

The emergency services program of a community mental health center,

A general hospital's emergency department that includes crisis services or a behavioral emergency program,

A psychiatric hospital with an emergency mental health or crisis component,

Any human service agency offering crisis services such as family service agencies or health maintenance organizations,

Specialty crises services such as youth hotlines, runaway shelters, victim services, domestic violence shelters, crisis chat and/or texting services etc.

Applicant programs must be organizational members of AAS. Initial application for AAS membership may be concurrent with application for accreditation. Current AAS membership fees are shown in the Application for Accreditation which is in the Appendix of this manual.

Organizations that are seeking accreditation for the first time must send at least one representative to the AAS annual conference during their 3 year accreditation. Those seeking a 5 year re-accreditation must send at least one representative to two AAS annual conferences during the five year accreditation period.

Those considering accreditation should read and become thoroughly familiar with this manual.

Application and Fees

Accreditation Preparation

AAS recommends that the applicant program conduct a self-evaluation, using the criteria and scoring sheet in this manual. This "trial run" should involve staff, volunteers, governing boards, funders and other interested community members. Should questions arise, the Director of Accreditation and Site Examiner Consultants are available for telephone consultation.

Accreditation Application

A complete application for accreditation includes the 3 page application, 1 page prescreening questionnaire (see Appendices), and a copy of the organization's active intervention policies as evidence that the center is ready for evaluation. For information concerning the application contact the Director of Accreditation or the AAS National Office. The application form and the prescreening questionnaire and the application and examination fees should be sent to the Director of Crisis Services Accreditation, c/o the AAS National Office at 5221 Wisconsin Avenue, NW, Washington, DC 20015 (202) 237-2280. The applicant will be notified of the names and contact information for their Accreditation Examiner (s) who will receive a copy of the application form, the prescreening questionnaire, and supplementary documents.

(Appendix 1)

Accreditation Fees

Fees for new organizations

If you are not yet accredited by AAS, you will pay a \$250 application fee, a \$2500 site visit fee plus the expenses of the examiner. The first period of accreditation is 3 years.

Application fee and site visit fee must accompany application for accreditation. The organization will be invoiced for examiner expenses after the site visit.

Fees for organizations that are currently accredited by AAS

To become re-accredited you will pay a \$1500 site visit fee plus the expenses of the examiner. Re-accreditations are for 5 years if the agency continues to meet the standards or 3 years if specific improvements are needed.

Site visit fee must accompany re-accreditation application. The organization will be invoiced for examiner expenses after the site visit.

Subsidies are available. Contact the Director of Crisis Services Accreditation

Accreditation Process

The AAS examiner will arrange the site examination with the director of the applicant program. The Accreditation Examiner will develop a tentative agenda, including an interview schedule and additional materials needed on site. The site examination will be conducted in accordance with policies and procedures established by AAS. The site examination is usually completed in one day but new organizations should be prepared for the site visit to last up to 2 days. At the conclusion of the day the Accreditation Examiner provides the program director with the general results of the evaluation including recommendations.

Reporting

A draft of the report may be sent to the program to help clarify issues or to check on specific remaining questions. The examination team files its final report with the AAS office. A copy of this report is sent within one month of the site visit to the program, after being approved by the Director of Crisis Services Accreditation along with the final decision regarding accreditation. **Annual Self-Survey Reports due every February are mandatory to maintain AAS accreditation.**

Accreditation

Upon accreditation, the Association provides each accredited agency or program with a certificate that includes the duration of the accreditation.

Accredited programs are recognized at the AAS Annual Conference. During the accreditation period the program must notify the Director of Crisis Services Accreditation of any changes in its program or personnel which would affect accreditation status or AAS's ability to contact the organization.

Non-accreditation

In the event that a program fails to meet the accreditation standards the evaluation team offers consultation and assistance to prepare for a later accreditation

Annual Self-Survey Reports

In order to maintain records on the annual progress of centers in maintenance of their accreditation status, AAS requires all accredited centers to complete the Annual Self-Survey Report before the end of February. The report will be reviewed and kept on file. This is a good tool to mark progress within your own center towards addressing recommendations made from your accreditation site visit. A copy of the annual report format with questions will be email to accredited center's contact person every December. A current copy will also be available on the AAS website.

Re-accreditation

Organizations seeking re-accreditation must apply to AAS using the application in the appendix of this manual. Organizations will be scheduled for re-accreditation before their current accreditation lapses. Failure to apply to re-accredit within 2 months of current accreditation period will require the organization to start the accreditation process again as a new center. Requests for an extension in the organization's accreditation period will be reviewed but a formal request must be made to the Director of Crisis Services Accreditation before the accreditation period has ended.

Applicant programs must be organizational members of AAS. **Initial application for AAS membership may be concurrent with application for accreditation. Current AAS membership fees are shown in the Application for Accreditation which is in the Appendix of this manual.**

Organizations that are seeking accreditation for the first time must send at least one representative

to the AAS annual conference during their 3 year accreditation. Those seeking a 5 year re-accreditation must send at least one representative to two AAS annual conference's during the five year accreditation period.

Appeal of Accreditation Results

Organizations may appeal an unfavorable decision by:

- 1) Submitting a written documentation to clarify a possible misunderstanding
- 2) Requesting a telephone consultation with the Director of Crisis Services Accreditation to present grievances
- 3) Based on the appeal, a second opinion may be sought and a new Examiner assigned to reevaluate the organization. The organization bears the cost of this reevaluation.

In all cases the decision of the Director of Crisis Services Accreditation is final.

Basis of Evaluation

Much of the AAS Accreditation process is modeled on the Program Analysis of Service Systems (PASS) developed by Wolf Wolfensberger.

The Accreditation Standards offer a range of levels of compliance. The Examiners seek to document levels of compliance through a variety of methods. Prior to the examination, written documents are reviewed. During the site survey, persons are interviewed, records are assessed, and the setting is inspected.

The Examiners are searching for three or more independent indicators, documenting ways in which the facility addresses each standard. For example, concerning the governing body, are there recorded minutes? Do these minutes reflect decisions being made? Is staff aware of these decisions? Can the agency show that these decisions are implemented?

Crisis services are varied in their style of delivery, the community needs which they address, and their overall focus. The AAS Accreditation Standards recognize and applaud this diversity. Accreditation Examiners are trained to both acknowledge this heterogeneity and apply the Standards as a comprehensive assessment tool.

General Criteria and Manual Format

The evaluation focuses on seven areas, each with its separate standards. These areas are:

- Area I: Administration and Organizational Structure
- Area II: Screening, Training and Monitoring Crisis Workers
- Area III: General Service Delivery System
- Area IV: Services in Life-threatening Crises
- Area V: Ethical Standards and Practice
- Area VI: Community Integration
- Area VII: Program Evaluation

The Accreditation Standards Manual considers each area separately. An explanatory statement is followed by discussion of the standards used to evaluate that area. The structure for each of the seven areas is outlined below.

1. Area
 - A. Explanatory Statement
 - B. Standards
 1. Component 1
 - a. Description
 - b. Rating Scale
 - Level I
 - Level II
 - Level III
 2. Component 2
(etc.)

Rating

All components are labeled in the Manual and on the summary sheet (a copy of which may be found in the Appendix).

Within Area IV (Services in Life-threatening Crises), Component 1 (Lethality Assessment) and Component 2 (Rescue Services) each have a single required compliance level. The other components are scored at one of three compliance levels. Level I scores indicate that minimum standards have been met.

To achieve accreditation the organization must meet or exceed Level I standards for every component. AAS understands that some organizations do not have the resources to achieve Level II or Level III in all areas.

Standards for Level II and Level III ratings build upon the lower level(s) such that a score of II indicates that all Level I and Level II standards have been met and a score of III indicates that standards for all three levels have been met.

Total scores are not relevant to the determination of accreditation status. However, Level II and Level III scores demonstrate an organization's commitment to continuous quality improvement, reward the organization's efforts to develop and adopt best practices, and favorably impress colleagues, community stakeholders and funding entities.

Public Recognition

The Association provides each accredited agency or program with a certificate, the notation on which includes the effective dates of the accreditation. AAS logos are available upon request. Annually re-accredited and newly accredited organizations in any given year are acknowledged at the AAS Conference in April.

Confidentiality

Information received by the Association during the accreditation process is treated confidentially. The following are exceptions:

- 1) AAS will confirm receipt of an application for accreditation.
- 2) AAS will confirm that a Site Examination is pending or has been conducted.
- 3) AAS will confirm the current and historical accreditation status of an agency or program.
- 4) AAS reserves the right to publish aggregate data based on Accreditation Examinations and Applications.
- 5) Serious situations uncovered during the accreditation process that will potentially affect public health and safety will be reported to the program director immediately.

Procedures for Handling Complaints Against AAS Accredited Centers

The following procedures will be followed should a complaint be received about an AAS Accredited Center:

- 1) AAS requires the complaint be made in writing and sent to the attention of the Director of Accreditation, c/o the National Office.
- 2) The Director of Accreditation will send a letter to the complainant acknowledging receipt of the grievance and informing him/her of the action to be taken.
- 3) The Director of Accreditation will send a copy of the complaint to the identified center, with a request that the center respond to the complaint to AAS within 30 days.
- 4) The Director of Accreditation will review the center's response. Based on that review, the Director will make one of the three determinations: a. Accreditation Continues, No further action is needed; b. Accreditation Continues, with recommendations to implement changes; or c) Accreditation is suspended, pending compliance with recommended changes.
- 5) The decision of the Director is final.
- 6) A copy of all correspondence will be kept in the organization's file in the National Office.

STANDARDS

AREA I: ADMINISTRATION AND ORGANIZATIONAL STRUCTURE

Explanatory Statement

The Administration and Organizational Structure provides three important lines of authority. It functions as the official decision making body concerning agency policy. It is responsible for the operation and monitoring of agency services. It establishes and helps maintain liaison with other community services. Therefore, the quality of the Administration and Organizational structure is vital to the stability of the agency, a key factor in insuring consistency and continuity, and ultimately the quality and effectiveness of the agency's program. Agency administration should be responsible to a board or parent governmental body. For example, an agency which has no formal system of getting advice from or measuring its accountability to governing boards and consumer groups runs the risk of jeopardizing its program's effectiveness, relevance, continued funding and community support.

Administration determines personnel policies, job descriptions and performance requirements, which in turn directly affect the quality of service delivered to clientele. It is the administration that is responsible for initiating, supporting, and implementing program evaluation and outcome recommendations. Administrations should also maintain current financial records according to the prescription of established laws and regulations.

The Components of Administration and Organizational structure are:

1. Governance
2. Program Management
3. Accountability: Administrative, Personnel and Financial
4. Physical Setting
5. Technology
6. Cultural Competence

Component 1: Governance

Description

The description of this Component is apparent from the rating criteria.

Rating Scale

Level I.

The legally constituted Board meets at least four times a year.

OR

The program is a part of a for profit organization that is dedicated to serving the general community.

There is community input into governance.

Level 11

Level I requirements are met.

There are policies and procedures that detail the Board's responsibilities and role.

There is broad community representation on the board or there is a highly involved advisory board providing input to the program.

Level III

Level I and II requirements are met.

The Board has a succession plan for itself and Executive Director, a board orientation procedure and a strategic plan. The strategic plan is reviewed at least quarterly. The board arranges an annual audit or review of finances by an independent auditor.

Component 2: Program Management

Description

To meet the criteria in this Component, an academic or professional degree in health or mental health may neither be necessary nor sufficient. It is expected that program management or supervisors would have training as a suicidologist or crisis specialist, and supervised experience as designated in this standards manual (see Area II, Training Programs). Such training may be obtained in an AAS accredited crisis services agency or in formal academic training programs, including but not limited to preparing psychologists, nurses, psychiatrists, counselors and social workers as crisis specialists.

If a program is either located in, or is a component of a CMHC or general hospital, the personnel referred to in Level III may be professional staff of the CMHC.

Rating Scale

Level 1

The program has on site staff or access to professionally credentialed experts in the field of crisis work, psychology, or suicidology.

The program director or supervisor has at least 6 months of experience in crisis work and some formal education in the fields of crisis intervention, suicidology and management.

Level II

Level I requirements are met.

Supervisory responsibilities of the director are formulated in writing.

There are additional salaried staff members who perform other management duties, such as supervising crisis workers, arranging professional consultation and providing direct assistance to the crisis workers.

Level III

Level I and II requirements are met.

Professional consultants or staff experienced and trained in suicidology and crisis work is regularly used for the supervision of client care, training, organizational and program problems.

There is an up-to-date organizational chart, which defines areas of supervisory responsibility.

The supervisory functions of the program director and others are clearly specified and consistently followed.

Component 3: Accountability: Administrative, Financial, Personnel

Description

The description is apparent from the rating criteria.

Rating Scale

Level I

The program has a detailed budget and business records and audit or review with generally accepted accounting principles.

Approximately 25% of the operating budget is assured and there is evidence of financial planning.

Income is based on a single primary funding source.

Written job descriptions, for management and personnel include specific qualifications and functional tasks

Level II

Level I requirements are met.

Performance appraisals are conducted using specific criteria and a written record is kept.

Personnel policies are comprehensive and in writing.

Half of the operating budget is assured.

A written annual report is disseminated to governing entities, staff and funders.

Written or electronic records are kept on all personnel.

Level III

Level I and II requirements are met.

The majority of the budget is assured and has been consistently maintained for at least 3 years.

There is a written fund development and strategic plan that is implemented with Board or community involvement.

An independent auditor conducts the annual audit or review. A Compilation is not sufficient.

The annual report includes measurable objectives, data and analysis on management services.

Personnel are annually evaluated against clearly defined job performance requirements and a written record is kept in the personnel file.

There is evidence that the organization addresses issues that might place the organization, its consumers and its personnel at risk for injury or liability

The Board of Directors reviews an annual assessment of Risk and steps to improve management of risk are taken where needed.

There is evidence that the organization has committed time and resources to prepare for a

potential disruption in service delivery, i.e., natural disasters (i.e., floods, earthquakes, and blizzards), outbreaks of illness (swine flu) and even financial discontinuity.

Component 4: Physical Plant

Description

The description is apparent from the rating criteria.

Rating Scale

Level I

There is a designated office space for both administrative and crisis response work and supervision.

At all times, AAS standards for crisis delivery are being met, regardless of where or how the services are being delivered.

Level II

Level I requirements are met.

There is a central location containing staff offices, which includes a separate room for crisis workers and a central location for client related records and training materials.

The facility is adequate for the delivery of crisis services and used on a twenty-four hour basis.

Level III

Level I and II requirements are met.

The facility incorporates staff and client safety, confidentiality and practicality into the design.

The site is accessible for volunteers, staff and clients who have accessibility needs (ADA compliant).

There are suitable offices for face-to-face contact and online emotional support.

All client-related records, materials and necessary equipment are available and accessible.

Communication between workers and supervisors is easily accomplished while allowing for private crisis contacts.

Component 5: Technology

Description

AAS believes technology is an important component in providing better crisis services. When properly implemented, technology will improve accuracy of information, speed of delivery, and empower the crisis worker with more knowledge. AAS has always been an early adopter of technology, however, AAS believes technology is a tool and its intent is not to remove or diminish the human interaction of helping those in need. (Appendix 8)

Rating Scale

Level I

There are policies and procedures that govern the use of technology.
The program has integrated current technology phone and Internet into its service delivery.
Crisis workers are trained in the use of all the organization's technology.

Level II

Level I requirements are met.
There is a designated staff person to oversee technology issues including Internet services.
Phone system permits tracking call data and doing real time monitoring of calls.
The agency has an effective data management system.
Organization uses current up to date technology to promote their services, such as website, social media.

Level III

Level I and II requirements are met.
The organization has a written technology plan that includes a future orientation.
Information gleaned from technological resources is used to make management decisions.
There is evidence that crisis worker feedback is used to modify or make changes as necessary.
Technology is used as an integral part of quality assurance.
The organization has put in place security measures to protect client/staff confidentiality and data integrity.
Continuity of service plan includes back up for all technology.

Component 6: Cultural Competence

Description:

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, sexual orientations, gender identities and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

“Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations” (NASW, 2000b, p. 61).

Operationally defined, *cultural competence* is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (Davis & Donald, 1997). Competence in cross-cultural functioning means learning new patterns of behavior and effectively applying them in appropriate settings.

Cultural competence is the ability to think, feel, and act in ways that acknowledge, respect and build upon ethnic, cultural, linguistic, sexual orientation and gender identity diversity. It is an *ongoing* developmental process for organizations as well as for individuals, and a key component of effective crisis counseling. For organizations, being culturally competent means that diverse populations within the area served receive appropriate and relevant assistance. Rather than using a one-size-fits-all model for service delivery, organizations tailor their services to meet specific linguistic and cultural needs of their clients. In developing cultural competence the crisis worker improves the ability to effectively communicate and understand the community being served.

