AMERICAN ASSOCIATION OF SUICIDOLOGY

5221 Wisconsin Avenue NW, Washington, DC 20015

Application for Accreditation or Re-Accreditation

New:___________________________________ Re-accreditation: ___

I. DATA REGARDING PROGRAM

Name of Program:

Contact Person:

Address:

City: **State:** **Zip:**

Business Telephone Number: **Fax:**

E-mail of Executive Director:

E-mail Address of Person Completing This Application:

(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 certified)

(3) List below the name and address of major funding sources

Name	Address	City	State	Zip Code

II. SERVICES PROVIDED:

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

_____ Suicide Prevention Hotline
_____ Rape Crisis Counseling
_____ Teen Hotline
_____ Survivors of Suicide Support Group
_____ Alcoholism Information Service
_____ Sexually Transmitted Disease Info
_____ General Victim Services
_____ Face to Face Counseling
_____ Drop In Center
_____ General Grief Support Groups
_____ Compassionate Friends
_____ Specify Other:

_____ General Crisis Hotline
_____ Child Abuse Counseling
_____ Teen to Teen Hotline
_____ Drug Information Service
_____ Substance Abuse Counseling
_____ Sex Information
_____ Outreach Program
_____ Mental Health I & R
_____ Domestic Violence
_____ Mobile outreach

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:_____

Number of salaried employees with degrees in Mental Health Disciplines (e.g., Ph.D., M.S.W.) _____

Total Number of Volunteers (organizational wide)_________

I have included:

________ A copy of my organization’s active intervention (see definition below) 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:

<u>For new organizations:</u>
$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.

<u>For re-accreditations:</u>
$1500 accreditation fee, 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 $200
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 $350
For organizations with budgets from $500,000 to $749,999 the dues are $450
For organizations with budgets from $750,000 to $999,999 the dues are $550
For organizations with budgets greater than $1,000,000 the dues are $650

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 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, address, phone numbers, email, or URL.

6. We agree to submit the annual self - survey report (located in the appendix of the accreditation manual) to AAS by February 1 unless we have been newly certified or re-certified in the last 6 months of the year or are to be in the first six months of the coming year.

____

Program Director

____

Date

Before proceeding with the application can you answer “yes” that you subscribe to and practice the AAS intervention policy in cases of an involuntary client as highlighted below and as printed in this 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 citizen has the basic right to necessary assistance in life-threatening or other crises. This value reflects the basic philosophy that an active intervention must be done in life threatening situations. Being mindful of the caller/client’s confidentiality and, in some case, anonymity, the intervention would ideally be done with the client’s consent and only after all other options have been exhausted. When that is not possible, the intervention will occur without the client’s consent or knowledge. Some examples of proactive approaches for intervention and support of suicidal clients include: using caller ID, triaging, calling police or ambulance, making follow up calls to suicidal callers and third party callers who are suicidal.”

What is Active Intervention?

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 few years, 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. Thus, in order for a center to be certified by AAS, it must be practicing active intervention throughout its services.

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

The basic tenet of active intervention is that anyone who is suicidal deserves aggressive intervention to keep them alive. Individuals in the throes of 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 certified by AAS must accept this tenet. How, then do 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:

- To use caller ID to locate the caller even when the caller does not want to be located.
- Calling a neighbor or friend 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 say they don’t want help. AAS believes this is 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.

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

Follow-ups
Just because a crisis center has one contact with a suicidal person, who at the call's end has a lowered lethality, does not mean that the job of keeping them safe is over. 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 suicidal 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 suicidal caller alive. In general people, who are suicidal but don't call the hotline, are likely even 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 suicidal intervention and risk assessment. 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.

It is also unfair to expect that the 3rd party caller will welcome being identified to the person at-risk as the one who called about them. That is expecting too much of the caller. Sometimes they will agree but more often not.

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. When the person at-risk complains about what we are doing, asks who called us, or denies being suicidal, we must use all of our skills to get them to realize that we are calling because we care about what happens to them. We can listen to their anger. We can tell them that a friend called about them. We can confront them with the question – "Why do you think your friend thinks you are suicidal? They told us you had given away your boat and bought a gun. Tell me about that."

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

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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 program 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 20 hours of pre-service training offered?		
7. Is there a written plan for screening prospective crisis workers?		
8. Do those with responsibility for the pre-service training have the experience, skills and competence to do so?		
9. Are ongoing supervision 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?		
16. Are there written procedures for actively intervening in life threatening cases? (Please enclose.)		
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.)		