February 16, 2012

Dear Nikki:

Thank you for bringing this concern to our attention. We are happy to provide some initial thoughts.

To begin, it is important to review the basic goals of the Crisis Counseling Program and the various tools that have been developed and used in the implementation. As you know, a major aspect of the service delivery model for the CCP is for crisis counselors to engage in outreach activities, including going door-to-door to identify individuals in need of support or disaster-related services. While conducting outreach, crisis counselors invariably identify individuals in need of more traditional mental health services or who are in imminent danger of harm. Melissa, along with members of her team, have had the opportunity to train counselors in CCP programs in three states in the past month. In discussions with counselors within these programs, a large number have indicated that they had knowledge of suicides occurring in their communities as well as of individuals at risk of harm to self. In fact, one of these suicides actually occurred during one of our trainings. So the fact of the matter is that suicidal risk represents a real problem that crisis counselors must address whether or not they specifically ask questions about possible harm to self or others.

Given that CCP counselors often deal with individuals (adults and children) who are in need of mental health referrals, we were getting the questions from them about when to make a referral. The assessment and referral tools represent a structured and organized method to assist crisis counselors in making appropriate and effective referrals. Let us emphasize that they are NOT asked to make clinical judgments about whether someone is depressed, has PTSD, or an anxiety disorder. Instead, they are asked to count whether certain numbers of items on the referral tool were rated as 3 or 4 by the survivor; and, on this basis, recommend a referral. Our expectations are that a mental health professional will then conduct formal interviews and make clinical judgments about depression, PTSD, etc. There also needed to be a question about suicidal/homicidal risk, highlighting that if a survivor endorsed current threat of harm, “STOP EVERYTHING” and get help (mental health or hotline). We agree with the writer of this email, that a clinical or trained professional should be involved and ask the additional questions to determine the seriousness of the threat and initiate the appropriate course of action. Crisis counselors need to know their limits and need to know what to do when they come across a person at-risk. We don't want crisis counselors going beyond their qualifications - that is precisely why we build in layers of supervision and recommend that these issues be addressed at the appropriate level.

I do have to highlight that this question is in alignment with other SAMHSA programs, including the Suicide Prevention LifeLine program. Please see the attached card http://www.suicidepreventionlifeline.org/App_Files/Media/PDF/NSPL_WalletCard_AssessingRisk_GREEN.pdf that you widely distribute. It says that anyone should ASK and then ACT. If the CCP makes a policy that only licensed mental health professionals can ask questions about threat to self or others, then other SAMHSA programs will need to adjust their policies accordingly. In addition, SAMHSA's strategic plan focuses on child welfare and juvenile justice.

Many individuals working with these populations are high school graduates and not licensed mental health professionals. These efforts include detection of children and families needing additional services. Whether it is the Systems of Care Program or some of the efforts with ACF, there is a movement to help individuals know about risk and then act so that these children and families get qualified help. Making policy for the CCP that only licensed mental health professionals can do this work is again not consistent with the other SAMHSA programs. We would also point out that other public mental health initiatives like National Depression Day also involve screenings by laypersons.

The referral tool and other CCP forms have been existence for the past 10 years. Some of the CCP programs have required the use of these tools. We were able to get the data from Louisiana Spirit. Of the 4,307 adults that filled out the adult tool after Hurricane Katrina, 76 (1.8%) survivors indicated that they had thoughts of suicide and 121 (3%) indicated that they had thoughts of hurting someone else. Of the 818 youth that filled out the form, 29 (3.6%) indicated that they had thoughts of suicide at some point in their life, with 14 (1.7%) reporting a current plan and 24 (2.9%) reporting a previous attempt. 23 (2.8%) youth reported thoughts of hurting others. These data show that the crisis counselors are in contact with individuals at-risk.

These forms have also been used by other community programs (nationally and internationally) and have been supported by major professional organizations such as the American Academy of Child and Adolescent Psychiatry and ISTSS. These tools have been continuously refined since Project Liberty to address the needs of the crisis counselors. The tools were originally created in collaboration between researchers with psychometric expertise, licensed clinical research-practitioners, and clinical directors of the programs in New York City and New York State. Results from initial trials of the adult tool (reliability and validity tests) from programs in New York, Florida, and Baton Rouge Louisiana have been published in peer-reviewed scientific journals, and these articles are available upon request. When talking with the teams, they feel it is important that we provide guidance on these issues and that we help the crisis counselors know how to address such situations.

Given that suicidality is a risk and that crisis counselors are facing this issue, we believe it is vital that we inform and train them in regard to addressing these serious situations. This includes making sure that crisis counselors have basic knowledge about warning signs; that they ask about current concerns and risks; and that they understand their limits and when they need to ACT by having a professional make a further assessment and referral when indicated. I would reframe the question of the writer to ask, aren't we more liable if a suicide occurs because we didn't equip a paraprofessional to ask about current risk even though they are saying that they are dealing with these issues and need guidelines to help them appropriately address these situations.

Please let us know if you have further questions.

Melissa and Fran