Cultural competence is a goal toward which organizations and individual crisis workers strive. Each facet of the agency must participate in the process for it to be successful. At each level, the principles of valuing difference, assessing self, and building cultural knowledge are applied. As the attitudes, policies, and practices change the organization will become more culturally competent.

Level 1

The organization acquires data that describes the racial, ethnic, cultural, religion, sexual orientation and gender identity diversity of people in its service area.

Training is provided on cultural competence for all new crisis workers. Training addresses issues of diversity in culture, language, class, race, ethnicity, religion, sexual identity and other factors that may be relevant in the center’s service area. Training addresses the special concerns of populations known to be at elevated risk for suicide. These include, but are not limited to, African-American males, Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth, and older adults. There is documentation of completion of training.

Training as described above on cultural competence is done annually for the entire organization; there is documentation of attendance for every staff member. Training topics reflect characteristics of the service area.

Level II

Level I requirements are met.

The organization has identified the cultural dimensions and has processes for obtaining input from diverse populations within its service area.

The program has program and promotional information printed in multiple languages as appropriate for its service area.

Sensitivity to diversity issues and demonstration of cultural competence are addressed as part of the screening process, case reviews, call monitoring and supervision of staff.

There is documentation of completion of training and pre-test scores and post-test scores

Level II

Level I and II requirements are met.

The organization has a written cultural competence plan and/or there is evidence that cultural competence issues are addressed in policies pertaining to recruiting, hiring, training, resource development, program promotion, and client rights etc.

The organization documents an annual self-assessment of its level of cultural competence and uses the information obtained to advance its level of competence.

The organization identifies major cultural competence issues and takes initiative in providing programs, resources and promotional materials tailored to the specific sub-populations.

The program's crisis staff reflects the cultural and ethnic diversity of the population served. Where there are significantly large ethnic communities' staff are available who speak the appropriate languages.

Language translation services are available as needed for all callers.

AREA II: SCREENING, TRAINING and MONITORING CRISIS WORKERS

Explanatory Statement

The desired end product of a training program is a worker with the requisite knowledge, attitudes, and skills to perform an accepted standard level of service on behalf of those in crisis.

Six standards apply to training programs for crisis workers. These standards may also apply to front line crisis workers such as nurses, clergy, police or others whose routine work brings them into contact with persons in life-threatening or other crises, even though their full time occupation may not be crisis work.

Research substantiates that a quality crisis worker possesses empathy and social skills that cannot be taught in a brief training. It is therefore of the utmost importance that crisis centers do a thorough job of screening candidates who already possess the most essential attributes for the helping professions: ability to listen, be caring, and value human connection. While training is important, the intrinsic abilities of a natural helper are invaluable to quality crisis work.

Mishara, B. L. et al. (2005). *A silent monitoring study of telephone help provided over the Hopeline Network and its short-term effects*. Washington, DC: Substance Abuse and Mental Health Services Administration

The importance of training standards cannot be overemphasized. As high quality service delivery is related to the skill of workers, so is the skill of workers related to training. Training activity should be evaluated in terms of behavioral outcomes. As a result, application of a training standard to a prospective worker's previous training might result in the reduction of training time for some trainees and extension of training time for others. These standards are derived from the experience of trainers in the field of crisis intervention.

The total training time is an essential aspect of thorough planning. *Needs of trainees should be determined by pre- and post-evaluation*. In general, a minimum of 40 hours of training is indicated for those without previous formal training in suicidology, crisis management, and mental health counseling. The 40 hours should include a minimum of 32 hours formal training plus eight hours of co-worker experience prior to independent assignment. Further experience with a co-worker is strongly recommended. The co-worker experience should include active and supervised participation in management of at least three crisis situations.

If less than 40 hours of training is offered, there should be evidence that the worker has acquired the required knowledge, attitudes and skills through other sources, e.g. a university sponsored crisis course with supervised clinical practice or is an AAS Certified Crisis Worker or has equivalent experience in the crisis field.

Components of the training program area are:

1. Screening
2. Planned Curriculum Objectives, Content and Bibliography
3. Planned Curriculum Methodology

4. Pre- and Post-Evaluation of Trainees
5. Qualification of Trainers
6. Monitoring of Crisis Workers

Component 1: Screening

Description

Effective screening procedures, training, and evaluation of prospective trainees are critical in ensuring that clients receive the best care.

The screening procedure should be formal, related to agency objectives, culturally sensitive, offer equal opportunity, and stated in writing as opposed to being casual, subjective and based on the personal preferences of the director or trainer and/or personal goals of the applicant.

Recent research has shown that it is critical for an effective crisis worker to have basic empathic skills.

*Applicants must demonstrate the ability to be positive in their empathic responses (e.g. be understanding, have compassion, see the situation from the person in crisis' perspective), show respect for the client (e.g. allow the caller to feel what he/she feels, accept the caller where she/he is, be very open to talk to people of all different backgrounds) and have good initial contact (e.g. welcomes the caller and makes him/her feel that he is being heard and understood; responds on the phone in such a way that the caller wants to stay on the phone, starts with a good pace; helps the caller to feel comfortable, encourages the caller to talk freely). Because basic empathic skills can be difficult to teach and to acquire, trainees should be screened and recruited for these skills prior to training.

*See *Suicide and Life-Threatening Behavior* (2007), 37(3) for relevant evaluations by Mishara et al (pp. 291-307 and pp. 308-321), Kalafat et al (pp. 322-337), and Gould et al (pp. 338-352).

An acceptable trainee should demonstrate the *potential* for acquiring the necessary knowledge, attitudes and skills of an effective crisis worker (e.g. demonstrate an openness and desire to learn, convey an attitude of human regard for persons in stressful situations), be able to hear and incorporate feedback (a brief role-play, followed by brief feedback and re-role-play gives some indication of this) and pass a background check. Interviewers should be alert to the fact that previous experience in counseling or formal professional training in a mental health field does not necessarily qualify a person to work with people who are suicidal or otherwise in a crisis. Evaluation of an applicant's previous experience and professional training should not summarily be discounted, as it may include content that coincides with training objectives, e.g. a social worker, clinical psychologist or psychiatric nurse may have had a graduate course in suicidology or crisis management along with a clinical practicum in a crisis center. It is important to do primary source verification of persons who are credentialed.

Applicants should also be screened about their personal reasons for becoming involved in crisis work and providing assistance to acutely distressed persons. It is important to screen for the individual's emotional readiness to provide crisis work and attitudes in approaching persons in crisis. The training program itself, particularly when it includes role-playing and directly supervised crisis work prior to independent assignment, is an effective tool to screen applicants for their skills, knowledge and appropriate attitude. Screening should take place in several stages such as prior to training, during the application process, at the beginning of training, during training and during their first work with clients.

Rating Scale

Level I

Screening is done according to written criteria with particular focus on screening a person's ability to demonstrate positive empathy, respect for the client, cultural competence and ability to engage in good initial contact.

There is evidence that the process is selective in who becomes a crisis worker.

Screenings extend to the training and/or probationary period according to a written plan so that those crisis workers who do not meet standards are screened out before they are interacting with those in crisis.

Reference checks are done on all applicants

Level II

Level I requirements are met.

There is documentation that screening occurs throughout the training process.

There is evidence that staff is alert to ways to improve the screening process.

Written records are used to screen and assess the progress of all applicants.

If applicants are already employed in another part of the larger agency (e.g. CMHC), there is additional screening specifically for the crisis program.

There are multiple methods used for screening applicants throughout the screening process.

Level III

Level I and II requirements are met.

There is evidence that the screening process reflects the most current research on predicting how best to assess helper performance.

Multiple experienced staff is part of ongoing screening however one staff person is responsible.

There is evidence that the results of the screening process affect the training program and that the screening process is a component of Continuous Quality Improvement.

Reference checks, primary source verification, and/or background record checks are a highly integrated part of screening.

Component 2: Planned Curriculum Objectives, Content and Bibliography

Description

A planned curriculum for initial training includes behavioral objectives, a content outline, a methodology plan, and bibliography (i.e. a syllabus). The plan should be current and in written form. Ideally, it should include a resource manual of training materials, which is readily available to trainees. The objectives should be defined in terms of measurable behaviors and should include demonstrable knowledge, attitudes and skills of crisis intervention.

Experience has shown that crisis programs, in spite of their advertised focus in areas such as suicide prevention, mental illness, domestic violence or child abuse will receive a wide variety of crisis calls. Thus the ability to deliver effective crisis intervention services in a broad range of problem areas must be developed.

The curriculum plan should include these *attitudinal* outcomes:

1. Acceptance of persons different from oneself, and a non-judgmental response toward sensitive issues (e.g. not discussing suicidal ideation or abortion with a client in terms of its moral rightness or wrongness).
2. Balanced and realistic attitude toward self in the helper role (e.g. not expecting to "save" all potential suicides by one's own single effort, or to solve all the problems of the distressed person).
3. A realistic and humane approach to death, dying, self-destructive behavior and other human issues.
4. Coming to terms with one's own feelings about death and dying insofar as these feelings might deter one from helping others.

The curriculum plan should include at minimum the following *knowledge* areas:

1. Crisis theory and principles of crisis management,
2. Basic suicidology, including suicide assessment (lethality and probability of attempt), intervention strategies,
3. Victimology, including assessment of victimization and risk of assaulting others,
4. Legal/Ethical issues,
5. Community resources,
6. Record system and program policies,
7. The consultation process,
8. Cultural/diversity awareness, including the need and appropriateness of responding to individual and groups with regards to their cultural background and other diversity factors through behaviors, attitudes and policies,
9. Voluntary and involuntary hospitalization criteria and procedures, and
10. Psychopathology, psychiatric diagnosis, psychotropic medication, substance abuse.

The curriculum plan should include these *skill* outcomes:

1. Ability to assess in life-threatening situations, including risk of suicide and/or homicide,

2. Ability to actively engage,
3. Use of techniques of crisis management,
4. Ability to mobilize community resources in an efficient and effective manner,
5. Ability to respond with respect and effectiveness and render assistance to individuals in crisis and distress with appropriate regard to their cultural, racial or ethnic background; their religion or language; their socio-economic status; or other diversity factors.
6. Provide efficient record keeping and policy implementation (e.g. recording essential notes in succinct form within the same work shift so they are useful to the next worker), and
7. Use of the consultative process, e.g. knowing who to call under what conditions.

Rating Scale

Level 1

There are written objectives for the training curriculum.

Content and methodology of the training are consistent with stated objectives.

There is a written training syllabus.

Trainees are provided with a bibliography and resource materials.

Level II

Level I requirements are met.

Objectives are written and defined operationally in terms of expected knowledge, attitudinal and skill outcomes on the part of the trainee.

Objectives form the basis for content and methodology in a majority of training topics.

The training content outline is balanced among knowledge, attitude and skill areas.

A training manual is used as part of training.

A written plan is followed in training sessions.

There is evidence that the bibliography is updated regularly.

Level III

Level I and II requirements are met.

Objectives are measurable and used to evaluate the effectiveness of training and of the trainee's skills.

Training is comprehensive and broad enough to cover most issues of crisis callers.

Training topics may be added based on needs assessment or changing demographics of crisis calls.

Trainees have access to both a library of current crisis intervention resources on site or via the Internet.

Training content is based on the latest research and state of the art knowledge about service delivery.

Trainers and trainees have separate and comprehensive manuals that follow the curriculum.

Component 3: Planned Curriculum Methodology

Description

(Also see description for Component 1.) Training methodology may vary according to the training background, experiential and personal preference of particular trainers. However, trainers should adhere generally to basic and widely recommended educational and training practices. Some of these recommended training methods include:

1. Role playing and other experiential based methods
2. Use of audiovisual materials, such as simulated recorded calls and videotape
3. Opportunity to function as a co-crisis worker with experienced staff before assignment to work on an independent basis
4. Observation of trainee while handling a crisis call, e.g. silent monitoring
5. Sensitivity training techniques related to attitudinal training, and
6. Didactic presentation and reading assignments.

Rating Scale

Level I

There is a minimum of *40 hours* of training for those without previous formal training in suicidology, crisis management, and/or mental health counseling or are AAS certified.

The 40 hours should include a minimum of 32 hours formal training plus eight hours of co-worker experience prior to independent assignment.

All prospective crisis workers should be required to pass a test proving their capability for meeting the accepted crisis work standards.

There is a requirement of supervised role play or phone work prior to independent work at the crisis center.

Level II

Level I requirements are met.

Training methods involve considerable interaction between trainer and trainees.

Training techniques such as role-plays are used to aid in skill development.

Methods include teaching in all areas of functioning, i.e. knowledge, attitudes, skills.

Trainees have opportunities to function as co-workers with experienced staff prior to individual assignment.

Each trainee receives feedback on skills demonstrated.

Level III

Level I and II requirements are met.

There is a written plan of methodology which is adhered to consistently and which includes adaptations based on assessed needs of individual trainees.

Training methods are balanced in respect to the knowledge, attitudinal and skill areas of functioning.

There is opportunity for direct observation of, and supervision by an experienced trainer or worker, who complete a written report of the trainee's performance.

There is evidence that methodology is planned in accordance with evidence based training practices and that the trainer is consciously working to improve training methods.

An experienced trainer or worker, who completes a written report, formally observes trainees. Formal feedback is provided to all trainees.

Component 4: Pre- and Post-Evaluation of Trainees

Description

In order to effectively deliver training, and to make quality improvements, a crisis center should have ways to measure the performance of trainees. A pre-and post-evaluation is an effective way to both monitor trainee progress and to assess the training program itself. The crisis center should have standards of skills and knowledge that apply to all crisis workers, regardless of their educational level or prior training.

Rating Scale

Level 1

Trainees' knowledge, attitudes and skills are determined by a pre-and post-evaluation designed to help:

1. Determine extent of original training,
2. Adapt the present training program according to predetermined training needs,
3. Plan further training as indicated,
4. Determine the trainee's fitness to work with clients in crisis,
5. Measure the trainee's ability to express positive empathy, respect and good initial contact.

There should be a minimum expected achievement on the post-training evaluation as a requirement for successful completion of the training program.

The assessment should include items in the knowledge, skills and attitudes areas of the curriculum content. Post- evaluation measures the trainee's ability to express positive empathy and respect for the client as well as demonstrate the trainee's ability to develop a strong initial contact with the client. *

**Mishara, B. L. et al. (2005). A silent monitoring study of telephone help provided over the Hopeline Network and its short-term effects. Washington, DC: Substance Abuse and Mental Health Services Administration*

Level II

Level I requirements are met.

Outcomes of pre-evaluation of trainees are used in adapting the training program according to individual needs. Expected achievement is in writing.

The post-evaluation should be a role-play or response to simulated callers in which trainees demonstrate specific helping skills and strategies.

The evaluation should include agreed upon helping strategies such as the now widely accepted helping approach that includes 1) establishing rapport, 2) assessment and defining the problem(s), 3) exploring feelings, 4) exploring past coping or coping repertoire and 5) exploring alternatives and arriving at a plan. Helping skills such as active listening (e.g. reflecting content and affect) can also be included in the evaluation.

Level III

Level I and II requirements are met.

Trainees receive ongoing (e.g. after every role-play) written feedback during the training process. Trainees are able to evaluate the training and trainers in writing at the end of the training and this should be part of the center's ongoing self-evaluation. There is evidence that the pre-and post-evaluative process includes a wide variety of assessment instruments that helps to insure that only properly trained and qualified crisis workers move beyond the training process. There is evidence that some potential crisis workers have been rejected because of the training evaluation process. The training process continues to be modified as a result of the evaluation results.

Component 5: Qualification of Trainers

Description

Effectiveness of training can be enhanced or inhibited by the qualifications of the trainer. The assumption is often made that a skilled practitioner is also a skilled trainer. This may or may not be true. Likewise, the holding of a professional degree does not in itself qualify one as a trainer.

Qualifications of a trainer should include the following:

1. One year of supervised experience in crisis work - including work with suicidal and other persons in acute distress - in which the prospective trainer demonstrated at least above average performance in the knowledge, attitudinal and skill areas of functioning. Performance is measured by the agency's established criteria for satisfactory performance.
2. Basic instruction in training methodology and techniques. Instruction should include work as a supervised co-trainer, discussion of training problems, critique and evaluation by the trainer. The supervising trainer should specify the minimum performance required of a prospective trainer prior to functioning independently as a trainer.

The agency provides trainers with regular opportunities to learn new training methodologies and upgrade their skills through workshops and special courses. Trainers will attend at least one training improvement workshop or course per year.

Rating Scale

Level I

The prospective trainer has a record of demonstrated competence as a crisis worker for at least one-year, is interested in and enthusiastic about his/her training function.

The trainer has attended additional training to develop effective training skills or expertise.

Level II

Level I requirements are met.

The lead trainer (responsible for pre service training) has at least a year of experience teaching or training along with demonstrated knowledge and skills in crisis intervention.

The lead trainer uses creative techniques to provide training.

Expert consultants or speakers are used to present specialized information.

Level III

Level I and II requirements are met.

The lead trainer has extensive experience as a crisis worker with a demonstrated record of excellence.

He/she has had basic instruction in crisis training techniques either as a supervised co-trainer with critique and written evaluations, or in a formal educational setting.

The trainer is alert to use opportunities to obtain feedback on training techniques and improves their knowledge and skills through written evaluation, special consultants, and workshops.

Technical and clinical topics are provided by or supervised or reviewed by licensed professional or content experts.

Lead trainers with the program have presented at conferences (such as AAS) to demonstrate their skills and expertise.

Component 6: Monitoring Crisis Workers

Description

The organization has responsibility for assuring that trained crisis workers continue to practice effective crisis intervention techniques. This may be accomplished, for example, through in-service training, supervision – both overt and covert (meaning observation of the crisis worker’s skills without the crisis worker knowing they are being evaluated), busy signal monitoring, complaint investigations, call report logs, customer satisfaction questionnaires, program evaluations and peer evaluations. It is the responsibility of the organization to define its procedures for measuring the quality and show proof that it is using those procedures and have implemented these procedures in such a way to meet their state’s (province or countries) disclosure requirements.

Ongoing training is offered through a variety of modalities, that may include in-services, video tapes/DVDs, e-learning and reading articles. Ongoing training is required of all crisis workers.

The topics of training are directed by needs of the workers, program objectives and job requirements.

Ongoing training needs of workers can be assessed through questionnaires, interviews, and performance evaluations. There should be ongoing attention to suicide prevention and using feedback from program evaluation.

Supervision includes one hour of direct supervision for each 40 hours of crisis work (or in the case of part-time volunteers, their supervision should be done no less than every 3 months). Supervision may include monitoring both sides of calls, documentation review, case discussion and role-plays. Supervision of call records should occur more often and can complement direct contact.

Supervisors are selected on the basis of demonstrated competence, i.e. have been evaluated as skilled supervisors, and have been trained in the supervisory functions, according to the program's written performance requirements for the supervisory role.

Objectives of supervision include quality control, direction regarding clinical service problems, and increasing knowledge, skills and attitudes required for satisfactory job performance.

Rating Scale

Level I

There is evidence that the quality assurance program assures that the quality of crisis work is consistent. Monitoring of crisis workers is ongoing and routine.

Planned in-service training or ongoing training occurs two or three hours a year.

There is a written policy regarding required supervision and the criteria for assessing performance.

A combination of monitoring processes is used to measure the performance of crisis workers.

Level II

Level I requirements are met.

There is a planned program of ongoing training including at least six hours of instruction annually for all workers.

Supervisors have had training and/or supervision in the supervisory process.

There are other tools used for quality assurance.

There is clear proof that the results of the quality assurance monitoring efforts result in praise, discipline, training or termination.

There is a plan that focuses on making AAS crisis worker certification a priority for all eligible crisis workers.

Level III

Level I and II requirements are met.

There is planned ongoing training every month.

Workers are monitored for their attendance or completion of ongoing training.

There is written proof of the feedback given to crisis workers after supervision.

There is a written plan for assuring that the quality of crisis worker intervention is monitored, recorded and corrected.

At least 30% of the eligible staff and volunteer crisis workers are AAS Certified Crisis Workers.

AREA III: GENERAL SERVICE DELIVERY

Explanatory Statement

Just as there exist a wide variety of life crises (e.g. suicide, sexual assault, etc.) and situational issues (e.g. being severely mentally disabled) so are there a variety of effective service modalities in crisis intervention practice. The evaluation standards in this area relate to:

1. To what degree is a program willing and prepared to offer necessary help during a crisis, and
2. How well is the program organized for the efficient and effective practice of crisis intervention.

This section is designed to evaluate a crisis center's ability to respond to its clients. Standards for the six (6) components of General Service Delivery System include:

1. Telephone response,
2. Walk-In Services,
3. Outreach service, Mobile Crisis Outreach Teams
4. Follow-up,
5. Client record keeping,
6. Internet Services, Online Emotional Support

If, for example, a program does not provide walk-in counseling and outreach services itself, it must be able to secure such help for its callers from other community agencies. (See Area VI: Community Integration) The crucial question is that quality care is available *immediately, 24 hours a day*.

Component 1: Telephone Response

Description

The description for this component is apparent from the rating criteria but each level assumes that the crisis workers are able to intervene in life threatening situations even without the client's permission. This applies to any setting in which people are responded to.

Rating Scale

Level I

There is a dedicated phone number and line that is answered by the agency's 24 hour 7 days a week crisis service. If it isn't answered 24/7 by the agency then it is routed to an AAS Accredited Center by virtue of a signed Memorandum of Understanding agreement.

Crisis workers can do an active intervention in life threatening situations without interrupting the initial call.

The phone setting is set up to protect confidentiality.

Resource data is available wherever calls are answered.

(A person specifically on duty for the purpose of serving the agency's callers answers the telephone service twenty-four hours a day, seven days a week.

If a commercial answering service or call management system is used, most callers reach a trained crisis worker within one minute of placing a call.

If a commercial answering service is not used, the calls are forwarded to an AAS accredited center when the center's crisis workers are not available.

OR

If the center is serving a specialized, limited population (e.g. teen line, AIDS line, gay/lesbian line, etc.), it does not need to operate 24 hours a day, 7 days a week to meet this level. However, in off hours the line must be forwarded to an AAS accredited center.)

Level II

Level I requirements are met.

While on duty, workers have multiple telephone instruments and lines available for simultaneous calls.

More than one crisis worker is scheduled to be on-site for the majority of the peak hour time.

There is a system that permits monitoring and supervision of the worker.

There is support and access for the hearing impaired and foreign language interpretation available for callers.

If a back-up center takes the agency's calls then specialized training and resources are available to the back-up center.

There is a process to ensure that there is adequate staffing to respond to the agency's volume of calls.

Level III

Level I and II requirements are met.

The telephone service is an integrated component of the crisis program answered in the agency setting by trained personnel.

There is evidence that the crisis program has up-to-date telephone equipment to meet the needs of proactive intervention.

There are well-developed procedures to increase staff capacity should there be a sudden influx of calls.

The organization has a method of tracking call response rate and has a policy to ensure that they meet agency standards.

Component 2: Walk-in-Service

Description

Persons in an acute crisis may need immediate personal contact with helpers. The availability of a walk-in crisis service indicates that the program is capable of delivering high quality care.

Although it is an optimum situation, it is not mandatory that crisis programs provide walk-in crisis services in the agency's facilities. What is required of the agency to meet minimum standards is that it assures these services are available to provide immediate care to clients in the area served. Such arrangements should be specified by written contract or written operational agreements between the program and agencies such as a mental health center or an emergency department, which has crisis consultation available

Rating Scale

Level I

Walk-in service is available to clients through referral that telephone workers can initiate. The relationship between the crisis program and walk in services is well developed and procedures are in writing.

Level II

Level I requirements are met.

The program offers walk-in service or walk-in access during weekday office hours.

The crisis program will handle immediate walk-in service contacts referred either by its own staff or by other gatekeepers.

There is a system that permits monitoring and supervision of the workers.

OR

An equivalent or better level of service is provided by another agency through written agreement. Or, the agency does not operate its own walk-in service but has a seamless referral system and feedback to another service.

Level III

Level I and II requirements are met.

Walk-in face to face crisis service is an integral aspect of the service delivery design.

The Walk-in Service meets relevant AAS standards as outlined in this manual.

Walk-in service is available during extended hours and weekend times.

There are referrals that can be easily made to 24/7 walk-in services if the program doesn't operate this service 24/7.

Component 3: Outreach Services, (Mobile Crisis Outreach Team)

Description

Some persons in acute crisis or life-threatening situations are unable or unwilling to travel to a face to face meeting. Outreach service may be essential in such cases. As with walk-in service, if an agency cannot provide outreach as part of its own program, it should assure the provision of such service by written contract or written referral protocols.

Mobile outreach is a service whereby crisis workers are dispatched to meet with a client in person in order to get a more accurate and complete assessment or intervention than can be obtained by telephone or other methods. This assessment or intervention may be completed in client's home or in a public place (i.e. jail, restaurant, community agency, hospital). Based on the client's history and current need, a plan is developed to assist client in receiving the most appropriate service in the least restrictive environment.

Rating Scale

Level I

The crisis center can provide outreach service through a working agreement with another agency and telephone workers or those using texting or crisis chat can initiate this referral.

The program takes responsibility for calling police or other emergency, mental health or social service organizations.

Around-the-clock arrangements can be made to transport those in crisis to walk-in services, such as the local mental health center or hospital emergency department.

There are written criteria for when crisis workers should employ the crisis outreach service.

Level II

The organization operates a mobile team as advertised for at least 40 hours per week.

The mobile team meets the person in their residence, the Emergency Room of a local hospital or other community locations.

The mobile team members demonstrate competency in crisis intervention techniques, lethality assessment, problem solving and recognizing indicators of presenting problems. Mobile team members receive personal safety training.

There is a system that permits monitoring and supervision of mobile crisis team members.

A safety assessment is performed prior to dispatching the mobile team. This assessment should address whether there are weapons in the home, animals that could pose a threat, other persons in the home and the general safety of the neighborhood. If there are any safety concerns an alternate, safer meeting site may be arranged.

When meeting a client in their home the team member will not be dispatched to go alone.

Written program policies define collaborative efforts between the mobile crisis team, police, and mental health personnel responsible for implementing involuntary commitment laws.

The mobile team has a strong working relationship with police, hospital and other emergency service providers.

Level III

Level II requirements are met.

Mobile services are available 24/7.

Persons providing mobile services are trained in first aid and CPR.

There are written emergency procedures that address screening for medical conditions, making referrals to

emergency medical services when indicated, identifying personnel trained in emergency procedures, involuntary hospitalization.

Personnel demonstrate knowledge of the appropriate use of community resources, crisis intervention techniques and procedures for involuntary hospitalization.

Enhanced working relationships with police and other emergency services providers are demonstrated by regular meetings, ride-a-longs, debriefings cross training as examples.

The crisis assessment leads to an initial crisis intervention plan developed upon contact with each client that includes identified immediate response needs, identified follow-up when referral is made and a statement of crisis resolution.

Mobile team members have access to medical and/or psychiatric consultation 24/7.

Component 4: Follow-Up

Description

Crisis intervention follow up services should be an established part of the crisis program. Follow-up includes initiating contact with persons who may have been assessed at risk for suicide and others when appropriate. Follow up may include outreach contacts to the high-risk party of a third party call. This recognizes the reality that when someone calls for a person at risk, the person at risk is likely to be of higher risk for suicide and with more ambivalence about reaching out for help than persons who call the center directly.

Crisis centers should have policies and procedures that spell out how third party callers will be handled in situations where the caller won't agree to call the person at risk, but will give identifying information. These policies and procedures will document how the organization will reach out and offer appropriate support or intervention with the person at risk.

The policies and procedures for follow-up of such persons should be in writing and included in the crisis worker's manual. Follow-up contacts should be included in the client's record. **(Appendix 5)**

Rating Scale

Level I

The crisis program makes follow-up calls, specifically in cases involving suicide risk according to a written procedure.

Records of follow-up contacts are kept.

The program initiates active intervention when appropriate with third party calls.

Follow up need, contact information, and outcome is efficiently communicated between crisis workers and other shifts as necessary.

Level II

Level I requirements are met.

The crisis program attempts regular follow-up contacts with callers at risk not only of suicide but of other crisis situations.

There is evidence that the crisis center initiates third party contact.

Level III

Level I and II requirements are met.

There is a staff member dedicated to making sure that follow-up contacts are provided within 24 hours of crisis call for all risk cases.

The program integrates follow up into all crisis service contacts.

Supervisors are aware of when follow up is needed and when a follow up contact has been accomplished.

Follow up contacts to referrals and/or emergency responders is part of the program's protocol.

Component 5: Client Record Keeping

Description

Client record keeping and updating in most cases apply to clinical crisis programs. Crisis programs might not reflect longer term client record keeping but must demonstrate how caller records are handled in a confidential and orderly process.

Crisis workers have access to information of recent contacts, to identify repeat callers, or to have background history on at risk callers should they call again or require follow-up.

Rating Scale

Level I

An individual record is made for all crisis/caller contact.

There is a specific place on the record for recording degree of risk, interventions provided, the nature of the call and/or the need for follow up.

Crisis workers have access to pertinent call records.

Client records are kept in a confidential manner under two sets of locks or protective mechanisms.

Level II

Level I requirements are met.

Client records or files are organized so that client histories may be accessible on identified clients.

All client records record lethality assessments and allow a review of the quality of assessments.

Files are routinely reviewed and updated and/or destroyed according to policy.

Level III

Level I and II requirements are met.

Client records are easily accessed in a computer database that is used by the crisis workers on duty.

The program uses state of the art client record keeping that maximizes confidentiality and crisis worker efficiency and competency.

Client records have comprehensive information that includes prior lethality, pertinent risk factors, demographic information, prior contact history, and rescue information.

Computerized records can only be accessed by designated staff using secure passwords or other protective mechanism.

Component 6: Internet Services, Online Emotional Support

Description

AAS does not dictate whether programs use Internet services such as crisis chat or texting for online emotional support but at a minimum centers must have a website and be working towards more community accessibility on the internet.

If an AAS center is offering Online Emotional Support Services (OES) (crisis chat and/or texting) they must adhere to the standards developed by CONTACT USA (CUSO) see **Appendix 7 CUSO & AAS edition.**

CONTACT USA and the American Association of Suicidology (AAS), the two major accrediting bodies in the United States for crisis centers, now work together to ensure quality core standards are met in online service delivery.

Rating Scale:

Level I

The program has a website that is updated at least annually.

There are policies and procedures that govern the use of electronic communications. (**Appendix 8**)

If crisis chat and/or forums and/or emails and/or other forms of electronic communications are used as part of crisis services, policies and procedures that reflect AAS's philosophy and the agency's practices must be adhered to. All confidentiality standards must be met.

Level II

Level I requirements are met.

Crisis chat and/or forums and/or emails and/or other forms of online interaction are used as part of crisis services, policies and procedures that reflect AAS's philosophy and the agency's practices must be adhered to.

Internet intervention policies have been developed.

Workers are trained and supervised on program uses of their Internet services, and there are clear consequences for misuse or ethical violations.

There is a designated staff person to oversee Internet services.

Agency has an updated and comprehensive website.

Level III

Level I and II requirements are met.

The appropriate and latest generation of software is utilized to support online services.

An online service is available daily, scheduled times of operation are available and a designated staff person oversees the program.

There is evidence that crisis worker feedback is used to modify or make changes as necessary.

Agency website is updated quarterly and offers a portal to the agency's online crisis and support services.

AREA IV: SERVICES IN LIFE-THREATENING CRISES

Explanatory Statement

Provision of effective services to people in life-threatening crises is the most important objective of the American Association of Suicidology.

“One of the core values of AAS is that every person has the basic right to assistance in life-threatening or other crises. This value reflects the basic philosophy that an active intervention, including active engagement and active rescue and follow up should be implemented if a client’s life is in danger even when the client will not or cannot assent. Because we also value a client’s privacy and self-determination, ideally the intervention is done with the client’s consent. Active intervention describes the entire spectrum of actions taken to reduce the suicidal ideation and behavior of the at risk individual. Active intervention includes both the collaborative relationship (active engagement) and also, when necessary, more aggressive interventions which may include the involvement of third parties, such as law enforcement, friends and family (active rescue) , in cases involving imminent life threatening behavior. When possible, consent from the at risk individual will be obtained. When that is not possible, the intervention will occur without the client’s consent or knowledge only after all other options have been exhausted.

Some examples of proactive approaches for intervention and support of suicidal clients include; using caller ID, tracing, and calling police or ambulance, making follow up calls to suicidal callers and third party callers who are suicidal.

Crisis intervention services offer an effective means of reducing harm to oneself or others by providing primary suicide prevention, bereavement assistance to survivors of suicide, prevention and intervention around assault, and community information about these issues. Secondary prevention and intervention are also provided for persons who have attempted suicide, for the chronically self-destructive person, and for victims of violence, since these critical events increase one's vulnerability to crisis.

Lethality assessments are done routinely according to current, updated procedures and include the items listed in the description section of Component 1.

To be accredited by AAS, organizations must adhere to AAS’s philosophy and demonstrate their ability to do thorough risk assessments.

Components 1.Lethality Assessment and 2.Rescue Services have only one level in the Rating Scale that all organizations must meet to be accredited.

Components of services in life-threatening crises are:

1. Lethality Assessment
2. Rescue Services
3. Victims of Violence or Traumatic Death Services
4. Suicide Survivor Services
5. Community Education

Component 1: Lethality Assessment

Description

A program's lethality assessment protocol should include written procedures based on current research regarding lethality assessment as an integral part of crisis service. The actual lethality assessment is not meant to be a rote process of question asking by the crisis worker but is to be an integral part of developing an empathetic understanding of the person in crisis' situation.

Research shows that there are indicators of increased risk. A lethality assessment should include:

- an estimation of immediate risk of life-threatening behavior,
- 'Are you thinking of suicide' question must be asked,
- an assessment of the person at risk's suicidal ideation,
- asking questions that will get specific answers about a suicide plan including the availability of the means, access to a firearm, is the attempt in progress,
- resolve or rating of intent to die, ambivalence
- previous suicide attempts and lethality of any attempts,
- state of depression,
- psychiatric or mental health history,
- alcohol and drug use status,
- survivor status,
- history of recent loss and current stressors,
- degree of hopelessness, helplessness, psychological pain and feeling isolated, trapped
- availability of support resources

**An example of lethality assessment guidelines is available in Appendix:
NSPL Suicide Risk Assessment Standards (Appendix 6)**

After listening to the person in crisis, it is up to the crisis worker to make a good decision about how many of these questions need to be asked to determine the lethality of the situation. But when suicidal intent has been expressed, follow up assessment questions need to be asked before a decision is reached about an appropriate intervention to take.

Written procedures should include under what circumstances an assessment of lethality is initiated but at minimum should require that lethality assessment be done with all clients that have an emotional component (e.g. when the presentation by the caller has emotional content or the presence of emotions and is not simply a non-emotional request for information) or are clearly crisis calls. It is important for the program to define these criteria.

The decision to intervene, rescue, provide appropriate referrals and/or follow-up on a caller should be made based on the lethality assessment. Principals of active intervention require that crisis workers make extra efforts to gain necessary information on callers demonstrating suicide risk so that an appropriate intervention and rescue can be initiated.

Rating Scale (level 111)

There is evidence that lethality assessment is a highly developed component of this service.
Crisis workers have specific training in communication skills to elicit suicide ideation throughout a call.
Lethality assessment guidelines are written and easily accessible to all crisis workers.
It is evident crisis workers use lethality assessment in the overall engagement of the callers.
Crisis workers can demonstrate fluid lethality assessment as part of building rapport with caller.
The crisis worker has access to pertinent historical information on the caller, when appropriate.
The program has a clearly defined procedure for both doing a lethality assessment and making sure that the assessment is thorough.
All lethality assessments are documented.
Crisis workers receive refresher training on conducting lethality assessments annually.
Crisis workers are routinely supervised about their abilities in this area.
The quality assurance program has been influenced by the desire to accurately assess the lethality of clients.
The program refines its lethality assessment based on the latest research.

Component 2: Rescue Services

Description

Rescue capability refers to the established policy of a crisis program to intervene in life-threatening crisis,
OR

The established policy of a crisis program is to intervene in life-threatening crisis along with other community resources such as health and safety agencies. Well established interagency relationships are necessary for effective rescue efforts.

The crisis program should have formal arrangements with agencies specializing in responding to life-threatening situations, such as police and medical rescue services. The crisis service may also provide special teams for crisis outreach visits as an additional arm of rescue. Rescue may include the capability of tracing or locating the caller who may be unable or unwilling to give a phone number or address to make rescue possible. Policies and procedures for rescue should be clearly spelled out as part of the crisis worker's available resource material.

In order for a center to be accredited by AAS, it must be practicing active intervention, including active engagement, active rescue and immediate follow up when possible .throughout its services.

ACTIVE INTERVENTION (active engagement, active rescue and follow up) (**Appendix 5**)

The basic tenet of active intervention is that anyone who is suicidal deserves aggressive intervention to keep them alive. Individuals in a suicidal crisis do not think rationally; nor do they make reasoned judgments. Thus, crisis intervention demands active intervention; that is, crisis counselors must act to protect life. An agency that is accredited by AAS must accept this tenet, however centers practice active intervention.

If a crisis worker cannot de-escalate a suicidal caller, the crisis worker must use whatever means he/she can to intervene when the caller is judged to be intent on suicide. Some strategies would be:

- Using caller ID to locate the caller even when the caller does not want to be located,
- Calling a third party if appropriate,
- Sending the police or a mobile outreach team.

A crisis center that is practicing active intervention attempts to get suicidal persons to safety even if they won't go on their own or if they don't want help. AAS believes this is a crisis worker's job and professional obligation.

Policies should clearly spell out the crisis center's approach to suicidal callers including but not limited to: lethality assessment, rescue procedures, caller identification procedures and use of supervisory advice.

Rating Scale (level 111)

There is a written rescue procedure which is adhered to and which includes adaptations based on need. Protocols that dictate when rescue services are initiated are clear and workers are trained in implementing them.

Supervisors are available to workers during rescue procedures.

Crisis service resources are readily available to the crisis workers and are updated routinely.

Interagency resources for rescue are listed in a current resource manual with brief descriptions of services, policies, and procedures for initiating services.

There is evidence that follow up procedures are used with all suicidal callers, for example staying on the line until the police arrive or calling responders to check on the rescue .

There is evidence that rescue services are not over-used and that rescue is initiated in appropriate high risk situations.

Component 3: Victims of Violence or Traumatic Death Services

Description

This component addresses services to victims of two types of psychological trauma: 1) victims of assault such as rape, child abuse, or battering; 2) survivors of traumatic death. For example: A man accidentally shoots his son while deer hunting; a young mother is unable to save her children in an apartment fire; a man accidentally backs his car over his toddler niece. Outreach to those involved with less dramatic deaths is also included.

If services to victims are offered the program objectives, policies and procedures should be written and available to crisis workers. The crisis service should publicize the availability of such services through interagency communication and periodic media releases. Special supervision should be available to staff and volunteers who provide services to victims. Experienced staff should do supervision and training in victim services.

Rating Scale

Level I

Victim/survivor support is offered by the crisis line worker and appropriate referrals are made. Crisis workers have specialized training or resources to assist victims/survivors.

Level II

Level I requirements are met.

Specialized support groups or programs are used to help victims and these programs have strong working relationships.

The agency has a letter of agreement with the groups that offer these services.

Level III

Victim/survivor services are a highly developed component of the program, which allows the program to respond to victims and survivors in a systematic way.

The program conducts victim support groups.

The program disseminates information to the community for people at risk of victimization or trauma (e.g., distributes brochures to police departments, courts, funeral homes and hospital emergency services).

The program provides specialized outreach to victims/survivors.

Component 4: Suicide Survivor Services

Description

This component includes bereavement crisis services to survivors of suicide. It can utilize professional staff, volunteers, and self-help groups. Survivor services may be offered individually or in groups.

If survivor services are offered the program objectives, policies and procedures should be written and available to crisis workers. The crisis service should publicize the availability of such services through interagency communication and periodic media releases. Special supervision should be available to staff and volunteers who provide services to survivors. Experienced staff should do supervision and training in survivor services.

Rating Scale

Level I

Survivor support is offered by the crisis line worker and appropriate referrals are made.
The program keeps an up to date list of survivor resources.

Level II

Level I requirements are met.

There are written policies for survivor services, which are adhered to routinely.

Service may include phone calls or letters to survivors.

Or

There is a letter of agreement or written protocols and procedures with another group that specializes in survivor care for further services as needed.

Level III

Survivor services are a highly developed component of the program.

The program has a systematic way of learning about all suicides in the area.

The program includes a systematic method to contact survivors by phone, letter or other means.

It also conducts a survivors group, and routinely disseminates information for survivors to the community, (e.g., a brochure describing survivor services is made available to funeral homes).

The program has specialized information available to disseminate to survivors.

Component 5: Community Education

Description

Community education on suicide is an important part of the overall service in responding to life-threatening crises. Each program should have established connections with the news media. Staff should be available for community education to local groups. The program should work with national organizations during special promotional periods.

Concise and clearly written information should be available for persons studying suicide. Cooperative relationships should exist with local universities to accommodate those who wish to conduct research by using program data.

Target groups of gatekeepers, such as teachers, victim advocacy groups, nurses, police, EMTS, welfare workers, and clergy should receive special attention in community suicide prevention and education programs.

Rating Scale

Level I

Efforts are made to develop community information services such as sporadic media interviews and occasional public speaking in response to a community request.

At least one person has responsibility for community education activities.

Level II

Level I requirements are met.

A written plan for community education exists.

Records of community education are kept.

Written materials are available for distribution.

Community education activities occur regularly.

Level III

Level I and II requirements are met.

Responsibilities for community education activities are clearly defined.

All policies and procedures for community education are written and followed regularly, including a plan to keep the information current.

Training is available for those who conduct community education activities.

Special programs and promotional activities are conducted (e.g. Suicide Awareness Week).

Community education is a highly developed component of the program.

Multiple staff is responsible for education in multiple media outlets (i.e. internet, online training, TV, brochures, training, talks, etc).

AREA V: ETHICAL STANDARDS AND PRACTICE

Explanatory Statement

Human rights and client protection are basic issues whether the organization is rendering human service area treatment, training or research. A code of ethics covers a variety of issues. Of particular concern is that organizations promoting a particular religious or treatment orientation are open and honest about this orientation with the community and their clients.

Since 1966, the Public Health Services, DHEW, has had a policy requiring specific administrative procedures for the protection of human subjects in activities supported by grants and contracts. In 1974, DHEW issued a set of regulations and essentially codified these policies. All professional organizations have developed codes of ethical behavior for persons providing professional services. Local and regional associations maintain Ethics Committees to insure that when reports on violations by practicing members of the association are received, there is a formal investigation and appropriate action is taken.

To be accredited by the American Association of Suicidology crisis programs must operate according to ethical standards.

Components dealing with ethical issues are:

1. Code of ethics
2. Records Security
3. Confidentiality
4. Rescue Policies and Ethics
5. Advertising and Promotional Methods.

Component 1: Code of Ethics

Description

A crisis program should have a written statement, or codified set of ethical principles, which it follows in making clinical and administrative decisions. The code may be one established by the individual crisis program, or its' Board of Directors, or one adapted from a larger organization, like the AAS. (**Appendix 9**)

Rating Scale

Level I

The crisis program has a written code of ethics which may be adapted from another agency or AAS guidelines. The code should be posted in the phone room.

Level II

If crisis workers are mental health professionals there should be a written statement that all professionals will be guided by their respective code of ethics in addition to the agency's code of ethics.

If crisis workers are paraprofessional they will follow the agency's code of ethics.

The code is available for all workers to refer to when needed.

All workers are given a copy of the code.

There is documentation that workers agree to follow the code.

Level III

The crisis program, after carefully studying several samples of ethical standards (such as the AAS Guidelines for a Code of Ethics), reviewing recent court decisions, and potential problems in risk management, has formulated an ethical code.

This code, in addition to dealing with general issues, addresses itself to those issues specific to crisis work.

Training time is spent on understanding and resolving ethical issues.

Workers are supervised on their awareness of the ethical issues involved in their work.

Annually, at least, crisis workers review ethical issues involved in the crisis program.

Component 2: Records Security

Description

The design of a crisis program should include an awareness of appropriate procedures for maintaining security of client records.

1. Does the agency focus on providing sufficient security of records, including database records within the organization?
2. What provisions are made outside the organization when records are transferred?
3. Is the security plan feasible?
4. Has the security system been fully explained to all persons who come in contact with the system?

Rating Scale

Level I

Record system security includes client and staff/volunteer records.

Record security procedures are in writing.

There is at least one level of 'locks' on records be it paper or computer based.

Level II

Level I requirements are met.

The records' security system is periodically reviewed.

Training time is spent on the security system and its rationale.

Level III

Level I and II requirements are met.

Clinical and personnel records are maintained under a constant security system which shows extensive planning and regular evaluation of its efficiency.

Records are under three layers of 'locks' or passcodes.

Component 3: Confidentiality

Description

Program personnel exhibit sufficient competence to understand and appreciate the importance of safeguarding the client's confidentiality. The program institutes sanctions against persons who misuse client information, or otherwise show lack of respect for confidentiality. Ethical and privacy issues, including listening in on client-worker interaction, have been thoroughly explained, and workers are evaluated on their practices and adherence to these procedures.

Rating Scale

Level I

Confidentiality is included in agency policy and discussed in the training program.
Workers are required to understand the issues involved and sign a document of compliance.
Procedures exist to insure confidentiality.
There is a stated policy regarding the consequences of breaking confidentiality.
Confidentiality standards are also ensured for electronic communications and record keeping.

Level II

Level I requirements are met.
There is a designated staff member responsible for any disclosure of information either from client or personnel records.
Additional training concerning confidentiality occurs as new laws are enacted or situations arise.

Level III

Level I and II requirements are met.
The staff is well-trained and sensitive to the legal and ethical issues of confidentiality, including when confidentiality is mandated or does not apply.
Seminars or other in-service training programs are held annually on the topic..
There is an effort at constant monitoring to safeguard confidentiality (including any visitors to the program).
Consequences of violating confidentiality are written.

Component 4: Rescue Policies and Ethics

Description

Any program, which purports to be involved with life-threatening behaviors, must be, at the very least, capable of initiating or actually accomplishing a rescue in cases of life threatening acts already set in motion. Rescue is a response to a cry for help and may often involve taking extraordinary actions to save a life. Administrators should consider these questions.

1. Have these procedures been well thought out?
2. Have issues such as telephone monitoring, tracing calls and the consequence of sending out police and rescue been fully discussed with all staff?
3. Has staff become acquainted with state and local laws pertaining to these actions, for example, the Tarasoff case regarding the obligation of a therapist to warn potential victims of homicide?
4. Have consent procedures been developed in accordance with current law?

Rating Scale

Level I

There is evidence that rescue actions are based on lethality assessments and written procedures rather than strictly subjective criteria.

The program has attempted to address concerns about rescue and legal and ethical issues through written procedures and policy.

Level II

Level I requirements are met.

There is a clear indication that the ethical and legal issues are recognized, attended to, and included in the plan for rescue.

The crisis program appears well informed about risks associated with rescue, lethality assessments, and other emergency services.

Level III

Level I and II requirements are met.

All rescue and consent procedures have been carefully worked out with other agencies and the legal system, including law enforcement agencies, to assure compliance with legal regulations and ethical good practice.

All program personnel are fully informed about the legal and ethical issues involved in rescue operations.

Rescue policy is reviewed annually.

There is a specific policy for warning potential victims of high homicide risk.

The crisis program has established a wide base of responsibility for its actions through negotiation with local authorities.

Rescue and consent procedures have been reviewed by an attorney.

Component 5: Advertising and Promotional Methods

Description

Promotional materials, including printed material, websites, video/DVD and mass media must be honest, realistic and accurate in their message. Advertisements must avoid misrepresentation of services and outcomes of agency programs.

Rating Scale

Level I

The advertising and promotional material includes information about the crisis program.
The messages are clearly designed to inform the public of available services and information is current.
There is evidence of honesty, accuracy and realism in the advertising and promotional material. The organization has an annually updated website containing accurate information outlining their programs and contact information.

Level II

Level I requirements are met.
Promotional materials have multiple goals which may include educational or prevention messages that are accurate and designed to inform the public in a sensitive and effective manner.

Level III

Level I and II requirements are met.
Unusual care has been taken to develop and implement advertising and promotional material.
The materials also strive to educate the public without misrepresenting the issue or services offered.
Public relations and clinical experts are routinely and regularly consulted during the entire process of producing promotional materials.
Marketing materials are professional and effective.
There is one person designated to implement public relations for the program and be responsible for promotional materials.

AREA VI: COMMUNITY INTEGRATION

Explanatory Statement

Integrating crisis services into the community is crucial because integration facilitates reaching all potential clients in the target community. It also promotes acceptance of the crisis program by both consumers and providers while enhancing the possibility of identifying with, and becoming part of the community's total care system.

Community or service area is defined as all the persons in a specific geographic or target area. This identified population can be divided into consumers and providers of services.

Community integration is a reciprocal process between the crisis program, consumers and providers directly or indirectly related to crisis services, that includes the following four key elements.

1. Knowledge: The pool of information the crisis service, consumers and providers have about each other which forms the basis for present and future collaboration and utilization.
2. Communication: A verbal or written method of exchanging and obtaining information, promoting collaboration and utilization.
3. Collaboration: Working together for the purpose of reaching mutual goals.
4. Utilization: The actual use of available services.

To ensure that this reciprocal process exists, the following community integration components have been defined:

1. Consumers
2. Emergency Resources
3. Resource Data
4. Resource Collaboration

Component 1: Consumers

Description

The consumer of crisis services includes but is not limited to the following:

1. Persons who have attempted suicide
2. People communicating suicidal clues either directly or indirectly
3. Potential and actual victims of assaults
4. Persons experiencing a life crisis
5. Frail and elderly
6. Survivors of completed suicide or other traumatic death
7. Chemically dependent persons
8. Depressed individuals
9. Persons who are severely and chronically mentally ill
10. First responders (i.e. Police, Fire, EMT)

It is important that these high-risk groups and their families be informed of the program's existence and its services and that the crisis center makes efforts to address the needs of its active callers and consumer base.

Rating Scale

Level I

A publicity program exists with some citizen or consumer input.

There is some effort to identify and reach specific target groups.

Efforts are made to assess consumers' reactions to the agency's services.

There are efforts to include representation of key community or consumer groups on the Board or there are service focus groups or feedback forums.

Level II

Level I requirements are met.

A written publicity plan exists that targets specific populations.

The service has a plan to encourage access to underserved groups.

The service is used by a broad representation of the community it serves.

The service works collaboratively with consumers and other stakeholders in the community.

Level III

Level I and II requirements are met.

There is a well-planned publicity program aimed at consumer awareness of at least one underserved group.

The program relies on the responses of citizens and target groups for information and feedback (e.g. suicide attempters, victims, chemically dependent patients discharged from a acute setting, senior citizens, and other high risk groups).

There is evidence that high risk groups of all socioeconomic levels use the program.

The Board/management actively seeks consumer input and has representation of key consumer groups.

Component 2: Emergency Resources

Description

During a life-threatening crisis it is imperative to mobilize emergency resources to handle such a crisis effectively. These emergency resources are available 24 hours a day and include but are not limited to the following:

1. Ambulance and rescue squad
2. Telephone company
3. Police and fire departments
4. Mental health or mobile crisis teams
5. Hospital emergency departments.

Rating Scale

Level I

Access to emergency services is readily and easily available to all crisis workers, so that resources can be accessed promptly and efficiently

The crisis service is known to emergency resources.

There is evidence that the organization updates its emergency resource database at least annually.

Level II

Level I requirements are met.

The emergency resources know of the program's existence and have on-going coordination contact, either in writing or through periodic meetings.

There is evidence that there is an effective working relationship between the program and emergency resources.

These services are responsive to clients regardless of their ability to pay.

Level III

Level I and II requirements are met.

There are written agreements, letters of understanding and documentation of consultation between emergency responders and the crisis program.

There is evidence that emergency responders and crisis workers understand each other's roles and procedures.

Component 3: Resource Data

Description

If a crisis program is to function effectively within the community helping structure, it must have detailed, current information on all community resources specifically related to the crisis program. An accurate and comprehensive database of resources is essential to quality service delivery.

This comprehensive listing of community resources should include but is not limited to the following:

1. Psychiatric and medical emergency resources,
2. Emergency rescue resources,
3. Mental-medical health and social service resources, e.g. welfare, family and children's services, clinics, hospitals,
4. Specialized programs, e.g. rape crisis centers, AA, Recovery, Inc.,
5. Legal services, e.g. Legal Aid,
6. Emergency housing, food, and
7. Law enforcement and fire departments

Rating Scale

Level I

The crisis program has a comprehensive list of community resources for use by the crisis workers.

The resource list contains pertinent information such as:

1. Agency and individual's name, number, address
2. Description of services provided
3. Client eligibility
4. Restrictions
5. Geographical area served
6. Referral procedure and fees, and
7. Date information was recorded.

A plan and procedures exist for tailoring and updating resource data (changing, adding or deleting).

Workers have access to the entire resource database 24 hours of the day.

A crisis worker can easily demonstrate use of the community resource system.

Level II

Level I requirements are met.

Information about resources is tailored to the crisis program and its clients.

The resource list contains all pertinent information a crisis worker needs regarding the agency, individuals and services and is easily cross-referenced.

There is systematic review at least annually of resource listings and there is evidence that they are up-to-date.

This resource information is immediately accessible to workers 24 hours a day including staff not at the

office site (if applicable).

Resource information is on a computer database for efficient retrieval.

Level III

Level I and II requirements are met.

Resource data management is a high priority for the program and is integrated into overall service delivery.

There is a Memorandum of Understanding or other strong working relationship with the local or State 211 or Information and Referral Service, where available.

The maintenance of all resource data is supervised by a designated staff person.

Data is updated regularly as needed.

1. An inclusion/exclusion policy for resources is in place and uniformly applied.
2. The date of last update appears on each referral entry.

The computer resource database is user friendly.

Component 4: Resource Collaboration

Description

This Component concerns more general community resources and the programs' collaborative efforts to work with these resources. Resources may include but are not limited to the following;

1. Clergy
2. Community Gatekeepers
3. Self-help groups
4. Social service agencies
5. Mental health professionals
6. Medical resources

Rating Scale

Level I

The crisis program is known to most of the general resources.

Efforts have been made to make the program known through periodic mailing and phone contacts.

There exists a working relationship that is at least informal with general community resources.

There are specific written procedures for the identification and use of the resources.

Level II

Level I requirements are met.

Information regarding the crisis program is routinely disseminated to these resources and the program has a strong working relationship with several resources.

The program routinely surveys these resources regarding service delivery.

General procedures for referral and collaborative work with these community resources exist in writing and are operational.

Level III

Level I and II requirements are met.

Collaboration with community resources is an integral part of the crisis program.

There are written Memorandums of Understanding and procedures for crisis training, database sharing and collaboration.

The crisis program routinely interacts with community resources for purposes of community planning and addressing community needs.

Information regarding the community programs is routinely disseminated through agency inservices.

There is evidence of cross training between two community resources and the program in the last year.

AREA VII: PROGRAM EVALUATION

Explanatory Statement

Evaluation is an important element of service delivery. In the broadest sense, program evaluation tells providers whether what they are doing is effective.

The organization is committed at all levels to delivering the highest possible quality of services. The organization actively monitors, evaluates, and gains input into the quality of services provided; can demonstrate these efforts, and can demonstrate ongoing use of this data and feedback to continuously improve services. These processes are clearly described within the policies and practices of the agency and are reviewed periodically by management and the governing body. In this way evaluation becomes a critical and useful administrative tool.

The organization should attend to a variety of data/inputs including customer satisfaction, outcome measurement, case records review, as well as standards compliance, risk management practices, feedback and corrective action processes, incident reporting, and others.

The organization should demonstrate both long-term strategic planning as well as short-term planning. Evaluation of progress on these plans should be routinely conducted and shared among staff, management and governance.

Evaluation can give staff information about needs, about the results of the effort (amount of time, materials, money, human resources) that has gone into responding to these needs. Such evaluations (done on an ongoing and/or periodic basis) provide the staff or vendors information about whether these effects are desirable in relation to the needs and whether they were worth the effort it took to produce them.

The critical importance of program evaluation is highlighted by the increasing emphasis on providers' accountability to consumers and funding bodies for quality service.

Any service program should ask itself three basic evaluation questions:

1. Are our program objectives reasonable, given the condition and need of the community and its citizens?
2. Is our program meeting its objectives, and if so, at what costs?

3. What else is happening within the program and as a result of the program?

To help answer these questions, program evaluation should include the following:

1. A means to determine that every program activity is related to the program's objectives.
2. A method to evaluate the programs:
 - A. Activity: Resources available to and used by the program and activities planned and carried out by the program.
 - B. Achievement: Changes which take place in people who have been involved in the program. We are usually concerned with changes in clients, but changes in staff may also be considered.
 - C. Adequacy: Program impact on the community's total needs.
 - D. Efficiency: A determination of the cost in resources (personnel, funds, materials and facilities) in attaining the objectives.

In summary, each objective needs to be evaluated in terms of activity, achievement, adequacy and efficiency.

The Standards for Program Evaluation include the following components:

1. Evaluation Planning
2. Outcome Measures and Objectives
3. Evaluation Content and Scope
4. Implementation

Component 1: Evaluation Planning

Description

There is a written plan for how the organization will continuously work to improve quality. Required elements of this plan will include:

- 1) Description of Continuous Quality Improvement (CQI) activities
- 2) Assignment for conducting and coordinating CQI activities
- 3) Description of methods and timelines for monitoring and reporting results
- 4) Description of methods for using data to improve quality
- 5) Description of the method and frequency for updating the Plan

Rating Scale

Level I

There is a written plan to track at least one activity of the program.

There is a written plan to evaluate the effectiveness of at least one aspect of the program.

Level II

Level I requirements are met.

The evaluation plan includes effectiveness, efficiency and satisfaction of 50% of program activities.

There is a designated person(s) who coordinates the process.

Level III

Level I and II requirements are met.

The organization has a written strategic plan that is monitored and evaluated on an annual basis.

Program evaluation results are used in program development and improvements.

These results are also used in the monitoring of the strategic plan.

Component 2: Outcome Measures and Objectives

Description

The organization shall define and adopt **Outcome Measures** for all services. Outcomes are defined as the impact that service delivery has upon the lives of consumers and/or the community served. What impact has the service had on stakeholders and consumers? Outcome measures must be measurable, monitored and used as part of the continuous quality improvement program.

An **OBJECTIVE** is a statement of how achievement of a specific outcome will be measured so as to be verifiable. Ideally an objective should contain:

1. The measurement term (frequency, quantity, quality) which will be used to indicate movement towards the outcome (e.g., number of calls, percent increase, score on test),
2. The baseline, or existing condition, stated in measureable terms,
3. The direction and amount of desired movement toward the outcome,
4. The length of time in which the stated outcome will take place, and
5. Designation of a person responsible for the outcome.

Rating Scale

Level I

Outcome measures and objectives for the program or services are in writing.
There is a mechanism for at least an annual review by staff and management .

Level II

Level I requirements are met.
All outcomes measures and objectives are written in measurable terms.
The outcome measures and objectives are reviewed systematically and have some impact on the services, policies or procedures.
The program reports on its outcomes at least annually.

Level III

Level I and II requirements are met.
There is a formal written report that reflects the program outcomes and objectives that is disseminated annually to stakeholders.
Outcome measures and objectives are accurate measures of staff and program accountability.

Component 3: Evaluation Content and Scope

Description

Evaluation of *activity* represents the relationship between what was stated would be done and what is actually done. Evaluation of activity necessitates the existence of data sources, (e.g., records of clients, staff training activity, public education events, etc). An activity is done in a specific community or service area or to a specific population. Activity addresses the frequency or number of events and answers the question: How many?

Evaluation of *achievement* measures the results of activity rather than the activity itself. A way to determine a program's effectiveness is to compare the results of its current activities with earlier program objectives.

Evaluation may occur in one or two areas of a program's functioning or the evaluation process may permeate all aspects of the program. Acceptable documentation includes completed survey records, composite scores, data recording forms, or relevant written material beyond that found in records or minutes of meetings.

Evaluation can occur in relation to each of the seven areas of the manual: administration, training, service delivery system, services in life-threatening crises, ethics, community integration, and evaluation itself. Some examples of evaluation in each are provided below.

Administration

An organization may survey their board regarding attitudes or beliefs about the program. Other administrative evaluations might include cost and accountability studies such as comparative cost per unit of service and an audit or financial review by an independent CPA. The board might also include a review of policies and procedures and job descriptions, or periodic performance appraisals of administrators.

Training

Evaluation of training may include using standard evaluation forms completed by trainees after each section of initial training or after each in - service training session. This could also include evaluating the trainer's report on training results. Evaluating the trainees knowledge, skills and attitude, application of training content (and barriers to such application), and outcomes associated with training content can also be required.

General Service Delivery

Studies may address service capacity issues such as number and times worker "busy out" one or more lines, or callers receive a busy signal; response time from crisis call to outreach; information from follow-up calls regarding client perception of the service; or assessing records to determine the items or shifts on which problems exist.

Services in Life-Threatening Crises

Included here are studies comparing client profiles with those of identified high risk groups; studies of changes on the kind of timing of crisis contacts; measuring the effectiveness of rescue resources such as telephone tracking or police intervention; psychological autopsies evaluating gaps or deficiencies in program or community services, or assessing needs for survivor follow-up; or the effectiveness of community education programs on life-threatening crises.

Ethical Issues

Surveys of opinions of crisis workers on sample ethical dilemmas, security inventory studies; and comparative evaluation of resource procedures vs. rescue practice all address ethical issues.

Community Integration

Studies may concern the use of the program's resource list; the pattern of referrals to or from the program; the effectiveness of referrals; and surveys of the community's knowledge about, or perception of the program.

Evaluation

Evaluation itself can be examined. For example, determine what percent of evaluations are related to the stated objectives or in how many evaluations the outcomes were used to change the program sophistication or frequency of evaluations may be examined and compared to previous time periods.

Rating Scale**Level I**

A basic data gathering system (e.g., tabulating activity such as calls) exists.

Service area needs and the geographic area to which the program delivers its services are defined.

The organization calculates and documents the cost per unit of service.

There is documented evaluation in at least two areas within the past 12 months.

One area evaluated must involve the quality assurance of the crisis work.

Level II

Level I requirements are met.

There is a systematic and operational data collection mechanism, which is tied to objectives.

Service area needs are systematically evaluated.

There is documented evaluation in four areas within the past 12 months.

Level III

Level I and II requirements are met.

There is a well-organized and operational data collection system, which is closely related to the program objectives and outcomes.

Service area needs are systematically assessed through both consumer and providers.

Achievement, adequacy and efficiency analysis (e.g., cost-benefit ratios) is done for the purpose of making decisions.

There is documented evaluation in all six areas within the past 12 months.

Component 4: Implementation

Description

The implementation of program evaluations must include the following focal points:

Rigor and Formality

Persons within or outside the system can perform evaluations. The evaluator should have training and experience in program evaluation. Someone specifically designated for this function should do formal evaluations.

Frequency

Evaluation can occur regularly or occasionally. Routine and periodic evaluation should be done.

Program evaluations whose outcomes have no impact on program design and everyday practice are virtually useless. A key component of an evaluation program is the administrative mechanism for considering and appropriately applying evaluation results for program improvement or modification. This mechanism might be a formalized report or it might be found in staff or board meeting minutes, personnel records or in other more informal places. The commitment of management staff, governing boards and funding bodies to program evaluation is essential for evaluation outcomes to be included in overall agency program improvements and developments.

Rating Scale

Level I

Routine program evaluations are conducted.

Management reviews evaluation outcomes particularly those related to quality assurance.

There is clear evidence of the utilization of the evaluation results.

Level II

Level I requirements are met.

Implementation of the evaluation process is described in writing and is clearly an accepted process of the service.

The results of the evaluation are shared with staff and volunteers.

There is documentation of the evaluations completed.

There is a focus in the organization on utilizing evaluation results.

There is clear communication of evaluation results between those responsible for the evaluation and those responsible for program development.

Level III

Level I and II requirements are met.

Program evaluation is a well-developed component of the service.

There are evaluations done on all six areas in the Standards Manual.

There is a staff person designated with responsibility for program evaluation.

The program makes use of outside evaluators as necessary.

Records of the evaluation are easily accessible and are clearly written.

There is a written procedure for conducting evaluations and for the implementation of the outcomes.

There is evidence of consistent use of evaluation outcomes and recommendations, e.g., new policies and practices.

Management publicizes findings of its evaluation, at least to the Board and staff of the agency.

Appendices

1. Application for Accreditation or Re-accreditation
2. Pre-Screening Questionnaire
3. Accreditation Report Summary
4. Possible Supplementary Documents
5. Active Intervention, Follow up, Third Party Calls
6. NSPL Suicide Risk Assessment Standards
- 7. CUSO & AAS edition - Online Emotional Support Standards**
8. IT Usage Policy (sample)
9. Guidelines for a Code of Ethics for Suicide Prevention and Crisis Intervention
10. Glossary of Terms

Appendix 1

AMERICAN ASSOCIATION OF SUICIDOLOGY

5221 Wisconsin Avenue NW, Washington, DC 20015

Application for Accreditation or Re-Accreditation

New: _____ Re-accreditation: _____ Date: _____

I. DATA REGARDING PROGRAM

Name of Program:

Contact Person:

Address:

City:

State:

Zip:

Business Telephone Number:

After hours number (mobile)

Name of Executive Director:

Email:

E-mail of Contact Person: _____

(1) Current Annual Budget (crisis services only):

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

3) List below the name of major funding sources

II. SERVICES PROVIDED:

Check all services provided. Double check those considered major purposes or objectives

- | | |
|---|---|
| <input type="checkbox"/> Suicide Prevention Hotline | <input type="checkbox"/> General Crisis Hotline |
| <input type="checkbox"/> Rape Crisis Counseling | <input type="checkbox"/> Child Abuse Counseling |
| <input type="checkbox"/> Teen Hotline | <input type="checkbox"/> Teen to Teen Hotline |
| <input type="checkbox"/> Survivors of Suicide Support Group | <input type="checkbox"/> Drug Information Service |
| <input type="checkbox"/> Alcoholism Information Service | <input type="checkbox"/> Substance Abuse Counseling |
| <input type="checkbox"/> Sexually Transmitted Disease Info | <input type="checkbox"/> Sex Information |
| <input type="checkbox"/> General Victim Services | <input type="checkbox"/> Outreach Program |
| <input type="checkbox"/> Face to Face Counseling | <input type="checkbox"/> Mental Health I & R |
| <input type="checkbox"/> Drop In Center | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> General Grief Support Groups | <input type="checkbox"/> Mobile outreach |
| <input type="checkbox"/> Compassionate Friends | <input type="checkbox"/> crisis chat |
| | <input type="checkbox"/> text messaging |
| <input type="checkbox"/> Specify Other: | |

III. PERSONNEL INFORMATION

Program Director's Name: _____ Degree(s): _____

Director's Employment Status: "Full Time "Part Time "Salaried "Volunteer

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

Total Number of Volunteers (organizational wide) _____

I have included:

_____ A copy of my organization's active intervention (see accreditation manual policies and procedures).

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

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

AGREEMENT

1. We agree to prepare and provide copies of any written material that may be requested by the Committee on Accreditation as a part of the evaluation process.
2. We agree to pay the fees required and to maintain an organizational membership in AAS.

Accreditation Fees:

For new organizations:

\$250 application fee, \$2500 accreditation fee, all examiner expenses (\$50 maximum/day for meals). Send application fee and accreditation fee with this form. You will be billed for the examiner expenses.

For re-accreditations:

\$1500 accreditation fee and all examiner expenses. **Send accreditation fee with this form.** You will be billed for examiner expenses.

Annual Membership Dues:

For organizations with annual operating budgets below \$100,000 the dues are \$210

For organizations with budgets from \$100,000 to \$199,999 the dues are \$250

For organizations with budgets from \$200,000 to \$499,999 the dues are \$375

For organizations with budgets from \$500,000 to \$749,999 the dues are \$500

For organizations with budgets from \$750,000 to \$999,999 the dues are \$600

For organizations with budgets greater than \$1,000,000 the dues are \$750

3. We agree that the Examiners will not be offered or given any form of honorarium, stipend, consultation fee or remuneration for any activity or service rendered at the time of the site evaluation.
4. We agree to notify the Director of Crisis Services Accreditation immediately whenever any change in our program may affect our accreditation status.
5. We agree to notify AAS within 30 days of any changes to our Executive Director and contact person, address, phone numbers, email.

6. **We agree to submit the annual self - survey report (current form available on the AAS website) to AAS by the end of February.**

Program Director

Date

Before proceeding with the application can you answer “yes” that you subscribe to and practice the AAS active intervention/active rescue policy in cases of an involuntary client, offer third party calls and follow up calls as highlighted in the Standard’s manual. If you can’t you will not be qualified for accreditation. If you can, please proceed.

“One of the core values of AAS is that every person has the basic right to assistance in life-threatening or other crises. This value reflects the basic philosophy that an active intervention, including active engagement and active rescue and follow up should be implemented if a client’s life is in danger even when the client will not or cannot assent. Because we also value a client’s privacy and self-determination, ideally the intervention is done with the client’s consent. Active intervention describes the entire spectrum of actions taken to reduce the suicidal ideation and behavior of the at risk individual. Active intervention includes both the collaborative relationship (active engagement) and also, when necessary, more aggressive interventions which may include the involvement of third parties, such as law enforcement, friends and family (active rescue) , in cases involving imminent life threatening behavior. When possible, consent from the at risk individual will be obtained. When that is not possible, the intervention will occur without the client’s consent or knowledge only after all other options have been exhausted.

Some examples of proactive approaches for intervention and support of suicidal clients include; using caller ID, tracing, and calling police or ambulance, making follow up calls to suicidal callers and third party callers who are suicidal.”

Appendix 2

AMERICAN ASSOCIATION OF SUICIDOLOGY

Pre-Screening Questionnaire

Please complete this pre-screening questionnaire by marking (X) on the appropriate lines beside each question if the question pertains to your service, center or program. *If the answer to any of these questions is no, please explain on an additional page.*

Question	Yes	No
1. Does a corporate authority assume responsibility for the management of your program?		
2. Is there a specific designated director of the crisis program(s) who serves at least part time in that capacity?		
3. Are financial records kept in compliance with generally accepted accounting principles (GAAP)?		
4. Is there designated office space for workers to answer the crisis line and/or interview clients?		
5. Is there a written outline of pre-service training content, along with a bibliography?		
6. Is there a minimum of 40 hours of pre-service training offered?		
7. Is there a written plan for screening prospective crisis workers including how you screen out those who do not have the ability to be positive in empathy, to show respect for the client and to make a good initial contact?		
8. Do those with responsibility for the pre-service training have the experience, skills and competence to do so?		
9. Are ongoing supervision (minimum of 1 hour of individual supervision per 40 hours of service or 3 months whatever comes first) and in-service training provided?		
10. Is the telephone answered in person 24 hours a day, 7 days a week?		
11. Is walk-in, face-to-face counseling available to clients through referral that is initiated by the telephone worker?		
12. Are there arrangements to provide outreach, face-to-face services to those in crisis?		
13. Does the program provide follow-up calls or services to suicidal callers?		
14. Does the program complete an individual record for each caller/client at the time of their initial contact?		
15. Is an assessment of lethality routinely done on all crisis calls and other crisis support services?		
16. Are there written procedures for actively intervening in life threatening cases?		
17. Are there arrangements to provide bereavement services to survivors of suicide?		
18. Has the program adopted a written code of ethics?		
19. Is someone in the organization responsible for dealing with requests for community education?		

20. Is there a list (or database) that identifies general community resources?		
21. Have program goals/objectives been identified in writing and is there evidence of their review and evaluation?		
22. Does your center do outreach calls in third party situations involving suicidal risk? (Please enclose policies.)		

Appendix 3

Below is a Report Summary examiners use for a site visit. This is a good guideline for organizations to use as a self-survey to help prepare for accreditation.

AAS ACCREDITATION REPORT SUMMARY

Agency Name _____

Address _____

Instructions: For each component mark the level which best fits the program. Organizations must achieve level 1 in each area to be accredited.

Examiner: _____ Date: _____

Director	AREA	COMPONENT	I	II	III
I. <i>Administration</i>		1. Governance			
		2. Program Management			
		3. Accountability			
		4. Physical Plant			
		5. Technology			
		6. Cultural Competence			
II. <i>Screening, Training, Monitoring</i>		1. Screening			
		2. Planned Curriculum Objectives Content/Bibliography			
		3. Planned Curriculum Methodology			
		4. Pre-Post-Training Evaluation			
		5. Qualification of Trainers			

	6. Monitoring Crisis Workers			
III. <i>General Service Del.</i>	1. Telephone Response			
	2. Walk-in Service			
	3. Outreach Services, Mobile crisis			
	4. Follow Up			
	5. Client Record-Keeping			
	6. Internet Services, Online Emotional Support			
IV. <i>Services in Life Thr.</i>	1. Lethality Assessment	N/A	N/A	
	2. Rescue Services	N/A	N/A	
	3. Victims/Traumatic Death			
	4. Suicide Survivor			
	5. Community Education			
V. <i>Ethical Standards and Practice</i>	1. Code of Ethics			
	2. Records Security			
	3. Confidentiality			
	4. Rescue Policies and Ethics			
	5. Advertising/Promotional Methods			
VI. <i>Community Integration</i>	1. Consumers			
	2. Emergency Resources			
	3. Resource Data			
	4. Resource Collaboration			
VII. <i>Program Evaluation</i>	1. Evaluation Planning			
	2. Outcome Measures and Objectives			
	3. Evaluation Content & Scope			
	4. Implementation			

Appendix 4

AMERICAN ASSOCIATION OF SUICIDOLOGY

Possible Supplementary Documents

NAME OF PROGRAM _____

After you have submitted your application for accreditation you will be provided with the name of the Accreditation Examiner who will conduct the site evaluation. The Site Examiner may ask for a packet containing copies of the following. Feel free to include additional information relevant to the accreditation criteria. **You do not need to send any of the information below with your application.**

_____ Application for accreditation

_____ Pre-screening questionnaire

_____ Charter and bylaws incorporating the organization

_____ Current incorporation materials from state (or certificates of good standing)

_____ Table of organization showing relationship of crisis workers to governing body

_____ Personnel policies

_____ Job descriptions

_____ Current annual budget

_____ Most recent financial audit

_____ Training syllables (training manual must be available during, site evaluation)

_____ Clinical record-keeping form(s)

_____ Listing of in-service training provided in the past year

_____ Program code of ethics

_____ Program objectives

_____ Public advertising including (as available): cards, brochures, recent newspaper clippings, written script from public service announcements and all program telephone directory listings

_____ Copy of prior AAS Accreditation Examination Report(s).

Appendix 5

What is Active Rescue?

Since the 1960's, AAS's standards have left the specifics of crisis work to the agencies that we have been certifying. In the last decade, however, in an effort to increase the quality of our standards and the quality of crisis work, AAS has begun making accreditation standards more specific. The professionals responsible for these changes are relying on what the mental health profession almost universally practices in working with suicidal individuals – active intervention and active rescue. Thus, in order for a center to be accredited by AAS, it must be practicing active intervention and rescue throughout its services. As the science of Suicidology moves forward, AAS continues to enhance and improve these procedures.

However, there has been some confusion about what 'active intervention' and 'active rescue' mean and how crisis centers and accreditation examiners should interpret and make active intervention and rescue operational in crisis centers. As described below, there are some specific practices that will demonstrate that active intervention/rescue is practiced throughout the organization.

The basic tenet of active intervention is that anyone having thoughts of suicide deserves aggressive intervention and rescue to ensure their safety. Suicide crises are often characterized by irrational thought and impaired decision making ability. Thus, crisis intervention demands active intervention; that is, crisis counselors must act to protect life. An agency that is accredited by AAS must accept this tenet. How, then do centers practice active intervention?

If a crisis worker cannot de-escalate a caller with thoughts of suicide, the crisis worker must use whatever means he/she can to intervene when the caller's safety is at risk. Some strategies include:

- Use of technology to locate the caller even when the caller does not want to be located.
- Calling a third party if appropriate
- Sending a mobile outreach team
- Sending emergency personnel such as police, fire, etc.

A crisis center that is practicing active intervention/rescue attempts to get persons at risk of suicide to safety even when they are unwilling. AAS believes this is crisis worker's job and professional obligation.

Policies should clearly spell out the crisis center's approach to a callers at risk of suicide including but not limited to: lethality assessment, rescue procedures, caller identification procedures and use of supervisory advice.

Two other specific procedures must be practiced by agencies using active rescue – follow-up and third party intervention.

Follow-ups

The role of the crisis center/worker extends beyond the call – ensuring a safety plan is in place and being followed is critical to preventing suicide. We all know of callers who have contracted to call us back but don't. We also know of callers who end up killing themselves or attempting suicide after we have ended the call. When crisis workers have a sense that the caller will continue to be at-risk after the call, it is appropriate to have continuing contact with the caller by calling them back.

Some centers have set standards for follow-up based on the level of suicide risk. For example a caller with a risk designation of "immediate-high" must be contacted every hour; a "high risk" within 24 hours; a "medium risk" within 7 days and a "low risk" followed at the crisis worker's discretion. Most centers believe that once another professional is working with the caller, the crisis center can relinquish their responsibility for the caller. It is up to the center to establish their own guidelines, but it must be clear that follow-ups are routinely done because the center does not want to take a chance of losing a caller to suicide.

Third Party Calls

The higher the evaluated risk the more aggressive the crisis center needs to be to keep a caller at risk safe. In general, persons at risk of suicide who don't contact a crisis center, are likely higher at-risk than someone who calls. In many cases, those at-risk individuals come to our attention because of a third party call – someone who cares about them calls us.

Many times we can make the 3rd party caller an ally and use their contact with the person at-risk to help us keep them safe. We can train the caller about intervention with a person at risk. It is unfair, however, to give 3rd party callers the responsibility for actually providing the suicide intervention. They are personally and psychologically too close to the person at risk to be objective and effective as interventionists.

The center/worker must understand that the 3rd party caller may wish to be anonymous and may not want to be involved in an intervention. Policies should be clear regarding 3rd party involvement.

Active intervention suggests that what the caller does or what they permit is not important. What is important is that the crisis worker must talk *directly* to the person at risk. As noted above, these persons at-risk may, in fact, be the most suicidal callers we talk to. We need to do whatever we can to get their contact information and then call them directly.

These calls are more awkward than those we receive from persons at-risk. Crisis workers must be trained on the uniqueness of these calls – a person at risk may deny thoughts of suicide, complain about our intrusion, insist on knowing who called, etc. Crisis workers must use their active listening skills to complete an appropriate assessment.

Centers must have policies that guide crisis workers in these delicate but important calls and must demonstrate consistently that these policies are being followed.

Appendix 6

National Suicide Prevention Lifeline (NSPL) Suicide Risk Assessment Standards*

It is policy that each Lifeline caller be asked about suicidality. An affirmative answer will require that the telephone worker conduct a full suicide risk assessment with the caller consistent with the core principles and subcomponents below. These standards are guidelines for NSPL Centers as to the minimum requirements for the core principles and subcomponents of each Center's suicide risk assessment instrument. The Center can use its own suicide risk assessment instrument as long as all of the core principles and subcomponents are incorporated.

CORE PRINCIPLES & SUBCOMPONENTS

SUICIDAL DESIRE	SUICIDAL CAPABILITY	SUICIDAL INTENT	BUFFERS/CONNECTEDNESS
Suicidal Ideation <ul style="list-style-type: none">• Killing self and/or others	History of suicide attempts	Attempt in progress	Immediate supports
	Exposure to someone else’s death by suicide		Social supports
	History of/current violence to others		
Psychological pain	Available means of killing self/ other	Plan to kill self/other <ul style="list-style-type: none">• Method known	Planning for the future
Hopelessness	Currently intoxicated		Engagement with helper <ul style="list-style-type: none">• Telephone worker
	Substance abuse		
Helplessness	Acute symptoms of mental illness, for example: <ul style="list-style-type: none">• Recent dramatic mood change• Out of touch with reality	Preparatory behaviors	Ambivalence for living/dying
Perceived burden on others			Expressed intent to die
Feeling trapped	Sense of purpose		
Feeling intolerably alone			

* Developed by staff from the NSPL at Link2Health Solutions, Inc. in collaboration with the NSPL Certification and Training Subcommittee (for more information see Appendix 1 or <http://www.suicidepreventionlifeline.org/about/BioCertification.aspx>) under grant No. 6 U79 SM56176-02-3 from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Any opinions, findings, conclusions and recommendations expressed herein are those of the authors and do not necessarily reflect the views of the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Appendix 7

Online Emotional Support (OES)

Introduction to the OES Standards CONTACT USA AAS Edition

The idea behind Crisis Chat was conceived in May 2009 and dialogue among crisis center supervisors/directors focused on development of a comprehensive and thoughtful approach to online emotional support, combining the resources of many established crisis centers throughout the USA. Under the leadership of CONTACT USA, goals for the project were established: 1) develop a standardized model that can be easily replicated; 2) create a Crisis Chat website and promote use of its services and resources; 3) link visitors to appropriate local resources; and most importantly, 4) give people in emotional pain an opportunity for hope. Crisis Chat became a reality and services became available online at www.crisischat.org during the summer of 2010. Today CONTACT USA and the National Suicide Prevention Lifeline have joined efforts and created Lifeline Crisis Chat as a means to not only strengthen the National Network, but to work jointly to provide guidelines and standards to ensure the ongoing delivery of quality services to those in need.

To further ensure that centers offering online emotional support adhere to the newly developed standards **CONTACT USA and the American Association of Suicidology (AAS)**, the two major accrediting bodies in the United States for crisis centers, now work together to ensure quality core standards are met in online service delivery.

Basic Training Program

RATIONALE: Those who volunteer or are employed to provide a particular service have a right to expect that they will be given an adequate opportunity to acquire the requisite attitudes, knowledge, and skills and to integrate these into safe and competent practice. Visitors have the right to expect to be heard compassionately, non-judgmentally, and confidentially, and to be assisted appropriately.

STANDARD: The center's basic training program for volunteers or staff that responds to a visitor in crisis is a minimum of four hours and additional practice hours. OES training must be preceded by the successful completion of the crisis intervention training. OES specialists must be pre-screened for ability to effectively communicate with the written word. Training must include:

- Use of technology systems for OES service provision.
- Basic structure of an OES interaction which includes: Rapport, Facts, Feelings, and Options.
- Practical experience with mock visitor situations.

Core Competencies: The training program shall focus on demonstrable knowledge, and skills in the following areas:

- Understanding the role of the OES Specialist
- Understanding the program's policies and procedures
- Ensuring competent practice in the special techniques of OES work

COMPONENTS: The components of this standard include a minimum of a four-hour training program and

specific training requirements that encompass the core competencies in addition to basic crisis and suicide intervention training.

Component 801-OES: Four-Hour Basic Training Program

- Level 1: The basic training program consists of at least four hours of training in the core competencies and includes experiential learning in the form of role-play using mock chats/texts.
- Level 2: The basic training program consists of at least four hours of training in the core competencies, and trainees complete a supervised apprenticeship following training.
- Level 3: Training program is designed and modified based on written evaluations from trainees.

Component 802-OES: Demonstrable Competencies of OES Specialists

- Level 1: There are written objectives for training, focusing on the knowledge, attitudes, and skills essential to provide OES services.
- Level 2: A formal evaluation process demonstrates that OES Specialists have integrated the necessary knowledge, attitudes, and skills into safe, competent practice.
- Level 3: The formal evaluations of trainees are used to provide individual coaching and to revise trainings in the future.

Qualification of Trainers

RATIONALE: The effectiveness of a training program is influenced by all who participate.

STANDARD: Trainers have knowledge and skills appropriate for their roles.

COMPONENT: The component of this standard addresses the qualifications of the individual trainers or presenters.

Component 803-OES: Trainers' Experience, Knowledge, and Skills

- Level 1: The program has at least one dedicated trainer with the required experience, knowledge, and skills.
- Level 2: All trainers for the OES program have personal experience delivering OES crisis intervention, performing crisis intervention in general, and providing feedback and supervision to specialists.
- Level 3: Trainers' competence is indicated by overall positive written evaluations of the training program by the three most recent classes of newly commissioned OES Specialists.

Continuing Education

RATIONALE: Continuing education encourages the further development of skills and knowledge of OES Specialists.

STANDARD: The OES program has established a continuing education program for OES specialists to help maintain their skills and knowledge. All active OES specialists participate in at least one continuing

education activity annually.

COMPONENTS: The components of this standard are the provision of a program of continuing education and participation of all active OES specialists in the continuing education program. Relevant continuing education may include meetings, media presentations, readings, or classes.

Component 804-OES: Continuing Education Program

Level 1: The center infrequently offers relevant continuing education.

Level 2: The center regularly offers continuing education.

Level 3: The center offers a variety of continuing education opportunities including topics pertinent to OES service specifically (i.e. providing services to youth, LGBT issues, non-suicidal self-injury, bullying, violence, date-rape, or eating disorders). OES specialists are encouraged to participate in other continuing education opportunities available in the community.

Component 805-OES: OES Specialist Participation in Continuing Education Activities

Level 1: All active OES specialists participate in at least one continuing education activity annually.

Level 2: All active OES specialists participate in at least one continuing education activity annually and more than 50 percent participate in more than one.

Level 3: All active OES specialists participate in at least one continuing education activity annually and more than 90 percent participate in more than one.

Section 2 OES: Specialists' Standards

RATIONALE: Programs that rely on volunteers or staff to provide the services for which the organization was founded must become experts in recruitment, training, and management of staff/volunteers.

STANDARD: The Program is able to recruit and retain the number of OES Specialists that it needs to provide quality services. OES Specialists are supervised and their performance is evaluated annually. The Program maintains adequate statistics and recognizes the contributions of these staff/volunteers.

COMPONENTS: The components of this standard address recruitment, recognition, supervision, evaluation, record-keeping, and maintaining a sufficient number of staff/volunteers for OES operations.

Retention and Recruitment

Component 806-OES: Recruitment and Retention of OES Specialists

Level 1: The Program has sufficient specialists to cover advertised hours with at least one person on duty at all times.

Level 2: The Program has enough specialists to cover advertised hours with more than one person on duty for at least 50% of advertised hours.

Level 3: The Program has sufficient staff/volunteers to meet its advertised hours with more than one person on duty for all advertised hours.

Supervision

Component 807-OES: Supervision of OES Specialists

- Level 1: The OES Program has at least one person whose responsibility is the supervision of OES Specialists.
- Level 2: OES Specialists receive formal, regularly scheduled supervision.
- Level 3: Each OES specialist receives either written or in person feedback or coaching a minimum of monthly, which includes reviewing chat/text transcripts and addressing strengths and opportunities for growth.

Evaluation

Component 808-OES: Evaluation of OES Specialists

- Level 1: OES Specialists receive informal evaluation.
- Level 2: The OES Program has developed and uses a consistent system of annual evaluation of each OES Specialist, including a plan for addressing deficiencies.
- Level 3: Annual or more frequent evaluations are kept on file for each specialist and include an opportunity for the specialist to provide feedback about the program.

Component 809-OES: Individual OES Specialist hours of service are maintained.

- Level 1: Records are maintained for the agency, but are not updated annually.
- Level 2: Records are maintained for the agency and are updated annually.
- Level 3: Records are maintained for the agency and updated monthly.

Section 3 OES: Service Standards

RATIONALE: The public has a right to expect that the OES Program is available as advertised and is administered in a competent and ethical manner.

STANDARD: The Program is adequately managed. OES Specialists have direct access by website to visitors. The service is provided without regard to age, gender, race, religion, sexual orientation, gender identity and/or national origin. Centers have specific written policies and procedures regarding active rescue during emergencies, confidentiality and non-discrimination. OES Specialists must have access to these written documents.

COMPONENTS: The components of this standard address OES Program management, confidentiality, availability and adequacy of emergency response.

Program Management and Marketing

Component 810-OES: Program Management

- Level 1: A designated person has the assigned responsibility for the management of this program.
- Level 2: Program administration includes periodic updates of client records, keeping of program

statistics, and OES staff/volunteer recruitment.

Level 3: The program is evaluated annually and results are used to update and modify policies as needed.

Component 811-OES: Publicity and Linkages to Community Partners

Level 1: The OES program has done limited publicity in the community via media and community partners, utilizing one or two means of publicity (website, social media, fliers, staff or volunteers doing public speaking, having booths at fairs, newspaper articles or television or radio spots/interviews).

Level 2: The OES program has done some publicity via media and linkages with community partners, utilizing three or more means of publicity.

Level 3: The OES program had done extensive outreach in the community via media and community partners and the service is well-known in the community.

Component 812-OES: Addressing Chat or Text Conversations During Advertised Hours

Because OES services are new, demand is higher than supply in most areas. It may not be possible for a center to fully meet the demand for services. We do not want this to prevent a center from receiving accreditation. It is, however, necessary to at least address visitors and give them a realistic expectation of service availability.

Level 1: The portal is always open during advertised hours. Visitors are acknowledged with a message regardless of whether they are able to converse with an OES specialist. (This could be automated from the computer or a specialist could manually advise the visitor that someone will be with them soon.)

Level 2: Visitors who must wait (due to the specialist already serving another visitor) are given a rough approximate wait time.

Level 3: Statistics on abandonment rates are kept and the center adjusts staffing and hours in order to better meet demand.

Component 813-OES: Review of Visitor Records

Level 1: Visitor records are occasionally reviewed

Level 2: Visitor records are reviewed monthly

Level 3: Visitor records are reviewed weekly

Support Services

RATIONALE: OES Specialists on duty need access to support and assistance.

STANDARD: The OES Program's response to human need includes provision of immediate support and assistance to OES Specialists on duty. Support staff has been specifically trained to provide support and to assist the OES Specialist in cases of emergency.

COMPONENTS: The component of this standard is a support system for OES Specialists.

Component 814-OES: Support System

Level 1: Support people are always scheduled and available to OES Specialists on duty, and the OES

specialists on duty have access to the name and phone number to reach the person on-call if they are not in the building.

Level 2: Support staff/volunteer checks in with the OES specialists in person or by phone at least once during each shift.

Level 3: A formal debriefing system is in place for OES specialists and is held on a regular basis in the form of one on one or group meetings.

Component 815-OES: Support Staff Training

Level 1: OES specific training is provided to support staff/volunteers.

Level 2: Organized curriculum of training provided, including training about the software, website, and how to perform an active rescue with text or chat.

Level 3: Organized curriculum of training provided; ongoing support staff/volunteer continuing education provided.

Confidentiality and Anonymity

RATIONALE: OES specialists have the right to expect their identity to be protected appropriately. Visitors have the right to expect their identity and information to remain private.

STANDARD: The OES program is responsible for defining and regulating matters of confidentiality and anonymity, unless deemed at high risk for suicide.

COMPONENTS: The components of this standard are policies and procedures regarding confidentiality, disciplinary action, anonymity of the OES specialist, and confidentiality of visitor information.

Component 816-OES: Policies and Procedures Regarding Confidentiality

Level 1: There are policies and procedures regarding confidentiality. Everyone who has access to and/or use caller information is required to sign a “Pledge of Confidentiality.”

Level 2: Signed confidentiality forms are evident in employee and volunteer files.

Level 3: These policies are easily accessible by OES specialists (available online, hanging on a call-room wall, etc.) Any guests that may come in contact with confidential information while visiting the crisis center are required to sign a pledge of confidentiality.

Component 817: Policies and Procedures Regarding Off-Site Chat Confidentiality

Level 1: There are policies and procedures regarding off-site chat/text confidentiality. All employees and staff who have access to chat/text off-site are required to sign a “Pledge of Confidentiality.”

Level 2: Signed confidentiality forms are evident in employee and volunteer files.

Level 3: Computers used remotely receive an in person or remote inspection for security. If a center does not allow off-site chat/text, there is a policy that states that.

Component 818-OES: Policies and Procedures for Disciplinary Action

Level 1: There are guidelines for disciplinary action if confidentiality is broken and those guidelines are consistently enforced.

Level 2: Written records of any disciplinary action are kept in the specialist’s file.

Level 3: Specialists are aware of the disciplinary guidelines either through training or by having those guidelines easily accessible (in a handbook each specialist receives, available online, hanging on a call-room wall, etc.)

Component 819-OES: Anonymity

The level of anonymity expected of OES specialists is up to the individual center. Some centers may allow specialists to use their real first name or to use limited self-disclosure while others do not. AAS does not require a certain stance on anonymity, only that each center has a policy addressing it for the safety of their OES specialists.

Level 1: There are written formal policies regarding the anonymity of OES Specialists, and specialists are aware of their rights.

Level 2: The written policies regarding anonymity are incorporated into training of new specialists.

Level 3: These policies are easily accessible by OES specialists (in a handbook each specialist receives, available online, hanging on a call-room wall, etc.)

Component 820-OES: Visitor Records Retention and Security (Hard Copy and Electronic) As per AAS standards?

Level 1: The program has a visitor record retention policy and records are kept securely.

Level 2: Hard copies of visitor records are purged within a month of the period defined in the visitor record retention policy. Software used to store data automatically purges visitor records when they reach a specified age.

Level 3: Program has a Visitor record retention policy and records are kept securely; client record retention policy is available to users of the service if they inquire.

Component 821– OES: Mandatory Reporting of Abuse to Minors or Vulnerable Adults

Level 1: The Program has a mandatory reporting policy.

Level 2: The written policy regarding mandatory reporting is incorporated into training of new specialists

Level 3: This policy is easily accessible by OES specialists (in a handbook each specialist receives, available online, hanging on a call-room wall, etc.)

Visitor Statistics

RATIONALE: Statistics quantify the use and relevance of service.

STANDARD: The OES Service keeps accurate and current visitor statistics that include a range of demographic information.

COMPONENT: The component of this standard is the maintenance of OES visitor statistics.

Component 822-OES: Demographic Statistics

Level 1: The OES service has a process for keeping statistics; however, the statistics may not be consistent or current.

Level 2: The OES service's visitor statistics are consistent and current.

Level 3: The OES service's visitor statistics are consistent, current and are reviewed regularly

Component 823-OES: Outcome Measurements

Level 1: The OES service has a process for measuring outcomes. However, this data is not put to a consistent use.

Level 2: The OES service has a coherent method of measuring visitor outcomes which are reported to stakeholders, and which is used to improve the program.

Level 3: The OES service measures a complete set of visitor outcomes that include visitor satisfaction measures as well as follow-up procedures to survey impact of online emotional support intervention weeks after the intervention. Outcomes are reported regularly, along with other statistics, to community stakeholders.

Suicide Risk Management

RATIONALE: Considerations in managing high risk situations online is especially important for crisis centers due to the increased visibility of the transparency of the service due to the fact that all conversations are in written, not spoken word. Transcripts between visitors and OES specialists can be retained by both the crisis center and the visitor, creating a potentially more liable situation.

STANDARD: Risk assessment procedures, descriptions and limitations of service are clearly outlined. Necessary information is communicated to the visitor in crisis.

COMPONENT: The components of this standard are the policies/procedures that must be in place to assess risk and determine need for active rescue.

Component 824-OES: Lethality Assessment Form

Level 1: OES specialists have a risk assessment form which is used consistently on all OES communications which involve visitors with thoughts of suicide.

Level 2: Risk assessment forms are used consistently and are reviewed and feedback is given to the OES specialist.

Level 3: Policies exist regarding whether and how the risk assessment form is used to determine the need for an active rescue.

Component 825-OES: Policies on Intervention in Emergency Situations

Written intervention policy clearly outlines when emergency help will be sent to a Visitor in crisis and the limits to sending help. Only one level is acceptable.

Level 3: Written policy is in place and consistently followed.

Policy is easily accessible to all staff and volunteers.

Staff and volunteers are trained on the policy, and continuing education opportunities are available regarding risk assessment or how to perform active rescues.

Component 826-OES: Procedures for Contacting Police/ Law Enforcement

OES specialists and support staff need to understand the center's role in providing information to police.

Only one level is needed.

Level 3: All support staff are trained in how to look up the phone number for the 911 dispatcher in a given area. In addition, the support staff is trained on how to obtain the IP address or phone number and contact the appropriate service provider's legal department in order to initiate rescue.

Clear, written directions for contacting police/law enforcement are available in an easily accessible location in case of confusion.

A form or letter is available to fax or e-mail to dispatchers upon request if the dispatchers are not familiar with the process of locating someone based on their IP address or phone number.

Component 827-OES: Written Disclaimer on Website and Software Platforms

Written disclaimer(s) and privacy policy clearly outlines the scope of service, the limits to sending help in high risk situations and the manner in which visitor information is collected and used.

****Disclaimer Required**

Section 6 OES: Technology Platform

RATIONALE: Without appropriate software and Internet technology, communication with visitors would be compromised.

STANDARD: Ensure software system allows for the delivery of a quality on-line service to visitors.

COMPONENT: The components of this standard are policies and procedures necessary to monitor on-line emotional support and crisis intervention services to visitors.

Component 827-OES: Software allows for Consistent Communication with the Visitor

Level 1: Software allows for consistent communication with the visitor most of the time.

Level 2: OES specialists or support staff regularly report software malfunctions or connectivity issues to their IT or software provider for repair.

Level 3: Software allows for consistent communication with the visitor and provides a way to reconnect with a visitor in crisis if it fails.

Component 828-OES: Software allows for Collection of Visitor Demographic Information

Level 1: Software allows for the collection of minimal visitor information (i.e. phone number or email).

Level 2: Software allows for the collection of a useful range of visitor information (i.e. age, gender, issue, location etc.) and information is reviewed and utilized informally.

Level 3: Software allows for the collection of a useful range of visitor information and systematic

review of the aggregate information (i.e., software allows for statistical analysis or graphing)

Component 829-OES: Records of Individual Chats and Texts

Software allows for an organized compilation of records of individual text/chat conversations for the purposes of supervision, review and training as needed.

- Level 1: Records of individual conversations are maintained, with or without a complete transcript.
- Level 2: Organized records are maintained for easy supervision, review, and management.
- Level 3: Records are searchable by a variety of factors, including visitor or specialist name, phone number, IP address, and keywords.

Component 830-OES: Software Supports Geo-Location of Visitors

The software supports a protocol for handling visitors both within the center's defined geographic service areas and visitors outside the center's defined geographic service area.

- Level 1: The center has a defined service area (such as a specific state or country), and the software has a feature that provides the IP address or phone number.
- Level 2: The software provides the IP address or phone number and is able to distinguish which visitors are inside and outside the service area.
- Level 3: The software provides the IP address or phone number along with a general region that the chat/text originated from.

Component 831-OES: Website Portal Quality

Website provides clear platform for communication with the public and access to the OES service(s). (If OES service is not provided via the internet, as in the case of Texting, this component is not applicable and a Level 3 will be indicated in the scoring)

- Level 1: Website is stable, clear and available to users allowing quick access and login to services.
- Level 2: Usage policies are available to visitors.
- Level 3: The Website is easy to navigate and provides other complementary services, such as mental health information, resources, and links to other useful sites.

Appendix 8

IT Usage Policy (Sample)

Purpose

The purpose of this policy is to provide regulations and responsibilities regarding the use of information technology at ORGANIZATION, including acceptable use, Authorization, Remote Access, and End User responsibilities.

Procedure

It is the responsibility of all ORGANIZATION users to use information technology at ORGANIZATION, while using ORGANIZATION technology, and while performing work for ORGANIZATION expressly for business uses in a responsible and acceptable manner.

ORGANIZATION users must also follow all conditions and responsibilities listed in the IT Usage, IT Hardware, IT Software and all other applicable policies and procedures.

Acceptable Use

Use of information technology (including hardware, software, Internet, etc.) is provided and to be used for business purposes – specifically to enhance productivity and performance.

Incidental uses that do not present a risk or threat to ORGANIZATION or ORGANIZATION users and that do not interfere with or impede business operations may also be acceptable. See the IT Usage Procedure for more detail and examples of acceptable and incidental uses.

Unacceptable Use

Use of information technology that does or may present a risk, or may threaten, damage, conflict, interfere with, or impede business operations or its activities and objectives are expressly prohibited. This includes, but is not limited to, streaming Internet media (movies, online music/radio), or conducting other paid work. Use of information technology that does or may threaten harm to another person(s) is expressly prohibited.

Use of information technology that does or may threaten or result in unauthorized manipulation, deletion, alteration, damage, or otherwise harm ORGANIZATION data or ORGANIZATION technology or external information technology is expressly forbidden. This includes, but is not limited to, improperly disseminating protected data, spreading a virus or malware, or sending spam.

Use that violates HIPAA and/or reveals PHI or other protected data is expressly forbidden. This includes, but is not limited to, sending a personal email or IM that includes any client information.

Use that violates applicable laws and statutes. This includes, but is not limited to; illegal activities conducted or participated in through the Internet (email, web, IM) such as pornography, gambling, etc. See the IT Usage Procedure for more detail and examples.

Compliance, Monitoring, Violations, and Discipline

If any employee discovers that he or she has unintentionally violated this policy, please notify any ORGANIZATION management staff immediately.

Users are responsible for immediately reporting actual or suspected violations to IT staff or ORGANIZATION management directly or anonymously.

ORGANIZATION reserves the right at all times to monitor, disclose, decrypt or produce copies of information exchanges, data, communications, files or other work-product made from any ORGANIZATION technology or by an ORGANIZATION user.

ORGANIZATION may also inspect and/or search any work areas or ORGANIZATION Hardware in order to ensure compliance with internal policies and procedures.

Use of technology such as the Internet is a privilege, not a right. Violations of this policy will be reviewed for appropriate disciplinary actions, up to and including revocation of resource rights (such as the Internet, or email), job termination, or criminal prosecution, if appropriate.

Definitions

ORGANIZATION technology:

1. Any element under the aegis of the IT department including, but not limited to, ORGANIZATION Hardware, ORGANIZATION Software, and other technological resources and tools such as the Internet and the ORGANIZATION Intranet.

2. Information technology: includes, but not limited to, hardware, software, and other technological resources and tools such as the Internet.

3. User(s) or ORGANIZATION User(s): Any ORGANIZATION employee, contractor, consultant, temporary or other worker performing work for ORGANIZATION or under the auspices of ORGANIZATION.

IT Security Policy Sample**Purpose**

The purpose of this policy is to provide regulations and responsibilities regarding establishing and maintaining the security of ORGANIZATION's information technology systems.

Policy

ORGANIZATION IT department shall follow appropriate measures to protect the network against threats. Furthermore, the IT department will provide ORGANIZATION users appropriate rights and access to hardware, software, data and resources based on the need(s) of their position.

Access/Passwords:

1. Only authorized users may have access to ORGANIZATION's information technology systems.
2. Logins and other forms of validation or authentication may be required to access different parts of the IT systems.
3. Standard and widely used security practices will be applied to passwords and accounts.
4. IT Staff do not and should not have any individual passwords.
5. IT staff should have the ability to reset passwords if necessary.

Network/Data Access

Only authorized users may have access to ORGANIZATION's computer network. Network logins are required for access to the ORGANIZATION domain. Standard and widely used security practices will be applied to passwords and accounts.

Only authorized hardware may be connected to ORGANIZATION's computer network.

Database/Applications Access

Only authorized users may have access to ORGANIZATION's proprietary client/caller database/application.

Certain applications such as the client database or payroll require additional logins. Logins for these applications should be distinct from the network login, & additional requirements may be present.

Internet

Internet access is available to those connected to ORGANIZATION's network. Users are subject to ORGANIZATION's Acceptable IT Use Usage Policy & Procedures.

Wireless Internet access may be temporarily made available by IT staff as needed.

ORGANIZATION's IT department shall use appropriate technology to keep ORGANIZATION's internal network and secure from unwanted and malicious external Internet access.

Email

Externally connected (pop) email accounts are limited to authorized individuals. These accounts require separate unique passwords.

Internal email is restricted to authorized users. Internal email accounts are restricted and are unable to send to or receive messages from outside the ORGANIZATION network.

Virus/Malware

All reasonable measures are to be taken to ensure the prevention of infection of ORGANIZATION's computers by malicious software or code including, but not limited to, viruses, trojans, malware, bots, and spyware.

Physical Access

Physical access to specific areas of ORGANIZATION's offices where PHI information may be accessible shall be restricted.

Physical access to ORGANIZATION's computer network servers shall be restricted.

VPN/Remote Access

Remote access of any type is limited to authorized individuals. Authorization is granted on an individual basis. Remote access shall be governed by procedures specifically determined by ORGANIZATION's IT department. Remote access procedures are created to provide access to authorized users not at ORGANIZATION's office to the ORGANIZATION computer network, while providing sufficient security for such access.

Appendix 9

AMERICAN ASSOCIATION OF SUICIDOLOGY

Guidelines for a Code of Ethics for Suicide Prevention and Crisis Intervention

I. PURPOSE: To establish guidelines for a code of ethics for individual and organizational members of the American Association of Suicidology involved with prevention or crisis intervention (hereinafter referred to as crisis workers).

II. OBJECTIVES

- A. To protect the rights of persons provided services by or participating in programs of, members of AAS.

- B. To promote compliance with professional and community standards of conduct.
- C. To provide guidelines for the resolution of ethical conflicts in suicide prevention and crisis intervention procedures.

III. PRINCIPLES

- A. Integrity

The crisis worker shall place the highest value on integrity. Whether as a practitioner, teacher, trainer, or researcher, there should be no compromise with the best interests of the persons served being the overriding consideration at all times.
- B. Competence
 1. Responsibility should only be undertaken or assigned for those activities for which the person has been trained and has demonstrated an adequate level of competence. If the needs of the person being helped are beyond the competence of the crisis worker, referral to someone with the needed skills should be accomplished as expeditiously as possible, assuring that possible feeling of rejection or abandonment are appropriately dealt with.
 2. If lack of competence is observed in other persons or agencies, the observation should be made known to one's supervisor or to the individual responsible for taking corrective action.
 3. If physical or emotional problems interfere with the crisis worker's optimal functioning, appropriate steps should be taken to see that such problems do not compromise the quality of services offered. The interests of the person being helped are first dealt with, and measures to correct the crisis worker's problems instituted as well. Further crisis work should be deferred until such problems no longer interfere with the person's competence.
- C. Moral Standards: The crisis worker should respect the social and moral attitudes of the community in which he/she works, assuring that the reputation of persons or agencies not be unnecessarily jeopardized.
- D. Legal Standards: In the course of crisis work, illegal actions by the person in crisis should not be encouraged or facilitated. If the crisis worker recognizes a potential legal issue, of which the person is not aware, the crisis worker should inform the person of that issue. In no case should the crisis worker participate in an illegal act.
- E. Representation
 1. The crisis worker shall accurately represent his/her qualifications, affiliations and purposes when appropriate, and those of the agency with which he/she is associated.
 2. The crisis worker should not provide information that would imply the presence of qualifications or affiliations, professional or otherwise, which are not accurate, or would lead others to assume qualities or characteristics that are not correct. If misrepresented by others, or if others make incorrect assumptions, the crisis worker should rectify such misconceptions.
 3. The crisis worker should not use his/her affiliation with an organization, or its divisions, for

purposes, which are not consonant with the stated purpose of that organization

F. Public Statements

1. All public statements whether direct or indirect, should be accurate and free of sensationalism, bias, distortion or misrepresentation of any kind. - Special care in this regard is required in activities related to news articles aimed at stimulating public awareness and support of an agency, and for solicitation of funds to continue the agency's work.
2. When information is provided to the public about suicide prevention or crisis intervention techniques, it should be made clear that such techniques are to be used only by persons adequately trained in their use, when that is the case.

G. Confidentiality

1. Maintaining the confidentiality of information about persons helped is a primary responsibility. Such information should not be communicated to others unless specific provisions for such release are met according to state statutes.
2. Confidential information may be revealed after careful consideration indicates the presence of clear and present danger to an individual or to society, and then only to those who must be informed in order to reduce that danger.
3. Information about persons being helped is discussed only with others concerned with the case.
4. Except for 2 and 3 above, only when the person being helped gives permission may information be disclosed to another individual the person should specify what information might be given, and to whom. In circumstances judged by the crisis worker to constitute an emergency involving a threat to the life or safety of the person being helped, these restrictions may be suspended as necessary to provide the required assistance.
5. Written and oral reports should contain only information germane to the purpose of the report. Every effort should be made to protect the person's privacy.
6. In writing and teaching, care should be taken that any clinical material used should be presented in such a way that the identity of the individual is not revealed.
7. The identity of research subjects should not be revealed or rendered recognizable without explicit permission.
8. The crisis worker should assure that appropriate provisions are made for the maintenance of confidentiality in the storage, retrieval, use, and ultimate disposition of records.

H. Welfare of Persons Receiving Crisis Services

1. In accord with III.B.1 above, if it becomes clear that the person the crisis worker is responding to would best be served by referral to another crisis worker, or another type of assistance, such referral should be accomplished without undue delay. Full consideration should be given to the possible adverse effects of referral, and the procedure carried out in such a manner that these

potential adverse effects are minimized.

2. In the event of referral, the referring crisis worker should continue to render assistance as needed, until such time as the responsibility for helping the person is assumed fully, if that is appropriate, by the worker taking over the case.

I. Relationship with the Person Receiving Crisis Service

1. Crisis services should be provided only in the context of a professional type of program.

2. No illegal interaction should transpire in the course of providing crisis services.

3. The crisis worker should not provide services to his/her associates, friends or family members except in the most unusual circumstances, and then only with the concurrence of an experienced consultant.

4. Each individual agency should state, in its policies and procedures manual, precisely, under which circumstances a call may be taped or listened to by a third party without the caller's knowledge or consent. An opinion on this issue should be obtained from legal counsel that relevant federal or state laws would not be violated by these policies and procedures.

J. Offering of Services

1. Any proffering of suicide prevention and crisis services should be carried out within strict limits of community standards, propriety and good taste.

2. Notices designed for public use, such as telephone book, posters, or brochures may contain a statement of the name, degree, accreditation and sponsoring agency of the provider, the services offered, a description of those services, circumstances in which the services might appropriately be used, and how to obtain them. Reassurances, such as emphasizing twenty-four hour readiness to respond, and desire to be of help, may be included in material from agencies or organizations.

3. No evaluative statements or assurance of quality or efficacy should be expressed or implied in any form.

K. Professional Relations

1. The integrity, traditions and potential helping role of all professions and disciplines should be acknowledged and respected, both in relations between disciplines and in communications with persons in crisis. No suggestion of precedence among disciplines should be expressed or implied, though special needs may call for unique skills in individual cases.

2. Crisis workers should not knowingly enter into a competitive role with other providers in the community. If the person being helped has a previously established relationship with another caregiver, the crisis worker should attempt to integrate the efforts being made. In no case should there be an effort to prevent the other caregiver from being informed of the crisis worker's role. Mutual agreement of all concerned, as to the best way to assist the person in crisis, should be striven for.

L. Remuneration

1. No commission, rebate, or other consideration or inducement should be involved in a referral to or from a crisis worker for the provision of crisis services.
2. The crisis worker should not use his/her relationship with the person being helped to promote his/her own benefit or that of any agency or of any other enterprise.
3. A crisis Worker associated with an agency- or institution should not accept a fee or other form of remuneration for providing services to a person who is entitled to those services through the agency or institution.
4. A crisis worker in an agency or institution should not accept a gift from a person being helped, unless its nature and value falls within the limits established by the governing body of the agency or institution for such gifts.

M. Ownership of Materials

1. All materials prepared by a crisis worker, in carrying out his/her regular duties in an organization, shall be the property of that organization. Release or publication of such materials will be governed by the policies established by the organization.
2. Materials prepared by a crisis worker in an agency, other than those materials resulting from his/her regular duties, shall, if published, and the agency so desires, include a disclaimer of response ability on the part of the agency for the content of the published materials.

N. Promotional Activities

1. A crisis worker or agency associated with the promotion of services, books, or other products, should ensure that these are presented in a professional and factual manner.
2. Any claims made should be supported by scientifically acceptable evidence.
3. If a financial interest is held in any commercial product, care must be taken to assure that the clinical care of persons in crisis is not adversely affected by that interest.

O. Research

1. All research activity must be carried out with meticulous attention to the well being and dignity of all participants.
2. The design and methodology of clinical studies shall follow federal guidelines for research involving human subjects.
3. Research carried out in an agency or institution must be reviewed and approved by the governing board of that institution, which must determine that compliance with human rights regulations will be observed.

Appendix 10

Glossary of Terms

CLIENT: Used in this manual to mean the individual who uses the service provided by a crisis program. The client may be only a brief “caller” or a long term, chronically mentally ill “patient”.

CRISIS PROGRAM: A generic term used to include: suicide prevention centers, crisis intervention programs, emergency services of community mental health centers, psychiatric or behavioral sections of emergency medical services, services for victims of violence, runaway shelters, online services, mobile outreach etc.

CRISIS SPECIALIST: A person working on a paid or volunteer basis who has acquired specialized knowledge and skills in suicide prevention and crisis work; who adheres to the technical and ethical standards of suicidology, victimology, crisis and emergency mental health practice and who spends at least part of his/her time providing crisis intervention services.

GATEKEEPERS: Community service persons such as police, clergy and teachers who often are engaged in front line crisis situations; who often provide the initial service during acute crises in community settings and who set in motion the mechanism for linking persons in crisis to formal crisis services, rescue, or self-help groups.

LETHALITY ASSESSMENT: A lethality assessment is an evaluation based on research of how dangerous a situation is and addresses issues such as the person’s intentions, method, timing and state of mind. Questions include: Has the person already taken steps toward committing suicide by swallowing pills, slashing their wrists? Have there been previous attempts? Does the person have a specific plan? Are the means to carry out the plan readily available? What is the likely timeframe for a life -threatening event – the next few minutes of hours or longer? Has the individual had psychiatric help in the past and how to they feel about it? Are there other risk indicators such as depression, hopelessness, and feelings of isolation, intoxication or significant recent losses?

SUICIDOLOGISTS: All individuals who have appropriate training in, and spend a portion of their time specifically engaged in, suicidology activities; who promote purposes, goals and validated methods of suicide prevention, as do members of the American Association of Suicidology.

SUICIDOLOGY: A research, education and service specialty whose focus is life threatening and self-destructive behavior. Its primary, but not exclusive, concern is one of studying, intervening in, and preventing suicide. The service aspect of suicidology is an integral part of the field of crisis intervention and emergency mental health practice.

THIRD PARTY CALLER/CALL: An individual, or several persons, who are concerned about a suicidal, homicidal, or otherwise at-risk person; third party contacts are often through family members, friends or gatekeepers; these can be very difficult to work with, as the worker is one step removed from the person in crisis.

VICTIMOLOGY: A research, education and service specialty whose focus is on criminal behavior and its effects on victims. Its primary concern is that of preventing victimization, studying the process of victimization, and promoting strategies and services on behalf of victims. The service aspect of

victimology is an integral aspect of crisis intervention, criminal justice, and mental health practice.